FOR BHF USE

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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.

I. IDPH License ID Number: 0051607

Facility Name: Oregon Living & Rehab Center

Address: 811 South 10th St (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 01/01/2016 to 12/31/2016 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) RSM US 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 & Rehab Center # 0051607 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	1,983	156	1,427	3,566	8
9	SNF/PED					9
10	ICF	14,224	5,064	1,237	20,525	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,207	5,220	2,664	24,091	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.29%

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 1,427

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: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number Oregon Living & Rehab Center # 0051607 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	221,624	19,059	4,698	245,381		245,381		245,381			1
2	Food Purchase		160,247		160,247		160,247	(39)	160,208			2
3	Housekeeping	149,293	31,520		180,813		180,813	43	180,856			3
4	Laundry	54,698	6,085		60,783		60,783		60,783			4
5	Heat and Other Utilities			94,266	94,266		94,266	698	94,964			5
6	Maintenance	51,595	6,243	8,281	66,119		66,119	4,811	70,930			6
7	Other (specify):*											7
8	TOTAL General Services	477,210	223,154	107,245	807,609		807,609	5,513	813,122			8
	B. Health Care and Programs											
9	Medical Director			9,900	9,900		9,900		9,900			9
10	Nursing and Medical Records	1,286,605	54,257	7,751	1,348,613		1,348,613	(809)	1,347,804			10
10a	Therapy											10a
11	Activities	77,466	1,732		79,198		79,198		79,198			11
12	Social Services	34,436			34,436		34,436		34,436			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,398,507	55,989	17,651	1,472,147		1,472,147	(809)	1,471,338			16
	C. General Administration											
17	Administrative	78,300		184,509	262,809		262,809	(117,217)	145,592			17
18	Directors Fees											18
19	Professional Services			43,585	43,585		43,585	(3,657)	39,928			19
20	Dues, Fees, Subscriptions & Promotions			21,740	21,740		21,740	(4,119)	17,621			20
21	Clerical & General Office Expenses	106,302		46,538	152,840		152,840	14,722	167,562			21
22	Employee Benefits & Payroll Taxes			274,427	274,427		274,427		274,427			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,559	5,559		5,559	(465)	5,094			24
25	Other Admin. Staff Transportation			8,714	8,714		8,714	1,508	10,222			25
26	Insurance-Prop.Liab.Malpractice			13,303	13,303		13,303	36,733	50,036			26
27	Other (specify):* Mgmt Alloc of Benefit							6,264	6,264			27
28	TOTAL General Administration	184,602		598,375	782,977		782,977	(66,231)	716,746			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,060,319	279,143	723,271	3,062,733		3,062,733	(61,527)	3,001,206			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 & Rehab Center #0051607 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			4,069	4,069		4,069	73,869	77,938			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			113,313	113,313		113,313	164,130	277,443			32
33	Real Estate Taxes							42,692	42,692			33
34	Rent-Facility & Grounds			456,000	456,000		456,000	(456,000)				34
35	Rent-Equipment & Vehicles			233	233		233	654	887			35
36	Other (specify):* Mortgage Insurance							26,959	26,959			36
37	**TOTAL Ownership**			573,615	573,615		573,615	(147,696)	425,919			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		47,052	233,389	280,441		280,441		280,441			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			194,551	194,551		194,551		194,551			42
43	Other (specify):* Non-Allowable Cost			35,925	35,925		35,925	(35,925)				43
44	**TOTAL Special Cost Centers**		47,052	463,865	510,917		510,917	(35,925)	474,992			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,060,319	326,195	1,760,751	4,147,265		4,147,265	(245,148)	3,902,117			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 & Rehab Center # 0051607 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	(215,051)	30		9
10	Interest and Other Investment Income	(21,709)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(25)	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	(1,305)	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	(6,481)	43		24
25	Fund Raising, Advertising and Promotional	(3,275)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(133,660)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (381,506)		$	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)	136,358		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 136,358		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (245,148)		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

Oregon Living & Rehab Center

ID# 0051607

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	X Ray Expense Med A	$ (2,956)	43	1
2	Chamber of Commerce	(659)	20	2
3	Managed Care Costs	(21,883)	43	3
4	Non-Allowable Management Fees	(60,161)	17	4
5	To disallow lobbying expense	(3,521)	20	5
6	Miscellaneous Income against Expense	(33,800)	21	6
7	Disallow out of period travel & seminar	(600)	24	7
8	Disallow marketing consultant	(10,080)	19	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**	(133,660)		49

