		FOR BHF USE				

LL1

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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	PROPRIETARY	GOVERNMENTAL
[ ] 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 1/1/2020 to 12/31/2020 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: 1/1/2020 Ending: 12/31/2020

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	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	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	0	126	2,924	3,050	8
9	SNF/PED					9
10	ICF	16,605	2,905	829	20,339	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,605	3,031	3,753	23,389	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 61.45%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve 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 2,924

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: 12/31/2020 Fiscal Year: 12/31/2020

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

Facility Name & ID Number: Oregon Living Rehab Center # 0051607 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	239,699	31,066	4,844	275,609		275,609		275,609			1
2	Food Purchase		185,261		185,261		185,261	122	185,383			2
3	Housekeeping	132,706	57,261	-	189,967		189,967	10	189,977			3
4	Laundry	53,993	8,604	-	62,597		62,597		62,597			4
5	Heat and Other Utilities			105,149	105,149		105,149	797	105,946			5
6	Maintenance	75,871	50,818	24,185	150,874		150,874	1,433	152,307			6
7	Other (specify):*	-	-	-								7
8	**TOTAL General Services**	502,269	333,010	134,178	969,457		969,457	2,362	971,819			8
	B. Health Care and Programs											
9	Medical Director	-	-	-								9
10	Nursing and Medical Records	1,755,360	114,251	1,629	1,871,240		1,871,240	19,326	1,890,566			10
10a	Therapy	-	-	-								10a
11	Activities	123,055	4,932	-	127,987		127,987		127,987			11
12	Social Services	29,236	-	-	29,236		29,236		29,236			12
13	CNA Training	-	-	-								13
14	Program Transportation	-	-	-								14
15	Other (specify):*	-	-	-								15
16	**TOTAL Health Care and Programs**	1,907,651	119,183	1,629	2,028,463		2,028,463	19,326	2,047,789			16
	C. General Administration											
17	Administrative	92,100	-	212,244	304,344		304,344	(143,573)	160,771			17
18	Directors Fees			-								18
19	Professional Services			32,690	32,690		32,690	11,561	44,251			19
20	Dues, Fees, Subscriptions & Promotions			30,924	30,924		30,924	(5,872)	25,052			20
21	Clerical & General Office Expenses	128,211	-	60,965	189,176		189,176	45,527	234,703			21
22	Employee Benefits & Payroll Taxes			326,427	326,427		326,427		326,427			22
23	Inservice Training & Education			-								23
24	Travel and Seminar			775	775		775	277	1,052			24
25	Other Admin. Staff Transportation		-	30,721	30,721		30,721	295	31,016			25
26	Insurance-Prop.Liab.Malpractice			129,490	129,490		129,490	90,231	219,721			26
27	Other (specify):* Mgmt Alloc of Benefits			-				13,779	13,779			27
28	**TOTAL General Administration**	220,311		824,236	1,044,547		1,044,547	12,225	1,056,772			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,630,231	452,193	960,043	4,042,467		4,042,467	33,913	4,076,380			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.

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			242,075	242,075		242,075	268,788	510,863			30
31	Amortization of Pre-Op. & Org.			-								31
32	Interest			262,781	262,781		262,781	168,911	431,692			32
33	Real Estate Taxes			54,032	54,032		54,032	56,524	110,556			33
34	Rent-Facility & Grounds			-				(600,000)	(600,000)			34
35	Rent-Equipment & Vehicles			-				719	719			35
36	Other (specify):* Mortgage Insurance			-				24,266	24,266			36
37	TOTAL Ownership			558,888	558,888		558,888	(80,792)	478,096			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	-	-	-								38
39	Ancillary Service Centers	-	101,946	344,786	446,732		446,732		446,732			39
40	Barber and Beauty Shops	-	-	-								40
41	Coffee and Gift Shops	-	-	-								41
42	Provider Participation Fee			184,797	184,797		184,797		184,797			42
43	Other (specify):* Non-Allowable Cos	-	-	61,689	61,689		61,689	(61,204)	485			43
44	TOTAL Special Cost Centers		101,946	591,272	693,218		693,218	(61,204)	632,014			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,630,231	554,139	2,110,203	5,294,573		5,294,573	(108,083)	5,186,490			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: 1/1/2020 Ending: 12/31/2020

