

Facility Name & ID Number Oregon Healthcare Center

0037838 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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 _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	104	Skilled (SNF)	104	38,064	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	104	TOTALS	104	38,064	7

B. Census-For the entire report period.

	1 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	627	497	1,993	3,117	8
9	SNF/PED					9
10	ICF	13,100	7,841	21	20,962	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,727	8,338	2,014	24,079	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.26%

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 1,993

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2008 Fiscal Year: 12/31/2008

* 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: 01/01/2008 Ending: 12/31/2008

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	182,967	10,957	4,337	198,261			198,261		1	
2	Food Purchase		143,601		143,601			(3,488)	140,113	2	
3	Housekeeping	116,592	34,257		150,849			83	150,932	3	
4	Laundry	96,944	10,105		107,049				107,049	4	
5	Heat and Other Utilities			146,691	146,691			814	147,505	5	
6	Maintenance	28,810	27,430	6,630	62,870			1,795	64,665	6	
7	Other (specify):*									7	
8	TOTAL General Services	425,313	226,350	157,658	809,321			(796)	808,525	8	
	B. Health Care and Programs										
9	Medical Director			750	750				750	9	
10	Nursing and Medical Records	1,044,121	25,453	4,658	1,074,232			184	1,074,416	10	
10a	Therapy			169,193	169,193				169,193	10a	
11	Activities	52,960	4,166		57,126				57,126	11	
12	Social Services	36,352			36,352				36,352	12	
13	CNA Training									13	
14	Program Transportation									14	
15	Other (specify):*									15	
16	TOTAL Health Care and Programs	1,133,433	29,619	174,601	1,337,653			184	1,337,837	16	
	C. General Administration										
17	Administrative	53,130		201,125	254,255			(158,437)	95,818	17	
18	Directors Fees									18	
19	Professional Services			17,992	17,992			10,448	28,440	19	
20	Dues, Fees, Subscriptions & Promotions			9,185	9,185			(3,341)	5,844	20	
21	Clerical & General Office Expenses	70,655		24,248	94,903			27,634	122,537	21	
22	Employee Benefits & Payroll Taxes			228,506	228,506			3,198	231,704	22	
23	Inservice Training & Education									23	
24	Travel and Seminar			260	260			9	269	24	
25	Other Admin. Staff Transportation			8,681	8,681			824	9,505	25	
26	Insurance-Prop.Liab.Malpractice			12,885	12,885			390	13,275	26	
27	Other (specify):* Mgmt Alloc of Benefit							10,325	10,325	27	
28	TOTAL General Administration	123,785		502,882	626,667			(108,950)	517,717	28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,682,531	255,969	835,141	2,773,641			(109,562)	2,664,079	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:

01/01/2008

Ending:

12/31/2008

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			15,535	15,535		15,535	43,058	58,593			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			11,900	11,900		11,900	13,762	25,662			32
33	Real Estate Taxes			34,979	34,979		34,979	2,426	37,405			33
34	Rent-Facility & Grounds			186,000	186,000		186,000	(186,000)				34
35	Rent-Equipment & Vehicles							722	722			35
36	Other (specify):*											36
37	TOTAL Ownership			248,414	248,414		248,414	(126,032)	122,382			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		62,099		62,099		62,099		62,099			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			57,096	57,096		57,096		57,096			42
43	Other (specify):* Non-allowable cost			20,374	20,374		20,374	(20,374)				43
44	TOTAL Special Cost Centers		62,099	77,470	139,569		139,569	(20,374)	119,195			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,682,531	318,068	1,161,025	3,161,624		3,161,624	(255,968)	2,905,656			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	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	9,054	30		9
10	Interest and Other Investment Income	(80,417)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(300)	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	(8,534)	43		18
19	Entertainment				19
20	Contributions	(712)	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	(3,530)	43		24
25	Fund Raising, Advertising and Promotional	(80)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,409)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(790)	43		28
29	Other-Attach Schedule See Pg 5A	(12,078)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (99,796)		\$	30