Facility Name & ID Number Oregon Living & Rehab Center # 0051607 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	6	Maintenance		Oregon Property LLC	100%	3,200	3,200	1
2	V	19	Professional Services	$	Oregon Property LLC	100%	$ 7,570	$ 7,570	2
3	V	26	Insurance-Prop.Liab.Malpractice - Other		Oregon Property LLC	100%	62,599	62,599	3
4	V	30	Depreciation		Oregon Property LLC	100%	287,581	287,581	4
5	V	32	Interest	739	Oregon Property LLC	100%	181,663	180,924	5
6	V	32	Amortization-Mortgage Costs		Oregon Property LLC	100%	4,916	4,916	6
7	V	33	Real Estate Taxes		Oregon Property LLC	100%	38,802	38,802	7
8	V	34	Rent	456,000	Oregon Property LLC	100%		(456,000)	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 456,739			$ 586,331	$ * 129,592	14

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

Facility Name & ID Number Oregon Living & Rehab Center # 0051607 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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%	$ 204	$ 204	15
16	V	3	Housekeeping		SW Financial Services Company	100%	43	43	16
17	V	5	Utilities		SW Financial Services Company	100%	698	698	17
18	V	6	Maintenance		SW Financial Services Company	100%	1,611	1,611	18
19	V	17	Administrative	64,509	SW Financial Services Company	100%	7,453	(57,056)	19
20	V	19	Professional Services		SW Financial Services Company	100%	673	673	20
21	V	20	Dues, Fees, Subs. & Promotions		SW Financial Services Company	100%	61	61	21
22	V	21	Clerical & General Office Expenses		SW Financial Services Company	100%	48,522	48,522	22
23	V	24	Travel & Seminar		SW Financial Services Company	100%	135	135	23
24	V	25	Other Admin. Staff Transportation		SW Financial Services Company	100%	1,508	1,508	24
25	V	26	Insurance-Prop, Liab & Malpractice		SW Financial Services Company	100%	1,093	1,093	25
26	V	27	Other		SW Financial Services Company	100%	6,264	6,264	26
27	V	30	Depreciation		SW Financial Services Company	100%	1,338	1,338	27
28	V	33	Real Estate Taxes		SW Financial Services Company	100%	2,070	2,070	28
29	V	35	Rent - Equipment & Vehicles		SW Financial Services Company	100%	654	654	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			$ 72,327	$ * 7,818	39

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

Facility Name & ID Number Oregon Living & Rehab Center # 0051607 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	$ 7,180	S & E Medical Supply Co.	95%	$ 6,937	$ (243)	15
16	V	10	Medical Supplies	2,394	S & E Medical Supply Co.	95%	1,585	(809)	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			$ 9,574			$ 8,522	$ * (1,052)	39

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

Facility Name & ID Number Oregon Living & Rehab Center # 0051607 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	Prairie Crossing	Shabbona	Supportive Living	1
2	Stuart Milstein	7.33%	Caseyville Nursing and Rehab	Caseyville	Assisted Living		Facility	2
3	Ari Milstein	7.33%			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				6
7	James Wolfe	4.4%	Prairie Crossing Living & Rehab Center, LLC	Shabbona				7
8	Neil Wolfe	4.4%						8
9	Richard Wolfe	4.4%						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			Carriage Square	St. Joseph, MO	White Oak Living	Independence, MO	Residential	15
16			Linn Living & Rehab Center	Linn, MO	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 LI	Caseyville	Real Estate	22
23					Green Acres Property	Amboy	Real Estate	23
24								24
25								25
26					FOM Property LLC	Franklin Grove	Real Estate	26
27					Oregon Property LLC	Oregon	Real Estate	27
28					Prairie Crossing	Shabbona	Real Estate	28
29					Property LLC			29
30								30

Facility Name & ID Number Oregon Living & Rehab Center # 0051607 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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					Carriage Square Prop	St. Joseph, MO	Real Estate	17
18								18
19					Linn Property LLC	Linn, MO	Real Estate	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 & Rehab Center # 0051607 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	See Sch 7A	13.33	33.33	Salary & Fees	$ 59,839	17,3 & 17,7	1
2	David Zuckerman	Owner	Administrative	2.00	See Sch 7B	1	2.22	Salary	3,342	17, 7	2
3	Sheldon Wolfe	Administrative	Administrative	22.00	See Sch 7C	1	2.22	Salary	4,111	17, 7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 67,292		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 & Rehab Center # 0051607 Report Period Beginning: 01/01/2016 Ending: 2/31/2016

