

Facility Name & ID Number Oregon Healthcare Center

0037838 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	581	400	2,581	3,562	8
9	SNF/PED					9
10	ICF	14,013	8,416		22,429	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,594	8,816	2,581	25,991	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.47%

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 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

I. On what date did you start providing long term care at this location?
Date started 03/01/1992

J. Was the facility purchased or leased after January 1, 1978?
YES Date 03/01/1992 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 2,274

Medicare Intermediary Wisconsin Physicians Service

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oregon Healthcare Center # 0037838 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	169,675	10,091	3,783	183,549		183,549		183,549		1
2	Food Purchase		140,662		140,662		140,662	(3,026)	137,636		2
3	Housekeeping	135,280	39,544		174,824		174,824	113	174,937		3
4	Laundry	79,075	12,168		91,243		91,243		91,243		4
5	Heat and Other Utilities			119,274	119,274		119,274	1,040	120,314		5
6	Maintenance	58,726	30,175	7,635	96,536		96,536	1,340	97,876		6
7	Other (specify):*										7
8	TOTAL General Services	442,756	232,640	130,692	806,088		806,088	(533)	805,555		8
	B. Health Care and Programs										
9	Medical Director			3,600	3,600		3,600		3,600		9
10	Nursing and Medical Records	1,089,153	21,509	9,768	1,120,430		1,120,430	(93)	1,120,337		10
10a	Therapy			142,210	142,210		142,210		142,210		10a
11	Activities	74,659	2,521		77,180		77,180		77,180		11
12	Social Services	6,942			6,942		6,942		6,942		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,170,754	24,030	155,578	1,350,362		1,350,362	(93)	1,350,269		16
	C. General Administration										
17	Administrative	61,915		201,125	263,040		263,040	(160,978)	102,062		17
18	Directors Fees										18
19	Professional Services			17,141	17,141		17,141	16,234	33,375		19
20	Dues, Fees, Subscriptions & Promotions			8,971	8,971		8,971	(1,276)	7,695		20
21	Clerical & General Office Expenses	112,447		26,061	138,508		138,508	24,861	163,369		21
22	Employee Benefits & Payroll Taxes			241,681	241,681		241,681	3,069	244,750		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,210	1,210		1,210	37	1,247		24
25	Other Admin. Staff Transportation			7,418	7,418		7,418	465	7,883		25
26	Insurance-Prop.Liab.Malpractice			12,558	12,558		12,558	438	12,996		26
27	Other (specify):* Mgmt Alloc of Benefit							8,698	8,698		27
28	TOTAL General Administration	174,362		516,165	690,527		690,527	(108,452)	582,075		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,787,872	256,670	802,435	2,846,977		2,846,977	(109,078)	2,737,899		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

Oregon Healthcare Center

#0037838

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			42,960	42,960		42,960	13,023	55,983			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			18,396	18,396		18,396	51,118	69,514			32
33	Real Estate Taxes			32,862	32,862		32,862	2,432	35,294			33
34	Rent-Facility & Grounds			186,000	186,000		186,000	(186,000)				34
35	Rent-Equipment & Vehicles							733	733			35
36	Other (specify):*											36
37	TOTAL Ownership			280,218	280,218		280,218	(118,694)	161,524			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		47,544		47,544		47,544		47,544			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):* Non-allowable Cos			12,846	12,846		12,846	(12,846)				43
44	TOTAL Special Cost Centers		47,544	69,786	117,330		117,330	(12,846)	104,484			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,787,872	304,214	1,152,439	3,244,525		3,244,525	(240,618)	3,003,907			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

Facility Name & ID Number Oregon Healthcare Center

0037838

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	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	(20,916)	30		9
10	Interest and Other Investment Income	(18,396)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(242)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,525)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(3,110)	43		24
25	Fund Raising, Advertising and Promotional	(796)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,162)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,156)	43		28
29	Other-Attach Schedule See Pg. 5A	(9,576)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (57,879)		\$	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	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)	(182,739)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (182,739)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (240,618)		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	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	TOTAL (C): (sum of lines 38-46)			\$	47

