



Facility Name & ID Number Oregon Healthcare Center

# 0037838 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	37,960	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	104	TOTALS	104	37,960	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other		5 Total
8	SNF		365	1,704	2,069	8
9	SNF/PED					9
10	ICF	14,426	8,065		22,491	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,426	8,430	1,704	24,560	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.70%

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  NO

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

I. On what date did you start providing long term care at this location?

Date started 3/1/92

J. Was the facility purchased or leased after January 1, 1978?

YES  Date 3/1/92 NO

K. Was the facility certified for Medicare during the reporting year?

YES  NO  If YES, enter number of beds certified 10 and days of care provided 1,248

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

Is your fiscal year identical to your tax year? YES  NO

Tax Year: 12/31/06 Fiscal Year: 12/31/06

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

Facility Name & ID Number Oregon Healthcare Center # 0037838 Report Period Beginning: 01/01/06 Ending: 12/31/06

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	155,612	6,952	3,507	166,071		166,071		166,071		1
2	Food Purchase		124,508		124,508		124,508	(2,328)	122,180		2
3	Housekeeping	107,853	38,499		146,352		146,352	251	146,603		3
4	Laundry	70,746	12,988		83,734		83,734		83,734		4
5	Heat and Other Utilities			81,035	81,035		81,035	1,214	82,249		5
6	Maintenance	58,052	29,041	5,385	92,478		92,478	960	93,438		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	392,263	211,988	89,927	694,178		694,178	97	694,275		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			3,600	3,600		3,600		3,600		9
10	Nursing and Medical Records	923,321	19,076	5,338	947,735		947,735	(530)	947,205		10
10a	Therapy			70,556	70,556		70,556		70,556		10a
11	Activities	60,726	1,542		62,268		62,268		62,268		11
12	Social Services										12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	984,047	20,618	79,494	1,084,159		1,084,159	(530)	1,083,629		16
	<b>C. General Administration</b>										
17	Administrative	54,445		203,705	258,150		258,150	(176,647)	81,503		17
18	Directors Fees										18
19	Professional Services			15,820	15,820		15,820	17,567	33,387		19
20	Dues, Fees, Subscriptions & Promotions			9,188	9,188		9,188	(1,382)	7,806		20
21	Clerical & General Office Expenses	111,405		19,388	130,793		130,793	44,642	175,435		21
22	Employee Benefits & Payroll Taxes			221,211	221,211		221,211	2,612	223,823		22
23	Inservice Training & Education										23
24	Travel and Seminar			499	499		499	1	500		24
25	Other Admin. Staff Transportation			6,658	6,658		6,658	356	7,014		25
26	Insurance-Prop.Liab.Malpractice			12,047	12,047		12,047	499	12,546		26
27	Other (specify):* <b>Mgmt Alloc of Benefi</b>							10,712	10,712		27
28	<b>TOTAL General Administration</b>	165,850		488,516	654,366		654,366	(101,640)	552,726		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,542,160	232,606	657,937	2,432,703		2,432,703	(102,073)	2,330,630		29

SEE ACCOUNTANTS' COMPILATION REPORT

\*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.

\*\*See schedule of adjustments attached at end of cost report.

Facility Name &amp; ID Number

Oregon Healthcare Center

#0037838

Report Period Beginning:

01/01/06

Ending:

12/31/06

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			11,532	11,532		11,532	39,431	50,963			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			33,673	33,673		33,673	31,707	65,380			32
33	Real Estate Taxes			33,652	33,652		33,652	2,409	36,061			33
34	Rent-Facility & Grounds			341,640	341,640		341,640	(341,640)				34
35	Rent-Equipment & Vehicles							777	777			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			420,497	420,497		420,497	(267,316)	153,181			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		27,526		27,526		27,526		27,526			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			56,940	56,940		56,940		56,940			42
43	Other (specify):* <b>Nonallowable Cost</b>			19,742	19,742		19,742	(19,742)				43
44	<b>TOTAL Special Cost Centers</b>		27,526	76,682	104,208		104,208	(19,742)	84,466			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,542,160	260,132	1,155,116	2,957,408		2,957,408	(389,131)	2,568,277			45