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	717,580	13	$ 3,854	$	38,064	$ 204	1
2	3	Housekeeping	Bed Days Available	717,580	13	817		38,064	43	2
3	5	Utilities	Bed Days Available	717,580	13	13,161		38,064	698	3
4	6	Maintenance	Bed Days Available	717,580	13	30,368		38,064	1,611	4
5	19	Professional Services-Legal	Bed Days Available	717,580	13	46		38,064	2	5
6	19	Professional Services-Other	Bed Days Available	717,580	13	12,642		38,064	671	6
7	20	Dues, Fees, Subs. & Promotions	Bed Days Available	717,580	13	1,154		38,064	61	7
8	21	Clerical & General Office Expense	Bed Days Available	717,580	13	748,843	748,843	38,064	39,722	8
9	21	Clerical & General Office Expense	Bed Days Available	717,580	13	165,903		38,064	8,800	9
10	24	Travel & Seminar	Bed Days Available	717,580	13	2,553		38,064	135	10
11	25	Other Admin. Staff Transportion	Bed Days Available	717,580	13	28,429		38,064	1,508	11
12	26	Insurance-Prop, Liab & Malpract	Bed Days Available	717,580	13	20,601		38,064	1,093	12
13	27	Other - Mgmt Allocation of Benefi	Bed Days Available	717,580	13	118,085		38,064	6,264	13
14	33	Real Estate Taxes	Bed Days Available	717,580	13	39,025		38,064	2,070	14
15	35	Rent - Equipment & Vehicles	Bed Days Available	717,580	13	12,328		38,064	654	15
16										16
17	17	Administrative	Avg. Hours Worked	45	13	185,000	185,000	1	4,111	17
18	17	Administrative	Avg. Hours Worked	45	13	150,387	150,387	1	3,342	18
19	30	Depreciation	Direct Cost	25,216	13				1,338	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,533,196	$ 1,084,230		$ 72,327	25

Facility Name & ID Number Oregon Living & Rehab Center # 0051607 Report Period Beginning: 01/01/2016 Ending: 2/31/2016

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			$	$		$ 6,937	1
2	10	Medical Supplies	Direct Cost						1,585	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					$	$		$ 8,522	25

Facility Name & ID Number Oregon Living & Rehab Center # 0051607 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	Lancaster Pollard Mortgage Co		X	Mortgage	23051.32	11/25/13	$ 4,375,700	$ 4,103,845	12/1/40	0.0438	$ 181,663	1
2												2
3												3
4	Amortization of Loan Costs										60,382	4
5												5
	Working Capital											
6	Sheldon Wolfe	X		Working Capital		9/1/11	250,000	164,614	8/31/15	0.0138	4,853	6
7	Albert Milstein	X		Working Capital		9/1/11	250,000	164,614	8/31/15	0.0138	4,853	7
8	See Schedule 9A		X	Working Capital	See Sch 9A	See Sch 9A	1,646,532	1,075,364	See Sch 9A	See Sch 9A	48,140	8
9	TOTAL Facility Related				$23,051.32		$ 6,522,232	$ 5,508,436			$ 299,891	9
	B. Non-Facility Related*											
10												10
11												11
12								Interest Income			(22,448)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (22,448)	14
15	TOTALS (line 9+line14)						$ 6,522,232	$ 5,508,436			$ 277,443	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 26,959 Line # 36

* 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: Oregon Living & Rehab Center
IDPH License ID Number: 0051607
Fiscal Year End: 12/31/2016

Schedule 9A

IX. Interest Expense and Real Estate Tax Expense

	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							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Oregon Associates	X		Working Capital	$10,179.94	12/1/13	896,532	675,364	12/1/23	0.0650	48,140	6
7	MB Financial		X	Line of Credit	Interest Only	1/1/16	750,000	400,000	1/1/18	0.0500		7
8												8
9	TOTAL Facility Related				$10,179.94		$ 1,646,532	$ 1,075,364			$ 48,140	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related				$0.00		$ 0	$ 0			$ 0	14

Facility Name & ID Number Oregon Living & Rehab Center # 0051607 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$ 36,675	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.)	2015	$ 37,177	2
3. Under or (over) accrual (line 2 minus line 1).		$ 502	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 38,300	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$ 1,820	5
	Alloc. Fr. Mgmt Co.	2,070	
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.		$ 42,692	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	36,944	8
	2012	35,535	9
	2013	35,760	10
	2014	35,604	11
	2015	37,177	12

2015 Tax Accrual = $37,177* 1.03 = $38,293.
Use $38,300

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2015	$	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.