SEE ACCOUNTANTS' COMPILATION REPORT

Oregon Healthcare Center

ID# 0037838

Report Period Beginning: 01/01/2007

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NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Lab Expense-Med A	\$ (4,680)	43	1
2	X-Ray Expense-Med A	(1,087)	43	2
3	Trust Fees	(250)	43	3
4	Gain/Loss in Partnership	(2,233)	43	4
5	Association Fees	(1,326)	20	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(9,576)		49

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Oregon Healthcare Center

0037838

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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%	\$ 2,175	\$ 2,175	1
2	V	30 Depreciation		Oregon Associates	100.00%	32,028	32,028	2
3	V	32 Interest		Oregon Associates	100.00%	72,212	72,212	3
4	V	32 Amortization-Mortgage Costs		Oregon Associates	100.00%	3,436	3,436	4
5	V	34 Rent	186,000	Oregon Associates	100.00%		(186,000)	5
6	V	43 Other		Oregon Associates	100.00%	4,395	4,395	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 186,000			\$ 114,246	\$ * (71,754)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 Mangement Co.	100.00%	\$ 19	\$ 19
16	V	3 Housekeeping		SW Mangement Co.	100.00%	113	113
17	V	5 Heat and Other Utilities		SW Mangement Co.	100.00%	1,040	1,040
18	V	6 Maintenance		SW Mangement Co.	100.00%	1,340	1,340
19	V	17 Administrative	201,125	SW Mangement Co.	100.00%	40,147	(160,978)
20	V	19 Professional Services		SW Mangement Co.	100.00%	6,345	6,345
21	V	20 Dues, Fees, Subs & Promotions		SW Mangement Co.	100.00%	50	50
22	V	21 Clerical & General Office Expense		SW Mangement Co.	100.00%	24,861	24,861
23	V	24 Travel and Seminar		SW Mangement Co.	100.00%	37	37
24	V	25 Other Admin Staff Transport.		SW Mangement Co.	100.00%	465	465
25	V	26 Insuranc-Prop. Liab. Malpractice		SW Mangement Co.	100.00%	438	438
26	V	27 Mgmt. Allocation of Benefits		SW Mangement Co.	100.00%	8,698	8,698
27	V	30 Depreciation		SW Mangement Co.	100.00%	1,911	1,911
28	V	32 Interest		SW Mangement Co.	100.00%	1,012	1,012
29	V	33 Real Estate Taxes		SW Mangement Co.	100.00%	2,432	2,432
30	V	35 Rent-Equipment & Vehicles		SW Mangement Co.	100.00%	733	733
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 201,125			\$ 89,641	\$ * (111,484)

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 291	S & E Medical Supply Co.	100.00%	\$ 315	\$ 24	15	
16	V	10 Medical Supplies	255	S & E Medical Supply Co.	100.00%	162	(93)	16	
17	V							17	
18	V							18	
19	V							19	
20	V							20	
21	V							21	
22	V							22	
23	V							23	
24	V							24	
25	V							25	
26	V							26	
27	V							27	
28	V							28	
29	V							29	
30	V							30	
31	V							31	
32	V							32	
33	V							33	
34	V							34	
35	V							35	
36	V							36	
37	V							37	
38	V							38	
39	Total		\$ 546			\$ 477	\$ *	(69)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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%	\$ 7,714	\$	7,714	15
16	V	32 Interest-Bonds	72,212	SFO Associates	0.00%	65,066		(7,146)	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 72,212			\$ 72,780	\$ *	568	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Oregon Healthcare Center

0037838

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01/01/2007

Ending:

12/31/2007

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	\$ 13,519	L17, C7	1
2	Ronnie Klein	Shareholder	Administrative	15.87	See Schedule 7B	3.5	8.75	Salary&Fees	13,109	17,3&17,7	2
3	Moshe Herman	CFO	Administrative	2.40	See Schedule 7C	2.8	6.00	Salary	13,519	L17, 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	\$ 40,147		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:

01/01/2007

Ending: 2/31/2007

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	645,320	11	\$ 319	\$ 37,960	\$ 19	1	
2	3	Housekeeping	Bed Days Available	645,320	11	1,918	37,960	113	2	
3	5	Heat and Other Utilities	Bed Days Available	645,320	11	17,688	37,960	1,040	3	
4	6	Maintenance	Bed Days Available	645,320	11	22,780	37,960	1,340	4	
5	19	Professional Services	Bed Days Available	645,320	11	107,864	37,960	6,345	5	
6	20	Dues, Fees, Subs & Promotions	Bed Days Available	645,320	11	844	37,960	50	6	
7	21	Clerical & General Office Exp	Bed Days Available	645,320	11	422,637	373,471	24,861	7	
8	24	Travel and Seminar	Bed Days Available	645,320	11	625	37,960	37	8	
9	25	Other Admin. Staff Transport.	Bed Days Available	645,320	11	7,906	37,960	465	9	
10	26	Insurance-Prop. Liab. & Malp	Bed Days Available	645,320	11	7,442	37,960	438	10	
11	27	Mgmt. Allocation of Benefits	Bed Days Available	645,320	11	147,860	37,960	8,698	11	
12	32	Interest	Bed Days Available	645,320	11	17,198	37,960	1,012	12	
13	33	Real Estate Taxes	Bed Days Available	645,320	11	41,339	37,960	2,432	13	
14	35	Rent-Equipment & Vehicles	Bed Days Available	645,320	11	12,453	37,960	733	14	
15									15	
16	17	Administrative	Avg. Hours Worked	40	11	360,500	360,500	3	27,038	16
17	17	Administrative	Avg. Hours Worked	55	7	180,250	180,250	4	13,109	17
18									18	
19	30	Depreciation	Direct Cost			32,495		1,911	19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 1,382,118	\$ 914,221	\$ 89,641	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oregon Healthcare Center

0037838

Report Period Beginning:

01/01/2007

Ending: 2/31/2007

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		\$	\$		\$ 315	1
2	10	Medical Supplies	Direct Cost					162	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 477	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oregon Healthcare Center

0037838

Report Period Beginning:

01/01/2007

Ending: 2/31/2007

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Professional Services	Note Receivable	6,500,000	3	\$ 25,069	\$ 2,000,000	\$ 7,714	1
2	32	Interest-Bonds	Note Receivable	6,500,000	3	211,466	2,000,000	65,066	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 236,535	\$	\$ 72,780	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Oregon Healthcare Center

0037838

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	Name of Lender	2		3	4	5	6		7	8	9	10					
		Related**					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	Loan Payable-SFO Associates	X		Bonds	Annual Pmt of \$92,408	7/1/04	\$ 2,000,000	\$ 953,846	8/15/14	0.0665	\$ 65,066	1					
2												2					
3												3					
4												4					
5												5					
Working Capital																	
6												6					
7												7					
8												8					
9	TOTAL Facility Related						\$ 2,000,000	\$ 953,846			\$ 65,066	9					
B. Non-Facility Related*																	
10							Amortization of Loan Costs				3,436	10					
11							SW Management Allocation-Mortgage				1,012	11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$ 4,448	14					
15	TOTALS (line 9+line14)						\$ 2,000,000	\$ 953,846			\$ 69,514	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 2006 report.		\$	34,000	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.)	2006	\$	32,862	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(1,138)	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	34,000	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
	Allocation from Management Co.		2,432	
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.		\$	35,294	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2002	29,795	8	
	2003	30,145	9	
	2004	31,418	10	
	2005	32,052	11	
	2006	32,862	12	
2007 RE Tax Accrual = 32,862 X 1.03 = 33,848. Use 34,000.				
FOR BHF USE ONLY				
	13	FROM R. E. TAX STATEMENT FOR 2006	\$	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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 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 2006 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 2006.