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	25,454	30		9
10	Interest and Other Investment Income	(537)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(284)	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	(29,181)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(757)	43		24
25	Fund Raising, Advertising and Promotional	(17,964)	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 PG5A	(82,526)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (105,795)		$	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)	(2,288)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (2,288)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (108,083)		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 Rehab Center

ID# 0051607

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Lab Expense - Med A	$ (3,283)	43	1
2	X-ray Expense	(3,211)	43	2
3	Managed Care Costs	(6,524)	43	3
4	Disallow chamber of commerce fees	(186)	20	4
5	Non-Allowable Management Fees	(61,162)	17	5
6	Lobbying Fees	(7,675)	20	6
7	State replacement tax	(485)	43	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
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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**	(82,526)		49

Facility Name & ID Number Oregon Living Rehab Center # 0051607 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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 Services	$	Oregon Property LLC	100%	$ 8,515	$ 8,515	1
2	V	26	Insurance-Prop.Liab.Malpractice - Other		Oregon Property LLC	100%	113,325	113,325	2
3	V	30	Depreciation		Oregon Property LLC	100%	240,353	240,353	3
4	V	32	Interest	439	Oregon Property LLC	100%	163,513	163,074	4
5	V	33	Real Estate Taxes		Oregon Property LLC	100%	54,032	54,032	5
6	V	34	Rent	600,000	Oregon Property LLC	100%		(600,000)	6
7	V	21	Bank service charges		Oregon Property LLC	100%	25	25	7
8	V	43	Penalities and State Replacement Tax		Oregon Property LLC	100%	485	485	8
9	V	20	Licenses		Oregon Property LLC	100%	75	75	9
10	V	32	Amortization		Oregon Property LLC	100%	6,374	6,374	10
11	V								11
12	V								12
13	V								13
14	Total			$ 600,439			$ 586,697	$ * (13,742)	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: 1/1/2020 Ending: 12/31/2020

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	Food	$	SW Financial Services Company	100%	$ 122	$ 122	15
16	V	3	Housekeeping		SW Financial Services Company	100%	10	10	16
17	V	5	Utilities		SW Financial Services Company	100%	797	797	17
18	V	6	Maintenance		SW Financial Services Company	100%	1,433	1,433	18
19	V	17	Administrative	92,244	SW Financial Services Company	100%	9,833	(82,411)	19
20	V	19	Professional Services		SW Financial Services Company	100%	3,046	3,046	20
21	V	20	Dues, Fees, Subscriptions & Promotions		SW Financial Services Company	100%	1,914	1,914	21
22	V	21	Clerical & General Office Expenses		SW Financial Services Company	100%	64,828	64,828	22
23	V	24	Travel & Seminar		SW Financial Services Company	100%	277	277	23
24	V	25	Other Admin. Staff Transportation		SW Financial Services Company	100%	295	295	24
25	V	26	Insurance-Prop, Liab & Malpractice		SW Financial Services Company	100%	1,172	1,172	25
26	V	27	Other		SW Financial Services Company	100%	13,779	13,779	26
27	V	30	Depreciation		SW Financial Services Company	100%	2,981	2,981	27
28	V	33	Real Estate Taxes		SW Financial Services Company	100%	2,492	2,492	28
29	V	35	Rent - Equipment & Vehicles		SW Financial Services Company	100%	719	719	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			$ 92,244			$ 103,698	$ * 11,454	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: 1/1/2020 Ending: 12/31/2020

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 Compa	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%	Tower Hill Rehabilitation, LLC	South Elgin				7
8	Neil Wolfe	4.4%			Groves Community	Independence, MO	Hospice	8
9	Richard Wolfe	4.4%			Hospice			9
10	Robin Krystal	4.0%	Beauvais Manor Healthcare and Rehab	St. Louis, MO	Forest View Senior	Independence, MO	Independent	10
11	David Zuckerman	2.0%	Hillside Manor Healthcare and Rehab	St. Louis, MO	Residences		Living	11
12			Rancho Manor Healthcare and Rehab	Florissant, MO	White Oak Living	Independence, MO	Residential	12
13			Rosewood Health & Rehab	Independence, MO	Center		Care	13
14			Seasons Care Center	Kansas City, MO				14
15			Carriage Square	St. Joseph, MO	Seasons Day Services	Kansas City, MO	Adult Day Care	15
16					Program LLC			16
17								17
18					Cahokia Building LLC	Cahokia	Real Estae	18
19					Caseyville Property LI	Caseyville	Real Estate	19
20					Green Acres Property	Amboy	Real Estate	20
21					LLC			21
22								22
23					FOM Property LLC	Franklin Grove	Real Estate	23
24					Oregon Property LLC	Oregon	Real Estate	24
25					Prairie Crossing	Shabbona	Real Estate	25
26					Property LLC			26
27								27
28					Tower Hill Property LI	South Elgin	Real Estate	28
29								29
30								30

Facility Name & ID Number: Oregon Living Rehab Center # 0051607 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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 Prope	St. Joseph, MO	Real Estate	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 Rehab Center # 0051607 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	Moshe Herman	Owner	Administrative	50	See Sch 7C	15	33.33%	Salary & fees	$ 63,171	17,3 & 17,7	1
2	David Zuckerman	Owner	Administrative	2	See Sch 7B	1.25	2.8%	Salary	5,139	17, 7	2
3	Sheldon Wolfe	Administrative	Administrative	22	See Sch 7A	1.25	2.8%	Salary	361	17, 7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 68,671		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: 1/1/2020 Ending: 2/31/2020

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	678,198	12	$ 2,175	$	38,064	$ 122	1
2	3	Housekeeping	Bed Days Available	678,198	12	179		38,064	10	2
3	5	Utilities	Bed Days Available	678,198	12	14,206		38,064	797	3
4	6	Maintenance	Bed Days Available	678,198	12	25,536		38,064	1,433	4
5	19	Professional Services-Legal	Bed Days Available	678,198	12	29,559		38,064	1,659	5
6	19	Professional Services-Other	Bed Days Available	678,198	12	24,713		38,064	1,387	6
7	20	Dues, Fees, Subscriptions & Promo	Bed Days Available	678,198	12	34,103		38,064	1,914	7
8	21	Clerical & General Office Expense	Bed Days Available	678,198	12	962,284	962,284	38,064	54,008	8
9	21	Clerical & General Office Expense	Bed Days Available	678,198	12	192,782		38,064	10,820	9
10	24	Travel & Seminar	Bed Days Available	678,198	12	4,935		38,064	277	10
11	25	Other Admin. Staff Transportion	Bed Days Available	678,198	12	5,250		38,064	295	11
12	26	Insurance-Prop, Liab & Malpracti	Bed Days Available	678,198	12	20,882		38,064	1,172	12
13	27	Other - Mgmt Allocation of Benefit	Bed Days Available	678,198	12	245,503		38,064	13,779	13
14	33	Real Estate Taxes	Bed Days Available	678,198	12	44,398		38,064	2,492	14
15	35	Rent - Equipment & Vehicles	Bed Days Available	678,198	12	12,804		38,064	719	15
16										16
17	17	Administrative	Avg. Hours Worked	45	12	13,000	13,000	1	361	17
18	17	Administrative	Avg. Hours Worked	45	12	185,000	185,000	1	5,139	18
19	17	Administrative	Avg. Hours Worked	45	3	13,000	13,000	15	4,333	19
20	30	Depreciation	Direct Cost	53,119					2,981	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,830,309	$ 1,173,284		$ 103,698	25

Facility Name & ID Number Oregon Living Rehab Center # 0051607 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	Lancaster Pollard Mortgage Co.		X	Mortgage	23,051.32	11/25/13	$ 4,375,700	$ 3,681,201	12/1/40	0.0438	$ 163,513	1
2												2
3												3
4	Amortization of Loan Costs										61,841	4
5												5
	Working Capital											
6	Sheldon Wolfe	X		Working Capital		9/1/2011	250,000	172,052	8/31/2021	0.0036	617	6
7	Albert Milstein	X		Working Capital		9/1/2011	250,000	172,052	8/31/2021	0.0036	617	7
8	See Schedule 9A		X	Working Capital	See Sch 9A	See Sch 9A	2,284,082	969,695	See Sch 9A	See Sch 9A	36,239	8
9	TOTAL Facility Related				$23,051.32		$ 7,159,782	$ 4,994,999			$ 262,827	9
	B. Non-Facility Related*											
10												10
11								Credit card charges			(46)	11
12								Interest Income Offset			(976)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,022)	14
15	TOTALS (line 9+line14)						$ 7,159,782	$ 4,994,999			$ 261,805	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 24,266 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: 12/31/2020

Schedule 9A

IX. Interest Expense and Real Estate Tax Expense

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1												1
2												2
3												3
4												4
5												5
	Working Capital											
6	SBA-PPP Loan		X	Payroll & Oper Exp	None	4/28/20	479,730	479,730	4/28/22	0.0100	-	6
7	Wisconsin Physician Services		X	MCR Advance Payments	$6,575.83	4/30/20	157,820	157,820	4/30/22	0.0000	-	7
8	M B Financial		X	Line of Credit	Interest Only	02/10/12	750,000	-	02/10/20	0.0425	10,805	
9	Oregon Associates	X		Working Capital	$10,179.94	12/1/13	$ 896,532	$ 332,145	12/1/23	0.0650	$ 25,434	8
10	TOTAL Facility Related				$16,755.77		$ 2,284,082	$ 969,695			$ 36,239	9
	B. Non-Facility Related*											
11												10
12												11
13												12
14												13
15	TOTAL Non-Facility Related				$0.00		$ -	$ -			$ -	14

Facility Name & ID Number Oregon Living Rehab Center # 0051607 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

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

Item		Amount	Line
1. Real Estate Tax accrual used on 2019 report.		$ 51,300	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.)	2019	$ 53,232	2
3. Under or (over) accrual (line 2 minus line 1).		$ 1,932	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 52,100	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
	Alloc. Fr. Mgmt. Co.	2,492	
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.		$ 56,524	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

Year	Amount	Line
2015	37,177	8
2016	48,168	9
2017	50,362	10
2018	50,571	11
2019	53,232	12

2020 Tax Accrual = 53,232.14 * 1.03 = $52,088.40
Use $52,100

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	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.

2019 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 2019 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 2019.

	(A)	(B)	(C)	(D)
	Tax Index Number	**Property Description**	**Total Tax**	**Tax Applicable to Nursing Home**
1.	16-04-476-009	Long Term Care Property	$ 53,232.14	$ 53,232.14
2.	10-28-412-049-0000	SW Financial Services Co. Allocation	$ 44,397.67	$ 2,492.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 97,629.81	$ 55,724.14

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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.

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	2	3	4	
	Use	Square Feet	Year Acquired	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: 1/1/2020 Ending: 12/31/2020

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	$ 727,234	4
5											5
6	SW Management Allocation		1995		24,293		39	694	694	17,804	6
7											7
8											8
	Improvement Type**										
9	Various			1992	6,160		20			6,160	9
10	Various			1993	26,518		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			2,042	13
14	Various			1997	2,880		20			2,880	14
15	Various			1998	65,055		20			65,055	15
16	Various			1999	36,058		20			36,058	16
17											17
18	Model 10Kpa Code A/R			2001	1,189		20	59	59	1,153	18
19	Generator Repair			2001	1,010		20	51	51	970	19
20	Motor			2001	783		20	39	39	769	20
21	Glass Thermo Unit			2001	868		20	43	43	846	21
22	Install Board			2001	816		20	41	41	790	22
23	Gas Controller			2001	739		20	37	37	711	23
24	Clutch & Output Brd			2001	1,138		20	57	57	1,096	24
25	Vinyl Flooring			2001	912		20	46	46	909	25
26											26
27	Air Conditioners			2002	1,470		20			1,470	27
28	Air Conditioners			2002	1,366		20	58	58	1,366	28
29	Wall-Replaced			2002	5,000		20	250	250	4,646	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	1,397	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

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	$ 13,078	37
38	Counter tops	2004	4,668		20	233	233	3,850	38
39	Nurses Station	2004	1,290		20	65	65	1,066	39
40	Basin	2004	7,500		20	375	375	6,188	40
41									41
42	Flooring	2005	3,703		20	185	185	2,869	42
43	Fire Alarm System	2005	1,932		20	97	97	1,499	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	2,202	47
48	Smoke Stops-Attic	2006	1,140		20	57	57	827	48
49	Sidewalks	2006	5,106		20	255	255	3,701	49
50	Air Conditioners	2006	5,430		20	272	272	3,938	50
51	Sprinkler System	2006	62,467		20	3,123	3,123	45,288	51
52	Damper Switches - Sprinkler Systems	2006	1,505		20	75	75	1,091	52
53									53
54	Walk-in Freezer Condensing Unit	2007	6,016		20	301	301	4,061	54
55	Remodel Bathrooms	2009	14,939		20	747	747	8,590	55
56	Glue down carpet	2009	3,287		20	164	164	1,887	56
57									57
58	Rooftop A/C Unit	2010	13,256		20	663	663	6,959	58
59	Patio & Sidewalk	2010	3,575		20	179	179	1,877	59
60									60
61	Flooring	2011	18,785		20	939	939	8,921	61
62	Kitchen Flooring	2011	4,139		20	207	207	1,966	62
63	12 Ton Roof Top HVAC unit	2011	16,250		20	813	813	7,719	63
64	Sidewalk & Driveway	2011	5,550		20	278	278	2,637	64
65	Parking lot seal coating	2011	3,850		10	385	385	3,112	65
66									66
67	Dining Room Flooring	2012	12,629	415	10	1,263	848	10,051	67
68	Install Columns and Rails - Front Porch	2012	7,200	237	10	720	483	5,580	68
69	Parking Lot Lights	2012	10,223	302	20	511	209	4,344	69
70	TOTAL (lines 4 thru 69)		$ 1,443,369	$ 954		$ 39,527	$ 38,573	$ 1,074,429	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: 1/1/2020 Ending: 12/31/2020

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		$ 1,443,369	$ 954		$ 39,527	$ 38,573	$ 1,074,429	1
2									2
3	New Steel Door in Kitchen	2013	4,300	142	10	430	288	3,225	3
4	Water Heater	2013	4,928	163	10	493	330	3,696	4
5	Install 4" drain tile	2013	3,000	99	10	300	201	2,250	5
6									6
7	Water Conditioner-Entire Facility	2014	6,787		20	339	339	2,260	7
8	Upgrade Nurse Call System-Entire Facility	2014	4,563		10	456	456	2,812	8
9	Rooftop HVAC	2014	24,053		20	1,203	1,203	7,419	9
10									10
11	Rebuilding shower rooms with new tiles, sinks, lighting, faucets	2015	25,844		20	1,292	1,292	7,107	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	11,060	13
14	front of building								14
15	Installing surveillance camera system throughout the building	2015	14,508		5	1,451	1,451	14,508	15
16	Upgrading gas line and meter	2015	3,752		20	188	188	1,032	16
17	Seal Coating parking lots for the entire parking	2015	4,148		20	207	207	1,141	17
18	Replacing roof in the garage	2015	4,800		20	240	240	1,320	18
19	Upgrade call lights from pull to push buttons in all resident rooms	2015	4,828		5	517	517	4,828	19
20									20
21	Electrical for EMR Project	2016	6,044		20	302	302	1,410	21
22	Door alarms	2016	9,890		20	495	495	2,266	22
23	Drainage pipe	2016	8,750		20	438	438	1,896	23
24	Sewage lift station	2016	45,165		20	2,258	2,258	9,598	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)		$ 1,658,947	$ 1,358		$ 52,147	$ 50,789	$ 1,152,256	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: 1/1/2020 Ending: 12/31/2020

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		$ 1,658,947	$ 1,358		$ 52,147	$ 50,789	$ 1,152,256	1
2									2
3	Construction Draws 1 thru 10								3
4	Interior Lounge Expansion & Conversion	2017	14,238		20	712	712	2,492	4
5	Existing Dining Renovation & Expansion	2017	84,515		20	4,226	4,226	14,790	5
6	New PT Addition	2017	251,788		20	12,586	12,586	44,063	6
7	Site Improvements & New Patio	2017	50,424		20	2,521	2,521	8,824	7
8	New Dining/Activity Addition	2017	153,439		20	7,672	7,672	26,852	8
9	Miscellaneous	2017	25,155		20	1,258	1,258	4,400	9
10	(Draw #1-$82,667, Draw #2-$35,384, Draw #3-$58,195.25,								10
11	Draw #4-$87,152, Draw #5-$51,740, Draw #6-$50,610,								11
12	Draw #7-$64,148.67, Draw #8-$8,823.18, Draw #9-$54,335,								12
13	Draw #10-$86,504.22)								13
14									14
15	Magnetic power lock, key pads, power supply controller & fire	2017	6,266		20	313	313	1,097	15
16	alarm interface relay-Alzheimer's wing inside hall door &								16
17	exiting outside door								17
18	Rewire generator panel	2017	2,611		20	131	131	457	18
19	Install Lift station and phone emergency line for lift	2017	8,363		20	418	418	1,462	19
20	Electric Heating-Rooftop	2018	2,510		20	126	126	315	20
21	Water Heater-Mechanical Room	2018	13,580		20	679	679	1,698	21
22	20 PTAC Units- 10th street MOE Herman, Oregon, IL	2018	10,880		5	2,177	2,177	3,808	22
23									23
24	Plumbing work to regulate hot water in resident rooms	2020	6,480	189	20	162	(27)	162	24
25								-	25
26	Upgrading corridors with handrails, wall protection, skim coating,	2020	88,868		20	2,222	2,222	2,222	26
27	Generator	2020	57,162		20	1,429	1,429	1,429	27
28	Seal blacktop, fill cracks, striping	2020	4,020		20	101	101	101	28
29	Labor and materials to repair soffitt, fascia and install gutters and	2020	12,014		20	300	300	300	29
30								-	30
31								-	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,451,260	$ 1,547		$ 89,179	$ 87,632	$ 1,266,725	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: 1/1/2020 Ending: 12/31/2020

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 12C, Carried Forward		$ 2,451,260	$ 1,547		$ 89,179	$ 87,632	$ 1,266,725	1
2									2
3	Allocated from SW Financial Services Co. - Leasehold Improvemen	1995	2,719		20			2,719	3
4	Allocated from SW Financial Services Co. - Leasehold Improvemen	1996	453		20			453	4
5	Allocated from SW Financial Services Co. - Leasehold Improvemen	1997	525		20			525	5
6	Allocated from SW Financial Services Co. - Leasehold Improvemen	1998	449		20			449	6
7	Allocated from SW Financial Services Co. - Leasehold Improvemen	1999	1,246		20			1,246	7
8	Allocated from SW Financial Services Co. - Leasehold Improvemen	2005	2,578		20	129	129	1,998	8
9	Allocated from SW Financial Services Co. - Leasehold Improvemen	2007	1,459		20	73	73	985	9
10	Allocated from SW Financial Services Co. - Leasehold Improvemen	2009	3,046		20	152	152	1,752	10
11	Allocated from SW Financial Services Co. - Leasehold Improvemen	2013	1,627		20	81	81	610	11
12	Allocated from SW Financial Services Co. - Leasehold Improvemen	2014	1,641		20	82	82	533	12
13	Allocated from SW Financial Services Co. - Leasehold Improvemen	2015	337		20	22	22	123	13
14									14
15									15
16	To reconcile to book depreciation			175			(175)		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)		$ 2,467,340	$ 1,722		$ 89,718	$ 87,996	$ 1,278,118	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: 1/1/2020 Ending: 12/31/2020

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	$ 1,550,780	$	$ 178,796	$ 178,796	5-20	$ 1,248,749	71
72	Current Year Purchases	9,966		249	249	5-20	249	72
73	Fully Depreciated Assets							73
74	Allocated from Management Co.	10,803		557	557	5-20	8,421	74
75	TOTALS	$ 1,571,548	$	$ 179,602	$ 179,602		$ 1,257,419	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	2008 Chevy Van	2008	$ 31,512	$ -	$ -	$	10	$ 31,512	76
77										77
78										78
79	Allocated from Management (	2017 Land Rover Evoque	2017	5,950	-	1,190	1,190	5	4,165	79
80	TOTALS			$ 37,462	$	$ 1,190	$ 1,190		$ 35,677	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)	$ 4,126,350	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 1,722	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 270,510	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 268,788	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,571,214	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.

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.	/2021	$
13.	/2022	$
14.	/2023	$

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: $ N/A Description:
(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.		$	$ 719	17
18					18
19					19
20					20
21	TOTAL		$	$ 719	21

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

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

Facility Name & ID Number Oregon Living Rehab Center # 0051607 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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.

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	$	2,320	$ 167,028	$	2,320	$ 167,028	1
2	Licensed Speech and Language Development Therapist	L39, C3	hrs		633	30,385		633	30,385	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L39, C3	hrs		2,303	147,373		2,303	147,373	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				101,946		101,946	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			$	5,256	$ 344,786	$ 101,946	5,256	$ 446,732	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:** **1/1/2020** **Ending:** **12/31/2020**

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** **12/31/2020** **(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	$ 791,203	$ 873,759	1
2	Cash-Patient Deposits	43,228	43,228	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 20,638)	975,308	975,308	3
4	Supply Inventory (priced at)	-	-	4
5	Short-Term Investments	-	-	5
6	Prepaid Insurance	60,652	93,700	6
7	Other Prepaid Expenses	-	-	7
8	Accounts Receivable (owners or related parties)	-	-	8
9	Other(specify): See Schedule 17A	929,515	1,210,275	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,799,906	$ 3,196,270	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	-	-	11
12	Long-Term Investments	-	-	12
13	Land	104,000	154,000	13
14	Buildings, at Historical Cost	1,976,000	3,009,173	14
15	Leasehold Improvements, at Historical Cost	1,073,087	2,449,321	15
16	Equipment, at Historical Cost	1,569,352	3,107,365	16
17	Accumulated Depreciation (book methods)	(2,601,805)	(5,079,162)	17
18	Deferred Charges	-	-	18
19	Organization & Pre-Operating Costs	-	-	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(45,267)	(45,267)	20
21	Restricted Funds	-	-	21
22	Other Long-Term Assets (spe Goodwill	388,246	388,246	22
23	Other(specify):	-	-	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,463,613	$ 3,983,676	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,263,519	$ 7,179,946	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 131,271	$ 131,271	26
27	Officer's Accounts Payable	-	-	27
28	Accounts Payable-Patient Deposits	54,366	54,366	28
29	Short-Term Notes Payable	3,681,201	3,681,201	29
30	Accrued Salaries Payable	34,710	34,710	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,749	4,749	31
32	Accrued Real Estate Taxes(Sch.IX-B)	52,100	104,200	32
33	Accrued Interest Payable	15,234	28,669	33
34	Deferred Compensation	-	-	34
35	Federal and State Income Taxes	-	-	35
	Other Current Liabilities(specify):			
36	See Schedule 17A	1,255,211	617,661	36
37		176,187	176,187	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,405,029	$ 4,833,014	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	676,248	4,994,999	39
40	Mortgage Payable	(132,725)	(132,725)	40
41	Bonds Payable	-	-	41
42	Deferred Compensation	-	-	42
	Other Long-Term Liabilities(specify):			
43	Prior Owner Balance	1,178	1,178	43
44		-	-	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 544,701	$ 4,863,452	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,949,730	$ 9,696,466	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 592,343	$ (2,516,519)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,542,073	$ 7,179,946	48

***(See instructions.)**

Facility Name: **Oregon Living Rehab Center**
IDPH License ID Number: **0051607**
Fiscal Year End: **12/31/2020**

Schedule 17A

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

Description	Operating	After Consolidation
Due From State - Interest	135,717	135,717
Escrow - Replacement Reserve	-	247,313
Escrow - Insurance	-	43,882
Escrow - Re Taxes	-	19,375
Escrow - Mip	-	24,267
Reimbursement Due	14,710	14,710
Short Term Loan Exchange	100,600	100,600
Employee Payroll Advance	148,896	148,896
Escrow - Repairs	48,046	48,046
Loan Costs	-	132,725
Accum Amortization - Loan Costs	-	(45,267)
Due T/F Operations	-	(128,141)
Due To Oregon Property	-	16,317
Due To Oregon Property	109,806	61,760
Due To Oregon Associates-Old	2,252	20,587
Total - Line 9	**560,027**	**840,787**
	(369,488)	(369,488)

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

Description	Operating	After Consolidation
Due To State Per Audit	(5,639)	(5,639)
Insurance Premiums Payable	17,316	17,316
Acc. Retirement (From P/R)	2,046	2,046
Accrued Expenses	195,638	195,638
Short Term Loan Exchange	1,045,361	407,811
Due To Public Aid	489	489
Total - Line 36	**1,255,211**	**617,661**
	-	-

Facility Name & ID Number Oregon Living Rehab Center # 0051607 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (362,213)	1
2	Restatements (describe):		2
3	Prior period adjustement	502	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (361,711)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	954,054	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 954,054	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)**	$ 592,343	24 *

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

Facility Name & ID Number Oregon Living Rehab Center # 0051607 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	$ 5,264,865	1
2	Discounts and Allowances for all Levels	(-)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,264,865	3
	B. Ancillary Revenue		
4	Day Care	-	4
5	Other Care for Outpatients	-	5
6	Therapy	185,899	6
7	Oxygen	2,979	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 188,878	8
	C. Other Operating Revenue		
9	Payments for Education	-	9
10	Other Government Grants	775,778	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)**	$ 775,778	23
	D. Non-Operating Revenue		
24	Contributions	-	24
25	Interest and Other Investment Income***	976	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 976	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See SCH 19A	18,130	28
28a		-	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 18,130	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,248,627	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	969,457	31
32	Health Care	2,028,463	32
33	General Administration	1,044,547	33
	B. Capital Expense		
34	Ownership	558,888	34
	C. Ancillary Expense		
35	Special Cost Centers	508,421	35
36	Provider Participation Fee	184,797	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,294,573	40
41	**Income before Income Taxes (line 30 minus line 40)****	954,054	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 954,054	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,084,787	44
45	Private Pay - Net Inpatient Revenue	619,967	45
46	Medicare - Net Inpatient Revenue	1,522,231	46
47	Other-(specify) Hospice	37,880	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,264,865	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.

^Entity is a cash basis taxpayer.

Facility Name: **Oregon Living Rehab Center**
IDPH License ID Number: **0051607**
Fiscal Year End: **12/31/2020**

Schedule 19A

XVII. Income Statement
Line 28 Other Revenue (specify): Medicaid Inc. Adj., Misc. Inc. & Transport Inc.

Description	Amount
Van Charge	250
Transportation Income	1,150
Medicaid Income Adjustments	16,730
Total - Line 28	**18,130**
	-

Facility Name & ID Number Oregon Living Rehab Center # 0051607 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,086	2,086	$ 72,881	$ 34.94	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,536	14,123	471,617	33.39	3
4	Licensed Practical Nurses	7,851	8,134	225,447	27.72	4
5	CNAs & Orderlies	58,079	60,851	985,415	16.19	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	10,585	11,029	123,055	11.16	10
11	Social Service Workers	1,815	1,910	29,236	15.31	11
12	Dietician					12
13	Food Service Supervisor	1,874	1,939	30,415	15.69	13
14	Head Cook	3,637	3,831	48,134	12.56	14
15	Cook Helpers/Assistants	14,841	15,485	161,150	10.41	15
16	Dishwashers					16
17	Maintenance Workers	4,463	4,574	75,871	16.59	17
18	Housekeepers	11,879	12,531	132,706	10.59	18
19	Laundry	4,833	5,098	53,993	10.59	19
20	Administrator	2,232	2,344	92,100	39.29	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,192	6,598	128,211	19.43	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)	143,902	150,531	$ 2,630,231 *	$ 17.47	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 4,844	L1, C3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				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)		$ 4,844		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	31	$ 1,629	10(3)	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	31	$ 1,629		53

Facility Name & ID Number Oregon Living Rehab Center # 0051607 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Judy Ickes-Barker	Administrator	0%	$ 30,147
Erica Falk	Administrator	0%	61,953
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 92,100

B. Administrative - Other

Description	Amount
Moshe Herman/Momentum Healthcare, LLC	$ 120,000
SW Financial Services Fees (Eliminiated on Sch V. Col 7)	92,244
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 212,244

C. Professional Services

Vendor/Payee	Type	Amount
Ehrmann Gehlbach Badger & Consi	Legal	$ 70
RSM US LLP	Accounting	535
Rubinbrown Llp	Accounting	22,760
Personnel Planners Inc.	Unemployment Consultant	810
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 24,175

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 46,422
Unemployment Compensation Insurance	18,728
FICA Taxes	197,023
Employee Health Insurance	66,517
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Miscellaneous Employee Benefits	(1,789)
Employee Life Insurance	(474)
TOTAL (agree to Schedule V, line 22, col.8)	$ 326,427

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	$ 1,990
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 42)	5,569
Patient Background Checks 50	500
Health Care Council of Illinois	15,350
Miscellaneous Dues & Subscriptions	1,526
Miscellaneous Inspections & Licenses	5,989
Allocated from Management Co.	1,914
Less: Chamber of Commerce	(186)
Less: Public Relations Expense	(7,675)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 24,977

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	775
Allocated from Management Co.	277
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,052

**See instructions.

Facility Name: **Oregon Living Rehab Center**
IDPH License ID Number: **0051607**
Fiscal Year End: **12/31/2020**

Schedule 21C

XIX. SUPPORT SCHEDULES
C. Professional Services

Vendor	Type	Amount
Total (agree to Schedule V, line 19, column 3)		24,175
Allocated from Management Company	Legal Fees	1,659
Allocated from Management Company	Professional Services	9,902
Less: Non-Allowable Legal Fees		-
Total (agree to Schedule V, line 19, column 8)		35,736

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. **Health Care Council of Illinois: $ 15,350**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **35,578** 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. $ **184,797**
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. $ **-** 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 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.