2015 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 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	16-04-476-009	Long Term Care Property	$ 37,177.36	$ 37,177.36
2.	10-28-412-049-0000	SW Financial Services Co. Allocation	$ 39,174.84	$ 2,070.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 76,352.20	$ 39,247.36

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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 & Rehab Center # 0051607 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [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 & Rehab Center # 0051607 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	$ 626,346	4
5											5
6	SW Management Allocation		1995		22,106		39	632	632	13,677	6
7											7
8											8
	Improvement Type**										
9	Various			1992	6,160		20			6,160	9
10	Various			1993	26,517		20			26,517	10
11	Various			1994	5,324		20			5,324	11
12	Various			1995	3,498		20			3,498	12
13	Various			1996	2,042		20	100	100	2,042	13
14	Various			1997	2,880		20	144	144	2,820	14
15	Various			1998	65,055		20	3,253	3,253	62,332	15
16	Various			1999	36,058		20	1,803	1,803	32,078	16
17											17
18	Model 10Kpa Code A/R			2001	1,189		20	59	59	916	18
19	Generator Repair			2001	1,010		20	51	51	768	19
20	Motor			2001	783		20	39	39	613	20
21	Glass Thermo Unit			2001	868		20	43	43	672	21
22	Install Board			2001	816		20	41	41	627	22
23	Gas Controller			2001	739		20	37	37	564	23
24	Clutch & Output Brd			2001	1,138		20	57	57	868	24
25	Vinyl Flooring			2001	912		20	46	46	727	25
26											26
27	Air Conditioners			2002	1,470		20	74	74	1,251	27
28	Air Conditioners			2002	1,366		20	68	68	1,103	28
29	Wall-Replaced			2002	5,000		20	250	250	3,646	29
30											30
31	Roof Exhaust Fan			2003	3,128		10			3,128	31
32	Condensor walk - in Freezer			2003	3,193		7			3,193	32
33	Radiator			2003	3,473		10			3,473	33
34	Hot Water Repair			2003	1,610		20	81	81	1,075	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 & Rehab Center # 0051607 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	$	20	$ 793	$ 793	$ 9,908	37
38	Counter tops	2004	4,668		20	233	233	2,916	38
39	Nurses Station	2004	1,290		20	65	65	808	39
40	Basin	2004	7,500		20	375	375	4,688	40
41									41
42	Flooring	2005	3,703		20	185	185	2,129	42
43	Fire Alarm System	2005	1,932		20	97	97	1,112	43
44	Wanderguard	2005	1,632		10			1,632	44
45	Air Conditioners	2005	1,008		10			1,008	45
46									46
47	Vertical Rods with Panic Bars	2006	3,036		20	152	152	1,595	47
48	Smoke Stops-Attic	2006	1,140		20	57	57	599	48
49	Sidewalks	2006	5,106		20	255	255	2,680	49
50	Air Conditioners	2006	5,430		20	272	272	2,852	50
51	Sprinkler System	2006	62,467		20	3,123	3,123	32,794	51
52	Damper Switches - Sprinkler Systems	2006	1,505		20	75	75	790	52
53									53
54	Walk-in Freezer Condensing Unit	2007	6,016		20	301	301	2,857	54
55	Remodel Bathrooms	2009	14,939		20	747	747	5,602	55
56	Glue down carpet	2009	3,287		20	164	164	1,231	56
57									57
58	Rooftop A/C Unit	2010	13,256		20	663	663	4,308	58
59	Patio & Sidewalk	2010	3,575		20	179	179	1,162	59
60									60
61	Flooring	2011	18,785		20	939	939	5,165	61
62	Kitchen Flooring	2011	4,139		20	207	207	1,138	62
63	12 Ton Roof Top HVAC unit	2011	16,250		20	813	813	4,469	63
64	Sidewalk & Driveway	2011	5,550		20	278	278	1,527	64
65	Parking lot seal coating	2011	3,850		10	385	385	1,572	65
66									66
67	Dining Room Flooring	2012	12,629	459	10	1,263	804	4,999	67
68	Install Columns and Rails - Front Porch	2012	7,200	262	10	720	458	2,700	68
69	Parking Lot Lights	2012	10,223	393	20	511	118	2,300	69
70	TOTAL (lines 4 thru 69)		$ 1,441,181	$ 1,114		$ 44,849	$ 43,735	$ 907,956	70