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)	(156,172)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (156,172)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (255,968)		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						44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' COMPILATION REPORT

Oregon Healthcare Center

ID# 0037838

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Lab Expense - Med A	\$ (3,250)	43	1
2	X-Ray Expense - Med A	(519)	43	2
3	Trust Fees	(250)	43	3
4	Association Fees	(3,415)	20	4
5	Gain / Loss in Partnership	(4,644)	43	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	(12,078)		49

SEE ACCOUNTANTS' COMPILATION REPORT

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%	\$ 600	\$ 600	1
2	V	30 Depreciation		Oregon Associates	100.00%	32,028	32,028	2
3	V	32 Interest		Oregon Associates	100.00%	89,150	89,150	3
4	V	32 Amortization-Mortgage Costs		Oregon Associates	100.00%	3,436	3,436	4
5	V	34 Rent	219,979	Oregon Associates	100.00%		(219,979)	5
6	V	43 Other		Oregon Associates	100.00%	4,644	4,644	6
7	V	33 Real Estate Taxes		Oregon Associates	100.00%	33,979	33,979	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 219,979			\$ 163,837	\$ * (56,142)	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 :

Beauvais Manor Healthcare & Rehab	St. Louis, MO
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 <u>Food</u>	\$	<u>SW Management Co.</u>	100.00%	\$ 6	\$ 6
16	V	3 <u>Housekeeping</u>		<u>SW Management Co.</u>	100.00%	83	83
17	V	5 <u>Heat and Other Utilities</u>		<u>SW Management Co.</u>	100.00%	814	814
18	V	6 <u>Maintenance</u>		<u>SW Management Co.</u>	100.00%	1,795	1,795
19	V	17 <u>Administrative</u>	201,125	<u>SW Management Co.</u>	100.00%	42,688	(158,437)
20	V	19 <u>Professional Services</u>		<u>SW Management Co.</u>	100.00%	2,679	2,679
21	V	20 <u>Dues, Fees, Subs & Promotions</u>		<u>SW Management Co.</u>	100.00%	74	74
22	V	21 <u>Clerical & General Office Expense</u>		<u>SW Management Co.</u>	100.00%	27,634	27,634
23	V	24 <u>Travel and Seminar</u>		<u>SW Management Co.</u>	100.00%	9	9
24	V	25 <u>Other Admin Staff Transportation</u>		<u>SW Management Co.</u>	100.00%	824	824
25	V	26 <u>Insurance-Prop. Liab. Malpractice</u>		<u>SW Management Co.</u>	100.00%	390	390
26	V	27 <u>Mgmt. Allocation of Benefits</u>		<u>SW Management Co.</u>	100.00%	10,325	10,325
27	V	30 <u>Depreciation</u>		<u>SW Management Co.</u>	100.00%	1,976	1,976
28	V	33 <u>Real Estate Taxes</u>		<u>SW Management Co.</u>	100.00%	2,426	2,426
29	V	35 <u>Rent-Equipment & Vehicles</u>		<u>SW Management Co.</u>	100.00%	722	722
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 201,125			\$ 92,445	\$ * (108,680)

* 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	\$ 1,131	S & E Medical Supply Co.	100.00%	\$ 835	\$ (296)
16	V	10 Medical Supplies	57	S & E Medical Supply Co.	100.00%	241	184
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 1,188			\$ 1,076	\$ * (112)

* 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%	\$ 7,169	\$	7,169	15
16	V	32 Interest-Bonds	89,150	SFO Associates	0.00%	90,743		1,593	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		\$ 89,150			\$ 97,912	\$ *	8,762	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 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	7.50	Salary	\$ 13,920	L17, C7	1
2	Ronnie Klein	Shareholder	Administrative	15.87	See Schedule 7B	4	8.00	Salary&Fees	14,848	17,3&17,7	2
3	Moshe Herman	CFO	Administrative	2.40	See Schedule 7C	3	7.50	Salary	13,920	L17, C7	3
4											4
5											5
6											6
7	Note : All individuals work in excess of 40 hours per week.										7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 42,688		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:

01/01/2008

Ending: 2/31/2008

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	657,492	12	\$ 98	38,064	\$ 6	1	
2	3	Housekeeping	Bed Days Available	657,492	12	1,440	38,064	83	2	
3	5	Heat and Other Utilities	Bed Days Available	657,492	12	14,061	38,064	814	3	
4	6	Maintenance	Bed Days Available	657,492	12	31,014	38,064	1,795	4	
5	19	Professional Services	Bed Days Available	657,492	12	46,281	38,064	2,679	5	
6	20	Dues, Fees, Subs & Promotions	Bed Days Available	657,492	12	1,278	38,064	74	6	
7	21	Clerical & General Office Exp	Bed Days Available	657,492	12	477,338	410,633	27,634	7	
8	24	Travel and Seminar	Bed Days Available	657,492	12	157	38,064	9	8	
9	25	Other Admin. Staff Transport.	Bed Days Available	657,492	12	14,238	38,064	824	9	
10	26	Insurance-Prop. Liab. & Malp.	Bed Days Available	657,492	12	6,729	38,064	390	10	
11	27	Mgmt. Allocation of Benefits	Bed Days Available	657,492	12	178,342	38,064	10,325	11	
12	33	Real Estate Taxes	Bed Days Available	657,492	12	41,904	38,064	2,426	12	
13	35	Rent-Equipment & Vehicles	Bed Days Available	657,492	12	12,467	38,064	722	13	
14									14	
15									15	
16	17	Administrative	Avg. Hours Worked	40	11	371,200	371,200	3	27,840	16
17	17	Administrative	Avg. Hours Worked	50	6	185,600	185,600	4	14,848	17
18									18	
19	30	Depreciation	Direct Cost					1,976	19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 1,382,147	\$ 967,433	\$ 92,445	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oregon Healthcare Center

0037838

Report Period Beginning:

01/01/2008

Ending: 2/31/2008

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		\$	\$		\$ 835	1
2	10	Medical Supplies	Direct Cost					241	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				\$	\$		\$ 1,076	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oregon Healthcare Center

0037838

Report Period Beginning:

01/01/2008

Ending: 2/31/2008

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	\$ 23,300	\$ 2,000,000	\$ 7,169	1
2	32	Interest-Bonds	Note Receivable	6,500,000	3	294,915	2,000,000	90,743	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					\$ 318,215	\$	\$ 97,912	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Oregon Healthcare Center

0037838

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	Loan Payable-SFO Associates	X		Bonds	Varies	7/1/04	\$ 2,000,000	\$ 830,769	8/15/14	0.0665	\$ 90,743	1						
2					Annually							2						
3												3						
4												4						
5												5						
Working Capital																		
6												6						
7												7						
8												8						
9	TOTAL Facility Related						\$ 2,000,000	\$ 830,769			\$ 90,743	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ 3,436	14						
15	TOTALS (line 9+line14)						\$ 2,000,000	\$ 830,769			\$ 94,179	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 2007 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.)	2007	\$	33,979	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(21)	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	35,000	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.		2,426	
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.		\$	37,405	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2003	30,145	8	
	2004	31,418	9	
	2005	32,052	10	
	2006	32,862	11	
	2007	33,979	12	
2008 RE Tax Accrual = 33,979 X 1.03 = 34,998. Use 35,000				
FOR BHF USE ONLY				
	13	FROM R. E. TAX STATEMENT FOR 2007	\$	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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 2007 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 2007.

(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>33,978.78</u>	\$ <u>33,978.78</u>
2. <u>10-28-412-049-0000</u>	<u>SW Management Allocation</u>	\$ <u>43,500.34</u>	\$ <u>2,426.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>77,479.12</u>	\$ <u>36,404.78</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? X YES 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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oregon Healthcare Center

0037838

Report Period Beginning:

01/01/2008 Ending:

12/31/2008

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:

01/01/2008 Ending: 12/31/2008

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	\$ 1,008,881	\$	40	\$ 25,222	\$ 25,222	\$ 424,570	4
5										5
6	SW Management Allocation	1995		25,058		39	716	716	9,060	6
7										7
8										8
	Improvement Type**									
9	Various		1992	6,160		20			5,953	9
10	Various		1993	26,517	320	20	1,326	1,006	20,822	10
11	Various		1994	5,324		20	266	266	4,111	11
12	Various		1995	3,498		20	175	175	2,202	12
13	Various		1996	2,042	52	20	102	50	1,330	13
14	Various		1997	2,880	170	20	144	(26)	1,668	14
15	Various		1998	65,055	933	20	3,253	2,320	36,309	15
16	Various		1999	36,058	741	20	1,803	1,062	17,655	16
17										17
18	Model 10Kpa Code A/R		2001	1,189		20	59	59	441	18
19	Generator Repair		2001	1,010		20	51	51	363	19
20	Motor		2001	783		20	39	39	300	20
21	Glass Thermo Unit		2001	868		20	43	43	326	21
22	Install Board		2001	816		20	41	41	300	22
23	Gas Controller		2001	739		20	37	37	268	23
24	Clutch & Output Brd		2001	1,138		20	57	57	413	24
25	Vinyl Flooring		2001	912		20	46	46	361	25
26										26
27	Air Conditioners		2002	1,470		20	74	74	662	27
28	Air Conditioners		2002	1,366		20	68	68	557	28
29	Wall-Replaced		2002	5,000	91	20	250	159	1,646	29
30										30
31	Roof Exhaust Fan		2003	3,128		10	313	313	1,720	31
32	Condensor walk - in Freezer		2003	3,193		7	456	456	2,433	32
33	Radiator		2003	3,473		10	347	347	1,823	33
34	Hot Water Repair		2003	1,610		20	81	81	430	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:

01/01/2008 Ending: 12/31/2008

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	\$ 3,567	37
38	Counter tops	2004	4,668		20	233	233	1,050	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	648	42
43	Fire Alarm System	2005	1,932	70	20	97	27	339	43
44	Wanderguard	2005	1,632	59	10	163	104	571	44
45	Air Conditioners	2005	1,008	138	10	101	(37)	353	45
46									46
47	Vertical Rods with Panic Bars	2006	3,036	152	20	152	(0)	532	47
48	Smoke Stops-Attic	2006	1,140		20	57	57	210	48
49	Sidewalks	2006	5,106	437	20	255	(182)	893	49
50	Air Conditioners	2006	5,430	1,043	20	272	(772)	951	50
51	Sprinkler System	2006	62,467	2,326	20	3,123	797	7,808	51
52	Damper Switches - Sprinkler Systems	2006	1,505		20	75	75	188	52
53									53
54	Walk-in Freezer Condensing Unit	2007	6,016	218	20	301	83	451	54
55									55
56									56
57									57
58									58
59	SW Management allocation - Leasehold Improvements	1995	2,673		20	134	134	2,014	59
60	SW Management allocation - Leasehold Improvements	1996	467		20	23	23	293	60
61	SW Management allocation - Leasehold Improvements	1997	672		20	34	34	470	61
62	SW Management allocation - Leasehold Improvements	1998	463		20	23	23	249	62
63	SW Management allocation - Leasehold Improvements	1999	1,285		20	64	64	584	63
64	SW Management allocation - Leasehold Improvements	2005	2,659		20	133	133	465	64
65	SW Management allocation - Leasehold Improvements	2007	1,505		20	75	75	113	65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,340,175	\$ 7,636		\$ 41,700	\$ 34,064	\$ 559,009	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	\$ 54,850	\$ 2,659	\$ 4,565	\$ 1,906	10	\$ 34,520	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	331,103					331,103	73
74	Allocation from Management Co.	7,912		103	103	10	5,799	74
75	TOTALS	\$ 393,865	\$ 2,659	\$ 4,668	\$ 2,009		\$ 371,422	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	\$ 2,473	76
77	Resident Care	E-350 Van	2003	26,099	752	3,728	2,976	7	21,438	77
78	Resident Care	2008 Chevy Van & lift	2007	36,812	4,488	7,362	2,874	5	11,044	78
79	Allocation from Mgmt Co.	2004 Cadillac	2004	3,356		671	671	5	3,020	79
80	TOTALS			\$ 70,902	\$ 5,240	\$ 12,225	\$ 6,985		\$ 37,974	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)	\$ 1,854,942	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 15,535	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 58,593	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 43,058	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 968,405	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: NA
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:		<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>722</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$ <u>722</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>/2009</u>	\$ _____
13.	<u>/2010</u>	\$ _____
14.	<u>/2011</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. 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