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

\*\*See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF 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	(155,640)	34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	5,193	30		9
10	Interest and Other Investment Income	(12,777)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(316)	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	(9,920)	43		18
19	Entertainment				19
20	Contributions	(1,440)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(384)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(220)	43		24
25	Fund Raising, Advertising and Promotional	(110)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,901)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,469)	43		28
29	Other-Attach Schedule See Page 5A	(98,429)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (278,413)</b>		<b>\$</b>	<b>30</b>

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	2	
		Amount	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)	(110,718)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (110,718)</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (389,131)</b>		<b>37</b>

\*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	2	3	4
		Yes	No	Amount	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	Exceptional Care Program		x		44
45	Other-Attach Schedule		x		45
46	Other-Attach Schedule		x		46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>	<b>47</b>

BHF USE ONLY					
48		49		50	
				51	
					52

SEE ACCOUNTANTS' COMPILATION REPORT

## Oregon Healthcare Center

ID# 0037838

Report Period Beginning: 01/01/06

Ending: 12/31/06

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Lab Expense-Med A	\$ (2,526)	43	1
2	X-Ray Expense-Med A	(1,433)	43	2
3	Veterans Expenses-Misc	(908)	43	3
4	Trust Fees	(400)	43	4
5	Association Fees	(1,588)	20	5
6	Gain/Loss in Partnership	(3,720)	43	6
7	Management Fees	(84,782)	17	7
8	Management Fees	(3,072)	21	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	<b>Total</b>	(98,429)		49

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Oregon Healthcare Center

# 0037838

Report Period Beginning:

01/01/06

Ending:

12/31/06

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached Schedule 6A		See Attached Schedule 6B		See Attached Schedule 6B		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	19 Professional Fees	\$	Oregon Associates	100.00%	\$ 2,125	\$ 2,125	1
2	V	30 Depreciation		Oregon Associates	100.00%	32,028	32,028	2
3	V	32 Interest		Oregon Associates	100.00%	78,574	78,574	3
4	V	32 Interest Income-Intercompany	93,936	Oregon Associates	100.00%		(93,936)	4
5	V	32 Amortization-Mortgage Costs		Oregon Associates	100.00%	3,436	3,436	5
6	V	34 Rent	186,000	Oregon Associates	100.00%		(186,000)	6
7	V	43 Other		Oregon Associates	100.00%	5,621	5,621	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 279,936			\$ 121,784	\$ * (158,152)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Oregon Healthcare Center, Inc.  
 Provider # : 0037838  
 12/31/2006

Schedule 6B

VII. Related Parties - Page 6

Related Nursing Homes

City

In State:

Cahokia Nursing & Rehab	Cahokia
Caseyville Nursing & Rehab	Caseyville
Franklin Grove Nursing Center	Franklin Grove
Kenwood Healthcare Center	Chicago
Oregon Healthcare Center	Oregon
Shabbona Healthcare Center	Shabbona
Tower Hill Healthcare Center	South Elgin
Virgil Calvert Nursing & Rehab	East St. Louis

Out of State :

St. Elizabeth Healthcare Center	Florissant, MO
Hillside Manor Healthcare & Rehab	St. Louis, MO
Rancho Manor Healthcare & Rehab	Florissant, MO

Other Related Business Entities

S.W. Management Co.	Skokie	Bookkeeping/Management Company
S&E Medical Supply Co.	Skokie	Medical Supplies
* SFO Associates	Skokie	Finance Company
** Unity Hospice	Skokie	Hospice Services

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

\*\* Pages 6 and 8 are not required for this entity since there was no payment from the nursing homes to the related entity.

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.  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 Management Co.	100.00%	\$ 6	\$	6	15
16	V	3 Housekeeping		SW Management Co.	100.00%	251		251	16
17	V	5 Heat and Other Utilities		SW Management Co.	100.00%	1,214		1,214	17
18	V	6 Maintenance		SW Management Co.	100.00%	960		960	18
19	V	17 Administrative	143,705	SW Management Co.	100.00%	51,840		(91,865)	19
20	V	19 Professional Services		SW Management Co.	100.00%	6,322		6,322	20
21	V	20 Dues, Fees, Subs & Promotions		SW Management Co.	100.00%	108		108	21
22	V	21 Clerical & General Office Expense		SW Management Co.	100.00%	47,714		47,714	22
23	V	24 Travel and Seminar		SW Management Co.	100.00%	1		1	23
24	V	25 Other Admin Staff Transport.		SW Management Co.	100.00%	356		356	24
25	V	26 Insurance-Prop. Liab. Malpractice		SW Management Co.	100.00%	499		499	25
26	V	27 Mgmt. Allocation of Benefits		SW Management Co.	100.00%	10,712		10,712	26
27	V	30 Depreciaion		SW Management Co.	100.00%	2,210		2,210	27
28	V	32 Interest		SW Management Co.	100.00%	1,135		1,135	28
29	V	33 Real Estate Taxes		SW Management Co.	100.00%	2,409		2,409	29
30	V	35 Rent-Equipment & Vehicles		SW Management Co.	100.00%	777		777	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		\$ 143,705			\$ 126,514	\$ *	(17,191)	39

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

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.  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	\$ 641	S & E Medical Supply Co.	100.00%	\$ 919	\$ 278	15	
16	V	3 Housekeeping	824	S & E Medical Supply Co.	100.00%	824		16	
17	V	10 Medical Supplies	1,102	S & E Medical Supply Co.	100.00%	572	(530)	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		\$ 2,567			\$ 2,315	\$ *	(252)	39

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

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.  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	19 Professional Services	\$	SFO Associates	0.00%	\$ 9,602	\$ 9,602	15
16	V	32 Interest-Bonds	78,574	SFO Associates	0.00%	73,586	(4,988)	16
17	V	32 Interest-Intercompany		SFO Associates	0.00%	60,263	60,263	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		\$ 78,574			\$ 143,451	\$ * 64,877	39

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

Facility Name &amp; ID Number

Oregon Healthcare Center

# 0037838

Report Period Beginning:

01/01/06

Ending:

12/31/06

## 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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	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 Reference	
						Hours	Percent	Description	Amount		
1	Sheldon Wolfe	President	Administrative	31.74	See Schedule 7A	3	7.00	Salary	\$ 11,745	L17, C7	1
2	Ronnie Klein	Shareholder	Administrative	15.87	See Schedule 7B	3.5	8.75	Salary&Fees	15,313	17,3 & 21,7	2
3	Moshe Herman	CFO	Administrative	2.40	See Schedule 7C	2.8	6.00	Salary	10,962	L21, C7	3
4											4
5											5
6											6
7											7
8			Note : All individuals work in excess of 40 hours per week.								8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 38,020		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oregon Healthcare Center

# 0037838

Report Period Beginning:

01/01/06

Ending: 12/31/06

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  NO

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	2	Food	Bed Days Available	608,840	11	\$ 89	\$ 37,960	\$ 6	1
2	3	Housekeeping	Bed Days Available	608,840	11	4,018	37,960	251	2
3	5	Heat and Other Utilities	Bed Days Available	608,840	11	19,472	37,960	1,214	3
4	6	Maintenance	Bed Days Available	608,840	11	15,398	37,960	960	4
5	19	Professional Services	Bed Days Available	608,840	11	101,398	37,960	6,322	5
6	20	Dues, Fees, Subs & Promotions	Bed Days Available	608,840	11	1,732	37,960	108	6
7	21	Clerical & General Office Exp	Bed Days Available	608,840	11	765,293	711,669	47,714	7
8	24	Travel and Seminar	Bed Days Available	608,840	11	15	37,960	1	8
9	25	Other Admin. Staff Transport	Bed Days Available	608,840	11	5,704	37,960	356	9
10	26	Insurance-Prop., Liab. & Malp	Bed Days Available	608,840	11	8,000	37,960	499	10
11	27	Mgmt. Allocation of Benefits	Bed Days Available	608,840	11	171,812	37,960	10,712	11
12	32	Interest	Bed Days Available	608,840	11	18,211	37,960	1,135	12
13	33	Real Estate Taxes	Bed Days Available	608,840	11	38,636	37,960	2,409	13
14	35	Rent-Equipment & Vehicles	Bed Days Available	608,840	11	12,454	37,960	777	14
15									15
16									16
17	17	Administrative	Avg. Hours Worked	43	11	743,036	743,036	3	51,840
18									18
19									19
20	30	Depreciation	Direct Cost					2,210	20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,905,268	\$ 1,454,705	\$ 126,514	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oregon Healthcare Center

# 0037838

Report Period Beginning:

01/01/06

Ending: 12/31/06

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  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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	2	Food	Direct Cost		\$	\$		\$ 919	1
2	3	Housekeeping	Direct Cost					824	2
3	10	Medical Supplies	Direct Cost					572	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				\$	\$		\$ 2,315	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oregon Healthcare Center

# 0037838

Report Period Beginning:

01/01/06

Ending: 12/31/06

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  NO

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	Professional Services	Note Receivable	6,500,000	3	\$ 31,207	\$ 2,000,000	\$ 9,602	1
2	32	Interest-Bonds	Note Receivable	6,500,000	3	239,155	2,000,000	73,586	2
3									3
4	32	Interest-Intercompany	Direct Cost					60,263	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					\$ 270,362	\$	\$ 143,451	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Oregon Healthcare Center

# 0037838

Report Period Beginning:

01/01/06

Ending:

12/31/06

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Loan Payable-SFO Associates	X		Bonds	Annual Pmt of \$92,408	7/1/04	\$ 2,000,000	\$ 1,076,923	08/15/14	0.0665	\$ 73,586	1								
2												2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6												6								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>						\$ 2,000,000	\$ 1,076,923			\$ 73,586	9								
<b>B. Non-Facility Related*</b>																				
10							Amortization of Loan Costs				3,436	10								
11							Interest Income offset net of intercompany interest				(12,777)	11								
12							SW Management Allocation-Mortgage				1,135	12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (8,206)	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 2,000,000	\$ 1,076,923			\$ 65,380	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ None                      Line # N/A

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

**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.

1. Real Estate Tax accrual used on 2005 report.		\$	<b>32,400</b>	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.)	2005	\$	<b>32,052</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(348)</b>	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>34,000</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		5
	Allocation from Management Co.		<b>2,409</b>	
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. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>36,061</b>	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2001	<b>29,404</b>	8	
	2002	<b>29,795</b>	9	
	2003	<b>30,145</b>	10	
	2004	<b>31,418</b>	11	
	2005	<b>32,052</b>	12	
<b>2006 RE Tax Accrual = 32,052 X 1.03 = 33,013 Use 34,000</b>				
<b>FOR BHF USE ONLY</b>				
	13	FROM R. E. TAX STATEMENT FOR 2005	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

SEE ACCOUNTANTS' COMPILATION REPORT

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2005 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Oregon Healthcare Center COUNTY Ogle

FACILITY IDPH LICENSE NUMBER 0037838

CONTACT PERSON REGARDING THIS REPORT Sheldon Wolfe

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

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

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>16-04-476-009</u>	<u>Long-term care property</u>	\$ <u>32,051.94</u>	\$ <u>32,051.94</u>
2. <u>10-28-412-049-0000</u>	<u>SW Management Allocation</u>	\$ <u>39,720.37</u>	\$ <u>2,409.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>71,772.31</u>	\$ <u>34,460.94</u>

**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?        YES   X   NO

If YES, attach an explanation & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

Facility Name & ID Number Oregon Healthcare Center

# 0037838

Report Period Beginning:

01/01/06

Ending:

12/31/06

**X. BUILDING AND GENERAL INFORMATION:**

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

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (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?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

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F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
 If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
 3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs: \_\_\_\_\_  
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Resident Care</u>	<u>130,680</u>	<u>1992</u>	<u>\$ 50,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>130,680</b>		<b>\$ 50,000</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Oregon Healthcare Center

# 0037838

Report Period Beginning:

01/01/06

Ending:

12/31/06

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	104	1992	1992	\$ 1,008,880	\$	40	\$ 25,222	\$ 25,222	\$ 374,126	4
5										5
6	SW Mgmt	1995		27,314		39	780	780	9,096	6
7	Allocation									7
8										8
	Improvement Type**									
9	Various		1992	6,160		20			6,160	9
10	Various		1993	26,517	320	20	1,325	1,005	18,170	10
11	Various		1994	5,324		20	267	267	3,580	11
12	Various		1995	3,498		20	175	175	2,027	12
13	Various		1996	2,042	52	20	102	50	1,053	13
14	Various		1997	2,880	170	20	144	(26)	1,380	14
15	Various		1998	65,055	933	20	3,253	2,320	29,804	15
16	Various		1999	36,058	741	20	1,803	1,062	14,049	16
17										17
18	Model 10Kpa Code A/R		2001	1,189		20	59	59	321	18
19	Generator Repair		2001	1,010		20	50	50	260	19
20	Motor		2001	783		20	39	39	221	20
21	Glass Thermo Unit		2001	868		20	43	43	238	21
22	Install Board		2001	816		20	41	41	219	22
23	Gas Controller		2001	739		20	37	37	194	23
24	Clutch & Output Brd		2001	1,138		20	57	57	299	24
25	Vinyl Flooring		2001	912		20	46	46	271	25
26										26
27	Air Conditioners		2002	1,470		20	74	74	516	27
28	Air Conditioners		2002	1,366		20	68	68	420	28
29	Wall-Replaced		2002	5,000	91	20	250	159	1,146	29
30										30
31	Roof Exhaust Fan		2003	3,128		10	313	313	1,095	31
32	Condensor walk - in Freezer		2003	3,193		7	456	456	1,520	32
33	Radiator		2003	3,473		10	347	347	1,128	33
34	Hot Water Repair		2003	1,610		20	80	80	267	34
35										35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Oregon Healthcare Center

# 0037838

Report Period Beginning:

01/01/06

Ending:

12/31/06

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Nurses Station	2004	\$ 15,850	\$ 406	20	\$ 793	\$ 387	\$ 1,982	37
38	Counter tops	2004	4,668	120	20	233	113	583	38
39	Nurses Station	2004	1,290	33	20	65	32	162	39
40	Basin	2004	7,500	192	20	375	183	938	40
41									41
42	Flooring	2005	3,703	135	20	185	50	278	42
43	Fire Alarm System	2005	1,932	59	20	97	38	145	43
44	Wanderguard	2005	1,632	70	10	163	93	245	44
45	Air Conditioners	2005	1,008	383	10	101	(282)	151	45
46									46
47	Vertical Rods with Panic Bars	2006	3,036	67	20	76	9	76	47
48	Smoke Stops-Attic	2006	1,140	66	20	29	(38)	29	48
49	Sidewalks	2006	5,106	255	20	128	(127)	128	49
50	Air Conditioners	2006	5,430	1,086	20	136	(950)	136	50
51	Sprinkler System	2006	62,467	340	20	1,562	1,222	1,562	51
52	Damper Switches - Sprinkler Systems	2006	1,506	339	20	38	(301)	38	52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62	SW Management allocation - Leasehold Improvements	1995	2,914		20	146	146	1,904	62
63	SW Management allocation - Leasehold Improvements	1996	509		20	25	25	269	63
64	SW Management allocation - Leasehold Improvements	1997	733		20	37	37	439	64
65	SW Management allocation - Leasehold Improvements	1998	505		20	25	25	221	65
66	SW Management allocation - Leasehold Improvements	1999	1,401		20	70	70	496	66
67	SW Management allocation - Leasehold Improvements	2005	2,898		20	145	145	217	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,335,651	\$ 5,858		\$ 39,458	\$ 33,600	\$ 477,557	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 51,368	\$ 1,994	\$ 5,787	\$ 3,793	10	\$ 33,934	71
72	Current Year Purchases	10,883	2,177	544	(1,633)	10	544	72
73	Fully Depreciated Assets	320,730					320,730	73
74	Allocation from Management Co.	7,373		250	250	10	6,979	74
75	TOTALS	\$ 390,354	\$ 4,171	\$ 6,581	\$ 2,410		\$ 362,187	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Care	Wheelchair lift for van	2003	\$ 4,635	\$	\$ 464	\$ 464	10	\$ 1,546	76
77	Resident Care	E-350 Van	2003	26,099	1,503	3,728	2,225	7	13,981	77
78										78
79	Allocation from Mgmt. Co.	2004 Cadillac	2004	3,658		732	732	5	1,829	79
80	TOTALS			\$ 34,392	\$ 1,503	\$ 4,924	\$ 3,421		\$ 17,356	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,810,397	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 11,532	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 50,963	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 39,431	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 857,100	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?  YES  NO

If NO, see instructions.

		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:				\$			3
4	Additions		<u>N/A</u>					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: \_\_\_\_\_ \*

**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: \$ 777 Description: SW Management Allocation = \$777

(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			\$	\$	17
18					18
19			<u>N/A</u>		19
20					20
21	TOTAL		\$	\$	21

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. \_\_\_\_\_ /2007 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2008 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2009 \$ \_\_\_\_\_

\* 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.

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>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.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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

<b>COMPLETED</b>	
1. From this facility	
2. From other facilities (f)	
<b>DROP-OUTS</b>	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
  - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10A, C3	hrs	\$	1,917	\$ 27,790	\$	1,917	\$ 27,790	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		258	3,616		258	3,616	2
3	Licensed Recreational Therapist	L10A, C3	hrs		2,642	38,805		2,642	38,805	3
4	Licensed Physical Therapist		hrs							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 prescripts				27,526		27,526	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	<b>TOTAL</b>			\$	4,817	\$ 70,211	\$ 27,526	4,817	\$ 97,737	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oregon Healthcare Center

# 0037838

Report Period Beginning: 01/01/06

Ending:

12/31/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/06

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 46,038	\$ 46,038	1
2	Cash-Patient Deposits	3,181	3,181	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>None</u> )	613,040	613,040	3
4	Supply Inventory (priced at _____ )			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,980	2,980	6
7	Other Prepaid Expenses		756	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Schedule 17A</u>	14,581	1,025,959	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 679,820	\$ 1,691,954	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		50,000	13
14	Buildings, at Historical Cost		1,036,195	14
15	Leasehold Improvements, at Historical Cost	203,966	299,456	15
16	Equipment, at Historical Cost	269,798	424,746	16
17	Accumulated Depreciation (book methods)	(283,008)	(857,100)	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 (specify): <u>See Schedule 17A</u>		89,970	22
23	Other(specify): _____			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 190,756	\$ 1,043,267	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 870,576	\$ 2,735,221	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 43,991	\$ 43,991	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,287	6,287	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	67,051	67,051	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,548	8,548	31
32	Accrued Real Estate Taxes(Sch.IX-B)	34,000	34,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>See Schedule 17A</u>	36,436	36,436	36
37	_____			37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 196,313	\$ 196,313	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	458,042	1,076,923	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	_____			43
44	_____			44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 458,042	\$ 1,076,923	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 654,355	\$ 1,273,236	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 216,221	\$ 1,461,985	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 870,576	\$ 2,735,221	48

Oregon Healthcare Center, Inc.

Provider #: 0037838

12/31/2006

XV. BALANCE SHEET -

Other Current Assets (Specify) :	After	
	Operating	Consolidation
Due from State - Interest	7,686	7,686
Employee Loans	2,100	2,100
Short Term Loan Exchange	4,795	4,795
Due To/From SFO	-	1,011,378
		<hr/>
<b>Total Line 9-Other Current Assets (Specify)</b>	<b>14,581</b>	<b>1,025,959</b>

Other Long-Term Assets (Specify)

RE Investment in SFO	-	29,615
RE Loan Costs	-	103,078
RE Accumulated Amortization-Loan Costs	-	(42,723)
		<hr/>
<b>Total Line 22-Other Long-Term Assets (specify)</b>	<b>-</b>	<b>89,970</b>

Other Current Liabilities (Specify)

Insurance Premiums Payable	809	809
Accrued Expenses	35,627	35,627
		<hr/>
<b>Total Line 36-Other Current Liabilities (Specify)</b>	<b>36,436</b>	<b>36,436</b>

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>274,700</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>274,700</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(58,479)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(58,479)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>216,221</b>	<b>24</b> *

Operating Entity Only

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

SEE ACCOUNTANTS' COMPILATION REPORT

**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**

1

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 2,837,793	1
2	Discounts and Allowances for all Levels		2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,837,793	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	36,089	6
7	Oxygen	9,884	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 45,973	8
	<b>C. Other Operating Revenue</b>		
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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	12,777	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 12,777	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Cable TV	1,395	28
28a	Misc Income	991	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 2,386	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,898,929	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	694,178	31
32	Health Care	1,084,159	32
33	General Administration	654,366	33
	<b>B. Capital Expense</b>		
34	Ownership	420,497	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	47,268	35
36	Provider Participation Fee	56,940	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,957,408	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(58,479)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (58,479)	43

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

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

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Oregon Healthcare Center

# 0037838

Report Period Beginning:

01/01/06

Ending:

12/31/06

**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	2,029	2,029	\$ 47,841	\$ 23.58	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,947	3,081	64,827	21.04	3
4	Licensed Practical Nurses	13,469	14,039	266,735	19.00	4
5	CNAs & Orderlies	52,777	54,567	543,918	9.97	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,847	5,266	60,726	11.53	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,704	1,718	28,741	16.73	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,207	16,009	126,871	7.92	15
16	Dishwashers					16
17	Maintenance Workers	3,958	4,234	58,052	13.71	17
18	Housekeepers	11,904	12,999	107,853	8.30	18
19	Laundry	9,070	9,531	70,746	7.42	19
20	Administrator	2,080	2,080	54,445	26.18	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,316	6,596	111,405	16.89	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)	126,308	132,149	\$ 1,542,160 *	\$ 11.67	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	\$ 3,507	L1, C3	35
36	Medical Director	Monthly	3,600	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,338	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	Monthly	345	L10A, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 12,790		49

**C. CONTRACT NURSES**

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

SEE ACCOUNTANTS' COMPILATION REPORT

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
April Hunt	Administrator	0	\$ 54,445	Workers' Compensation Insurance	\$ 36,703	IDPH License Fee	\$ 2,025	
				Unemployment Compensation Insurance	23,710	Advertising: Employee Recruitment		
				FICA Taxes	117,975	Health Care Worker Background Check	1,049	
				Employee Health Insurance	41,925	(Indicate # of checks performed <u>88</u> )		
				Employee Meals	2,612	Resident Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Illinois Council on Long Term Care	3,421	
				Miscellaneous Employee Benefits	898	Miscellaneous Dues & Permits	393	
TOTAL (agree to Schedule V, line 17, col. 1)						Miscellaneous Inspections & Licenses	2,398	
(List each licensed administrator separately.)			\$ 54,445			Allocation from Management Co.	108	
<b>B. Administrative - Other</b>						Less: Expenditure for political purposes	(1,588)	
Description			Amount			Less: Public Relations Expense	( )	
SW Management-management fees			\$ 83,705			Non-allowable advertising	( )	
Ronnie Klein-management fees			120,000			Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 203,705	TOTAL (agree to Schedule V, line 22, col.8)	\$ 223,823	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 7,806	
(Attach a copy of any management service agreement)				<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>			<b>G. Schedule of Travel and Seminar**</b>	
<b>C. Professional Services</b>				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount					
Smith Hanson Hahn Morrow	Legal		\$ 384				Out-of-State Travel	\$
Ashman & Stein	Legal		1,770					
RSM McGladrey	Accounting		13,568	N/A			In-State Travel	
National Notary Sercive	Notary Fee		98					
							Seminar Expense	499
							Allocation from Management Co	1
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL	\$		(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 15,820				TOTAL	\$ 500

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

Oregon Healthcare Center, Inc.

Provider # : 0037838

12/31/2006

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (Agree to Schedule V, Line 19, Column 3)	15,820
Less : Reclass to Licenses	(98)
Allocated from Real Estate Entity - Accounting	1,875
Allocated from Real Estate Entity - Legal	250
Allocated from Real Estate Entity	<u>2,125</u>
Allocated from Management Company - Accounting	1,114
Allocated from Management Company-Legal	5,208
Allocated from Management Company	<u>6,322</u>
Allocated from SFO Associates-Accounting	16,869
Less : Non-Allowable Legal Costs	(384)
Total ( Agree to Schedule V, Line 19, Column 8)	<u><u>40,654</u></u>

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).**

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2003	FY2004	FY2005	FY2006
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								
2																				
3																				
4	N/A																			
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	<b>TOTALS</b>		\$	\$	\$	\$	\$	\$	\$	\$	\$	\$								

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Oregon Healthcare Center

# 0037838

Report Period Beginning:

01/01/06

Ending:

12/31/06

**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. IL Council on LTC : \$1,833
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 8,576 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 56,940  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (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. \$ 2,612 Has any meal income been offset against related costs? N/A 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? No**  
**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 The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees

**SEE ACCOUNTANTS' COMPILATION REPORT**