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

Facility Name & ID Number Oregon Living & Rehab Center # 0051607 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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		$ 1,441,181	$ 1,114		$ 44,849	$ 43,735	$ 907,956	1
2									2
3	New Steel Door in Kitchen	2013	4,300	156	10	430	274	1,505	3
4	Water Heater	2013	4,928	179	10	493	314	1,725	4
5	Install 4" drain tile	2013	3,000	109	10	300	191	1,050	5
6									6
7	Water Conditioner-Entire Facility	2014	6,787		20	339	339	904	7
8	Upgrade Nurse Call System-Entire Facility	2014	4,563		10	456	456	988	8
9	Rooftop HVAC	2014	24,053		20	1,203	1,203	2,607	9
10									10
11	Rebuilding shower rooms with new tiles, sinks, lighting, faucets	2015	25,844		20	1,292	1,292	1,938	11
12	in 100 North and 100 South								12
13	Replacing front doors (ADA compliance) and facility sings in	2015	40,218		20	2,011	2,011	3,016	13
14	front of building								14
15	Installing surveillance camera system throughout the building	2015	14,508		5	2,902	2,902	4,353	15
16	Upgrading gas line and meter	2015	3,752		20	188	188	282	16
17	Seal Coating parking lots for the entire parking	2015	4,148		20	207	207	311	17
18	Replacing roof in the garage	2015	4,800		20	240	240	360	18
19	Upgrade call lights from pull to push buttons in all resident rooms	2015	4,828		5	966	966	1,414	19
20									20
21	Electrical for EMR Project	2016	6,044	151	20	201	50	201	21
22	Door alarms	2016	9,890	247	20	288	41	288	22
23	Drainage pipe	2016	8,750	219	20	146	(73)	146	23
24	Sewage lift station	2016	45,165	1,129	20	565	(564)	565	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)		$ 1,656,759	$ 3,304		$ 57,075	$ 53,771	$ 929,608	34

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

Facility Name & ID Number Oregon Living & Rehab Center # 0051607 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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 12B, Carried Forward		$ 1,656,759	$ 3,304		$ 57,075	$ 53,771	$ 929,608	1
2									2
3	Allocated from SW Financial Services Co. - Leasehold Improveme	1995	2,474		20			2,474	3
4	Allocated from SW Financial Services Co. - Leasehold Improveme	1996	412		20	8	8	411	4
5	Allocated from SW Financial Services Co. - Leasehold Improveme	1997	478		20			478	5
6	Allocated from SW Financial Services Co. - Leasehold Improveme	1998	408		20	20	20	383	6
7	Allocated from SW Financial Services Co. - Leasehold Improveme	1999	1,134		20	57	57	968	7
8	Allocated from SW Financial Services Co. - Leasehold Improveme	2005	2,345		20	117	117	1,349	8
9	Allocated from SW Financial Services Co. - Leasehold Improveme	2007	1,328		20	66	66	631	9
10	Allocated from SW Financial Services Co. - Leasehold Improveme	2009	2,772		20	139	139	1,040	10
11	Allocated from SW Financial Services Co. - Leasehold Improveme	2013	1,480		20	74	74	259	11
12	Allocated from SW Financial Services Co. - Leasehold Improveme	2014	1,493		20	75	75	187	12
13	Allocated from SW Financial Services Co. - Leasehold Improveme	2015	306		20	20	20	29	13
14									14
15	Adjust to Financial Statements								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)		$ 1,671,389	$ 3,304		$ 57,651	$ 54,347	$ 937,817	34