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	\$	2,249	\$ 125,955	\$	2,249	\$ 125,955	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		44	1,948		44	1,948	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		723	37,570		723	37,570	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				62,099		62,099	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	3,016	\$ 165,473	\$ 62,099	3,016	\$ 227,572	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: 01/01/2008

Ending: 12/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 184,950	\$ 184,950	1
2	Cash-Patient Deposits	10,072	10,072	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 4,172)	763,279	763,279	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	3,026	3,026	6
7	Other Prepaid Expenses		615	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Schedule 17A	6,439	1,358,338	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 967,766	\$ 2,320,280	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		50,000	13
14	Buildings, at Historical Cost		1,033,938	14
15	Leasehold Improvements, at Historical Cost	209,982	306,237	15
16	Equipment, at Historical Cost	309,579	464,767	16
17	Accumulated Depreciation (book methods)	(341,503)	(968,405)	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		76,220	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 178,058	\$ 962,757	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,145,824	\$ 3,283,037	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 38,575	\$ 38,575	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,159	13,159	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	82,699	82,699	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,748	10,748	31
32	Accrued Real Estate Taxes(Sch.IX-B)	35,000	35,000	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	140,526	140,526	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 320,707	\$ 320,707	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	79,611	830,769	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)	\$ 79,611	\$ 830,769	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 400,318	\$ 1,151,476	46
47	TOTAL EQUITY(page 18, line 24)	\$ 745,506	\$ 2,131,561	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,145,824	\$ 3,283,037	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Oregon Healthcare Center, Inc.
Provider #: 0037838
12/31/2008

XV. BALANCE SHEET -

Other Current Assets (Specify) :	Operating	After Consolidation
Due from State - Interest	5,440	5,440
Employee Payroll Advance	999	999
Due To/From SFO	-	1,351,899
Total Line 9-Other Current Assets (Specify)	6,439	1,358,338

Other Long-Term Assets (Specify)

RE Investment in SFO	-	22,737
RE Loan Costs	-	103,078
RE Accumulated Amortization-Loan Costs	-	(49,595)
Total Line 22-Other Long-Term Assets (specify)	-	76,220

Other Current Liabilities (Specify)

Reimbursement Due	9,430	9,430
Insurance Premiums Payable	(4,664)	(4,664)
Accrued Expenses	(115,292)	(115,292)
Short Term Loan Exchange	(30,000)	(30,000)
Due to Public Aid	-	-
Total Line 37-Other Current Liabilities (Specify)	(140,526)	(140,526)

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 488,449	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 488,449	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	257,057	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)	\$ 257,057	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)	\$ 745,506	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	\$ 3,299,585	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,299,585	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	111,471	6
7	Oxygen	2,624	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 114,095	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,013	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,013	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Cable TV	1,500	28
28a	Miscellaneous Income	488	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,988	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,418,681	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	809,321	31
32	Health Care	1,337,653	32
33	General Administration	626,667	33
	B. Capital Expense		
34	Ownership	248,414	34
	C. Ancillary Expense		
35	Special Cost Centers	82,473	35
36	Provider Participation Fee	57,096	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,161,624	40
41	Income before Income Taxes (line 30 minus line 40)**	257,057	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 257,057	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:

01/01/2008

Ending:

12/31/2008

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	1,992	2,080	\$ 54,377	\$ 26.14	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,708	5,887	140,542	23.87	3
4	Licensed Practical Nurses	13,164	13,627	294,088	21.58	4
5	CNAs & Orderlies	51,732	53,118	555,114	10.45	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,303	5,707	52,960	9.28	10
11	Social Service Workers	2,657	2,734	36,352	13.30	11
12	Dietician					12
13	Food Service Supervisor	1,992	2,080	38,464	18.49	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,771	16,713	144,503	8.65	15
16	Dishwashers					16
17	Maintenance Workers	2,199	2,392	28,810	12.04	17
18	Housekeepers	13,443	13,976	116,592	8.34	18
19	Laundry	10,649	11,089	96,944	8.74	19
20	Administrator	1,640	1,760	53,130	30.19	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,368	4,640	70,655	15.23	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)	130,618	135,803	\$ 1,682,531 *	\$ 12.39	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly	\$ 4,337	L1, C3	35
36	Medical Director	Monthly	750	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,658	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	Monthly	3,720	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)		\$ 13,465		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	\$ 48,845	Workers' Compensation Insurance	\$ 38,291	IDPH License Fee	\$ 995				
Dana Cayton	Administrator	0	4,285	Unemployment Compensation Insurance	26,705	Advertising: Employee Recruitment					
				FICA Taxes	128,714	Health Care Worker Background Check	3,010				
				Employee Health Insurance	31,966	(Indicate # of checks performed 251)					
				Employee Meals	3,198	Patient Background Checks					
				Illinois Municipal Retirement Fund (IMRF)*		Illinois Council on Long Term Care	3,640				
				Miscellaneous Employee Benefits	2,830	Miscellaneous Dues & Permits	360				
						Miscellaneous Inspections & Licenses	1,180				
TOTAL (agree to Schedule V, line 17, col. 1)						Allocated from SW Management Co.	74				
(List each licensed administrator separately.)			\$ 53,130			Less : Non-Allowable Dues	(3,415)				
B. Administrative - Other						Less: Public Relations Expense	()				
Description			Amount			Non-allowable advertising	()				
SW Management - Management Fees			\$ 81,125			Yellow page advertising	()				
Ronnie Klein - Management Fees			120,000								
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 201,125	TOTAL (agree to Schedule V, line 22, col.8)	\$ 231,704	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 5,844				
(Attach a copy of any management service agreement)											
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			
Hepler, Broom, MacDonald, Hebrank	Legal		\$ 981	N/A			Out-of-State Travel	\$			
McGladrey & Pullen, LLP	Accounting		17,011								
							In-State Travel				
							Seminar Expense	260			
							Allocated from SW Management Co.	9			
							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.)			\$ 17,992				TOTAL	\$ 269			

* Attach copy of IMRF notifications
 SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Oregon Health Care Center, Inc.

Provider #: 0037838

12/31/2008

XIX. Support Schedule

C. Professional Services

Total (Agree to Schedule V, Line 19, Column 3)	17,992
Allocated from Real Estate Entity- Accounting	600
Allocated from Management Company-Accounting	578
Allocated from Management Company-Legal	2,101
Total Allocated from Management Company	<u>2,679</u>
Allocated from SFO Associates-Accounting	7,169
Total (Agree to Schedule V, Line 19, Column8)	<u><u>28,440</u></u>

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4		N/A											
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: 01/01/2008

Ending: 12/31/2008

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 = \$3640
- (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. \$ 7,886 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. \$ 57,096
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.

SEE ACCOUNTANTS' COMPILATION REPORT

- (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. \$ 3,198 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? N/A
Attach invoices and a summary of services for all architect and appraisal fees