(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>32,861.96</u>	\$ <u>32,861.96</u>
2. <u>10-28-412-049-0000</u>	<u>SW Management allocation</u>	\$ <u>42,503.98</u>	\$ <u>2,432.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>75,365.94</u>	\$ <u>35,293.96</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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:

01/01/2007 Ending:

12/31/2007

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

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	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	TOTALS	130,680		\$ 50,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oregon Healthcare Center

0037838

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

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	\$ 399,348	4
5										5
6	SW Management Allocation	1995		25,461		39	727	727	9,206	6
7										7
8										8
	Improvement Type**									
9	Various		1992	6,160		20			6,160	9
10	Various		1993	26,517	320	20	1,326	1,006	19,496	10
11	Various		1994	5,324		20	266	266	3,845	11
12	Various		1995	3,498		20	175	175	2,202	12
13	Various		1996	2,042	52	20	102	50	1,155	13
14	Various		1997	2,880	170	20	144	(26)	1,524	14
15	Various		1998	65,055	933	20	3,253	2,320	33,056	15
16	Various		1999	36,058	741	20	1,803	1,062	15,852	16
17										17
18	Model 10Kpa Code A/R		2001	1,189		20	59	59	382	18
19	Generator Repair		2001	1,010		20	51	51	312	19
20	Motor		2001	783		20	39	39	261	20
21	Glass Thermo Unit		2001	868		20	43	43	283	21
22	Install Board		2001	816		20	41	41	259	22
23	Gas Controller		2001	739		20	37	37	231	23
24	Clutch & Output Brd		2001	1,138		20	57	57	356	24
25	Vinyl Flooring		2001	912		20	46	46	315	25
26										26
27	Air Conditioners		2002	1,470		20	74	74	588	27
28	Air Conditioners		2002	1,366		20	68	68	489	28
29	Wall-Replaced		2002	5,000	91	20	250	159	1,396	29
30										30
31	Roof Exhaust Fan		2003	3,128		10	313	313	1,407	31
32	Condensor walk - in Freezer		2003	3,193		7	456	456	1,977	32
33	Radiator		2003	3,473		10	347	347	1,476	33
34	Hot Water Repair		2003	1,610		20	81	81	349	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 & ID Number Oregon Healthcare Center

0037838

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

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	\$ 559	20	\$ 793	\$ 234	\$ 2,774	37
38	Counter tops	2004	4,670		20	233	233	817	38
39	Nurses Station	2004	1,290		20	65	65	226	39
40	Basin	2004	7,500	192	20	375	183	1,313	40
41									41
42	Flooring	2005	3,703	135	20	185	50	463	42
43	Fire Alarm System	2005	1,932	70	20	97	27	242	43
44	Wanderguard	2005	1,632	59	10	163	104	408	44
45	Air Conditioners	2005	1,008	230	10	101	(129)	252	45
46									46
47	Vertical Rods with Panic Bars	2006	3,036	111	20	152	41	228	47
48	Smoke Stops-Attic	2006	1,140	41	20	57	16	86	48
49	Sidewalks	2006	5,106	485	20	255	(230)	383	49
50	Air Conditioners	2006	5,430	1,738	20	272	(1,467)	407	50
51	Sprinkler System	2006	62,467	2,271	20	3,123	852	4,685	51
52	Damper Switches - Sprinkler Systems	2006	1,505	55	20	75	20	113	52
53									53
54	Walk-in Freezer Condensing Unit	2007	6,016	209	20	150	(59)	150	54
55									55
56									56
57									57
58									58
59	SW Management allocation - Leasehold Improvements	1995	2,716		20	136	136	1,910	59
60	SW Management allocation - Leasehold Improvements	1996	474		20	24	24	274	60
61	SW Management allocation - Leasehold Improvements	1997	683		20	34	34	443	61
62	SW Management allocation - Leasehold Improvements	1998	470		20	24	24	229	62
63	SW Management allocation - Leasehold Improvements	1999	1,306		20	65	65	528	63
64	SW Management allocation - Leasehold Improvements	2005	2,701		20	135	135	338	64
65	SW Management allocation - Leasehold Improvements	2007	1,529		20	38	38	38	65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,340,734	\$ 8,462		\$ 41,531	\$ 33,069	\$ 518,229	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	\$ 68,765	\$ 4,434	\$ 5,702	\$ 1,268	10	\$ 46,694	71
72	Current Year Purchases	2,970	2,970	149	(2,821)	10	149	72
73	Fully Depreciated Assets	314,216					314,217	73
74	Allocation from Management Co.	6,870		46	46	10	5,786	74
75	TOTALS	\$ 392,821	\$ 7,404	\$ 5,897	\$ (1,507)		\$ 366,846	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	\$ 2,009	76
77	Resident Care	E-350 Van	2003	26,099	1,503	3,728	2,225	7	17,710	77
78	Resident Care	2008 Chevy Van & lift	2007	36,812	25,591	3,681	(21,910)	5	3,681	78
79	Allocation from Mgmt Co.	2004 Cadillac	2004	3,408		682	682	5	2,386	79
80	TOTALS			\$ 70,954	\$ 27,094	\$ 8,555	\$ (18,539)		\$ 25,786	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)		\$ 1,854,509	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 42,960	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 55,983	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 13,023	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 910,861	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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:		<u>N/A</u>		\$ _____			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: _____ *

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: \$ _____ 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	<u>SW Management Allocation</u>		\$ _____	\$ <u>733</u>	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ <u>733</u>	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.	<u>/2008</u>	\$ _____
13.	<u>/2009</u>	\$ _____
14.	<u>/2010</u>	\$ _____

* 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.

SEE ACCOUNTANTS' COMPILATION REPORT

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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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

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.
- 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	\$	3,436	\$ 96,204	\$	3,436	\$ 96,204	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		41	1,964		41	1,964	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		1,685	43,795		1,685	43,795	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				47,544		47,544	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	TOTAL			\$	5,162	\$ 141,963	\$ 47,544	5,162	\$ 189,507	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: 01/01/2007

Ending:

12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 251,233	\$ 251,233	1
2	Cash-Patient Deposits	3,409	3,409	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 3,000)	668,110	668,110	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,978	2,978	6
7	Other Prepaid Expenses		715	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Schedule 17A	7,912	1,060,355	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 933,642	\$ 1,986,800	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		50,000	13
14	Buildings, at Historical Cost		1,034,341	14
15	Leasehold Improvements, at Historical Cost	209,982	306,393	15
16	Equipment, at Historical Cost	309,579	463,775	16
17	Accumulated Depreciation (book methods)	(325,968)	(910,861)	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) See Schedule 17A		84,301	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 193,593	\$ 1,027,949	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,127,235	\$ 3,014,749	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 78,302	\$ 78,302	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,017	9,017	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	84,601	84,601	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,468	11,468	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
Other Current Liabilities(specify):				
36				36
37	See Schedule 17A	93,010	93,010	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 310,398	\$ 310,398	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	328,388	953,846	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 328,388	\$ 953,846	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 638,786	\$ 1,264,244	46
47	TOTAL EQUITY(page 18, line 24)	\$ 488,449	\$ 1,750,505	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,127,235	\$ 3,014,749	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Oregon Healthcare Center, Inc.

Provider #: 0037838

12/31/2007

XV. BALANCE SHEET -

	Operating	After Consolidation
<u>Other Current Assets (Specify) :</u>		
Due from State - Interest	7,912	7,912
Due To/From SFO	-	1,052,443
Total Line 9-Other Current Assets (Specify)	<u>7,912</u>	<u>1,060,355</u>

Other Long-Term Assets (Specify)

RE Investment in SFO	-	27,382
RE Loan Costs	-	103,078
RE Accumulated Amortization-Loan Costs	-	(46,159)
Total Line 22-Other Long-Term Assets (specify)	<u>-</u>	<u>84,301</u>

Other Current Liabilities (Specify)

Accrued Expenses	(31,837)	(31,837)
Short Term Loan Exchange	(30,000)	(30,000)
Due to Public Aid	(31,173)	(31,173)
Total Line 37-Other Current Liabilities (Specify)	<u>(93,010)</u>	<u>(93,010)</u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 216,221	1
2	Restatements (describe):		2
3	Prior Period Adjustment	155,638	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 371,859	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	116,590	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)	\$ 116,590	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)	\$ 488,449	24 *

* 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	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,233,129	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,233,129	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	100,258	6
7	Oxygen	9,787	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 110,045	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	100	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 100	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	15,095	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 15,095	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Cable TV	1,925	28
28a	Miscellaneous Income	821	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,746	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,361,115	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	806,088	31
32	Health Care	1,350,362	32
33	General Administration	690,527	33
	B. Capital Expense		
34	Ownership	280,218	34
	C. Ancillary Expense		
35	Special Cost Centers	60,390	35
36	Provider Participation Fee	56,940	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,244,525	40
41	Income before Income Taxes (line 30 minus line 40)**	116,590	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 116,590	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:

01/01/2007

Ending:

12/31/2007

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	1,848	1,928	\$ 48,128	\$ 24.96	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,853	3,966	91,622	23.10	3
4	Licensed Practical Nurses	13,084	13,784	292,479	21.22	4
5	CNAs & Orderlies	59,804	63,054	656,924	10.42	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,172	6,659	74,659	11.21	10
11	Social Service Workers	432	447	6,942	15.53	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	35,689	17.16	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,619	16,467	133,986	8.14	15
16	Dishwashers					16
17	Maintenance Workers	3,873	4,217	58,726	13.93	17
18	Housekeepers	14,724	15,451	135,280	8.76	18
19	Laundry	9,644	10,052	79,075	7.87	19
20	Administrator	2,080	2,120	61,915	29.21	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,906	6,285	112,447	17.89	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)	139,119	146,510	\$ 1,787,872 *	\$ 12.20	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	\$ 3,783	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	9,768	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	Monthly	247	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)		\$ 17,398		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		N/A		51
52	Certified Nurse Assistants/Aides				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	\$ 61,915	Workers' Compensation Insurance	\$ 24,470	IDPH License Fee	\$	
				Unemployment Compensation Insurance	28,822	Advertising: Employee Recruitment		
				FICA Taxes	136,773	Health Care Worker Background Check		
				Employee Health Insurance	48,933	(Indicate # of checks performed 161)	1,930	
				Employee Meals	3,069	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Illinois Council on Long Term Care	5,616	
				Miscellaneous Employee Benefits	2,683	Miscellaneous Dues & Permits	243	
						Miscellaneous Inspections & Licenses	1,182	
						Allocated from Management Co.	50	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 61,915			Less: Non-Allowable Dues	(1,326)	
B. Administrative - Other						Less: Public Relations Expense	()	
Description			Amount			Non-allowable advertising	()	
SW Management-Management Fees			\$ 141,125			Yellow page advertising	()	
Ronnie Klein-Management Fees			60,000					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 201,125	TOTAL (agree to Schedule V, line 22, col.8)	\$ 244,750	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 7,695	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Smith Hahn Morrow & Floski	Legal		\$ 734	N/A		\$	Out-of-State Travel	\$
RSM McGladrey	Accounting		16,407					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 17,141	TOTAL		\$	Seminar Expense	1,210
							Allocated from Management Co.	37
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 1,247

* Attach copy of IMRF notifications
 SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Oregon Health Care Center, Inc.
Provider #: 0037838
12/31/2007

XIX. Support Schedule
C. Professional Services

Total (Agree to Schedule V, Line 19, Column 3)	17,141
Allocated from Real Estate Entity- Accounting	2,175
Allocated from Management Company-Accounting	1,719
Allocated from Management Company-Legal	4,626
Total Allocated from Management Company	<u>6,345</u>
Allocated from SFO Associates-Accounting	7,714
Total (Agree to Schedule V, Line 19, Column8)	<u><u>33,375</u></u>

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2004	6 FY2005	7 FY2006	8 FY2007	9 FY2008	10 FY2009	11 FY2010	12 FY2011	13 FY2012
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oregon Healthcare Center

0037838

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Council on LTC = \$4,290
- (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. \$ 9,595 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? No YES 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. \$ 3,069 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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees

SEE ACCOUNTANTS' COMPILATION REPORT