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

Facility Name & ID Number Oregon Living & Rehab Center # 0051607 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	$ 186,897	$	$ 12,927	$ 12,927	5-10	$ 82,459	71
72	Current Year Purchases	147,897	765	6,095	5,330	5-20	6,095	72
73	Fully Depreciated Assets	351,510			-		351,510	73
74	Allocated from Mgmt Co	7,265		130	130		6,229	74
75	TOTALS	$ 693,569	$ 765	$ 19,152	$ 18,387		$ 446,293	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	$	$	$ -	5	$ 4,635	76
77	Resident Care	2008 Chevy Van & lift	2007	36,812			-	5	36,812	77
78	Resident Care	2004 Chevy Silverado	2013	11,352		1,135	1,135	10	3,973	78
79	Allocated from Management	2010 Infiniti	2010	3,907			-	5	3,907	79
80	TOTALS			$ 56,706	$ -	$ 1,135	$ 1,135		$ 49,327	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)	$ 2,471,664	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 4,069	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 77,938	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 73,869	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,433,437	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	Allocated from RE Entity	$ 573,612	92
93			93
94			94
95		$ 573,612	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 & Rehab Center # 0051607 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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.	/2017	$
13.	/2018	$
14.	/2019	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 233 Description: Medical Equipment $233
(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.		$	$ 654	17
18					18
19					19
20					20
21	TOTAL		$	$ 654	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 & Rehab Center # 0051607 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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 & Rehab Center # 0051607 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	$	1,404	$ 101,121	$	1,404	$ 101,121	1
2	Licensed Speech and Language Development Therapist	L39, C3	hrs		632	30,319		632	30,319	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L39, C3	hrs		1,593	101,949		1,593	101,949	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				46,472		46,472	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Oxygen	L39, C2					580		580	12
13	Other (specify):									13
14	TOTAL			$	3,629	$ 233,389	$ 47,052	3,629	$ 280,441	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 & Rehab Center # 0051607 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2016 (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	$ 500	$ 500	1
2	Cash-Patient Deposits	7,949	7,949	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 2,626)	1,050,055	1,050,055	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	30,456	68,494	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Schedule 17A	517,755	818,236	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,606,715	$ 1,945,234	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		50,000	13
14	Buildings, at Historical Cost		1,030,986	14
15	Leasehold Improvements, at Historical Cost	51,453	640,403	15
16	Equipment, at Historical Cost	101,943	750,275	16
17	Accumulated Depreciation (book methods)	(65,041)	(1,433,437)	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 Goodwill	610,132	610,132	22
23	Other(specify): CIP		573,612	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 698,487	$ 2,221,971	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,305,202	$ 4,167,205	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 226,928	$ 161,981	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	19,217	19,217	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	81,727	81,727	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,006	7,006	31
32	Accrued Real Estate Taxes(Sch.IX-B)		38,300	32
33	Accrued Interest Payable	203	15,182	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	133,057	133,057	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 468,138	$ 456,470	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,404,591	5,508,436	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)**	$ 1,404,591	$ 5,508,436	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,872,729	$ 5,964,906	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 432,473	$ (1,797,701)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,305,202	$ 4,167,205	48

***(See instructions.)**

Facility Name: **Oregon Living & Rehab Center**
IDPH License ID Number: **0051607**
Fiscal Year End: **12/31/2016**

Schedule 17A

XV. Balance Sheet
Line 9 Current Assets Other (specify):

Description	Operating	After Consolidation
Due from State-Interest	117,153	117,153
Escrow-Replacement Reserve		175,409
Escrow-Repairs		168,164
Escrow-Insurance		25,293
Escrow-RE Taxes		13,262
Escrow-MIP		833
Employee Payroll Advance	766	766
Reimbursement Due	15,773	15,773
Short Term Loan Exchange	600	600
Loan Costs		132,725
Accum Amortization-Loan Costs		(15,156)
Due t/f Operations		(152,003)
Due to Oregon Property	381,211	333,165
Due to Oregon Associates-Old	2,252	2,252
Total - Line 9	**517,755**	**818,236**

XV. Balance Sheet
Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
Insurance Premiums Payable	20,913	20,913
Acc Retirement (From P/R)	(150)	(150)
Accrued Expenses	112,846	112,846
Due to Public Aid	(552)	(552)
Total - Line 36	**133,057**	**133,057**

Facility Name & ID Number Oregon Living & Rehab Center # 0051607 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 410,815	1
2	Restatements (describe):		2
3	**Prior Period Adjustment**	(1,104)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 409,711	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	21,909	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	853	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)**	$ 22,762	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)**	$ 432,473	24 *

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

Facility Name & ID Number Oregon Living & Rehab Center # 0051607 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	$ 3,986,815	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,986,815	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	118,240	6
7	Oxygen	3,310	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 121,550	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***	21,709	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 21,709	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Medicaid Income Adjustments	39,100	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 39,100	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,169,174	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	807,609	31
32	Health Care	1,472,147	32
33	General Administration	782,977	33
	B. Capital Expense		
34	Ownership	573,615	34
	C. Ancillary Expense		
35	Special Cost Centers	316,366	35
36	Provider Participation Fee	194,551	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,147,265	40
41	**Income before Income Taxes (line 30 minus line 40)****	21,909	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 21,909	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,267,690	44
45	Private Pay - Net Inpatient Revenue	1,033,423	45
46	Medicare - Net Inpatient Revenue	666,213	46
47	Other-(specify) Hospice	19,489	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,986,815	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 & Rehab Center # 0051607 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	2,032	2,080	$ 65,710	$ 31.59	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,292	9,814	251,389	25.62	3
4	Licensed Practical Nurses	10,944	11,317	271,876	24.02	4
5	CNAs & Orderlies	56,268	57,408	697,630	12.15	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	7,276	7,668	77,466	10.10	10
11	Social Service Workers	1,952	2,080	34,436	16.56	11
12	Dietician					12
13	Food Service Supervisor	1,951	2,137	49,357	23.10	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,372	18,007	172,267	9.57	15
16	Dishwashers					16
17	Maintenance Workers	3,920	4,153	51,595	12.42	17
18	Housekeepers	14,012	14,798	149,293	10.09	18
19	Laundry	5,394	5,715	54,698	9.57	19
20	Administrator	1,992	2,080	78,300	37.64	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,835	5,154	106,302	20.63	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 Ca					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	137,240	142,411	$ 2,060,319 *	$ 14.47	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	$ 4,698	L1, C3	35
36	Medical Director	Monthly	9,900	L9, C3	36
37	Medical Records Consultant	Monthly	1,266	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,485	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 22,349		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 & Rehab Center # 0051607 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Magdalene Niemi	Administrator	0	$ 78,300
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 78,300

B. Administrative - Other

Description	Amount
Moshe Herman / Momentum Healthcare, LLC	$ 120,000
(Eliminated on Sch. V, Col. 7)	64,509
SW Financial Services Fees (Eliminated on Sch. V, Col. 7)	
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
Field and Goldberg, LLC	Legal	$ 958
Skidelsky &Associates	Legal	1,820
RSM US LLP	Accounting	19,640
HK Payroll Services Co	Payroll	3,633
Klein Consulting	Marketing Consultant	10,080
Personnel Planners Inc	Unemployment	360
Solus LLC	Computer Consultant	7,094
See SCH 21C		
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 43,585

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 49,935
Unemployment Compensation Insurance	13,110
FICA Taxes	153,117
Employee Health Insurance	54,485
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Miscellaneous Employee Benefits	2,602
Holiday Expense	204
Employee Life Insruance	1,087
Tuition Reimbursement	(113)
TOTAL (agree to Schedule V, line 22, col.8)	$ 274,427

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	$ 3,980
Advertising: Employee Recruitment	
Health Care Worker Background Check	2,544
(Indicate # of checks performed 212)	
Patient Background Checks	
Illinois Council on Long Term Care	10,670
Miscellaneous Dues & Permits	1,405
Miscellaneous Inspections & Licenses	3,141
Allocated from Management Co.	61
Less: Lobbying & Chamber of Commerce	(659)
Less: Public Relations Expense	(3,521)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,621

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,959
Allocated from Home Office	135
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,094

* Attach copy of IMRF notifications

**See instructions.

Facility Name: **Oregon Living & Rehab Center**
IDPH License ID Number: **0051607**
Fiscal Year End: **12/31/2016**

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
From Page 21 Section C		43,585
	Total (agree to Schedule V, line 19, column 3)	43,585
Allocated from Management Company	Legal Fees	2
Allocated from Management Company	Professional Services	671
Allocated from Real Estate	Professional Services	7,570
Disallow Marketing Consultant		(10,080)
Reclass Real Estate Tax Assesment		(1,820)
	Total (agree to Schedule V, line 19, column 8)	39,928

Facility Name & ID Number Oregon Living & Rehab Center # 0051607 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Council on Long Term Care-$10,670**

(3) Did the nursing home make political contributions or payments to a politica
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? **5-20 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **11,160** 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 fo
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 Departmen
during this cost report period. $ **194,551**
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 tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
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. $ **N/A** 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 fo
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
out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility?
See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees