



Facility Name & ID Number Franklin Grove Nursing Center

# 0037168 Report Period Beginning: 01/01/06 Ending: 12/31/06

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	70	Skilled (SNF)	70	25,550	1
2		Skilled Pediatric (SNF/PED)			2
3	51	Intermediate (ICF)	51	18,615	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	121	TOTALS	121	44,165	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,589	2,012	1,626	5,227	8
9	SNF/PED					9
10	ICF	17,535	15,866		33,401	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,124	17,878	1,626	38,628	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.46%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES  NO

Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES  NO

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

Date started 4/1/91

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

YES  Date 4/1/91 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 1,626

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

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

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

Facility Name & ID Number Franklin Grove Nursing Center # 0037168 Report Period Beginning: 01/01/06 Ending: 12/31/06

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	231,970	12,701	3,168	247,839		247,839		247,839		1
2	Food Purchase		209,098		209,098		209,098	(4,898)	204,200		2
3	Housekeeping	163,169	68,502		231,671		231,671	291	231,962		3
4	Laundry	96,386	9,539		105,925		105,925		105,925		4
5	Heat and Other Utilities			130,055	130,055		130,055	1,412	131,467		5
6	Maintenance	84,560	31,330	5,753	121,643		121,643	1,117	122,760		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	576,085	331,170	138,976	1,046,231		1,046,231	(2,078)	1,044,153		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			6,950	6,950		6,950		6,950		9
10	Nursing and Medical Records	1,534,922	23,975	14,479	1,573,376		1,573,376	20	1,573,396		10
10a	Therapy			138,254	138,254		138,254		138,254		10a
11	Activities	101,113	2,755		103,868		103,868		103,868		11
12	Social Services	28,184			28,184		28,184		28,184		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,664,219	26,730	159,683	1,850,632		1,850,632	20	1,850,652		16
	<b>C. General Administration</b>										
17	Administrative	120,103		280,730	400,833		400,833	(247,110)	153,723		17
18	Directors Fees										18
19	Professional Services			14,346	14,346		14,346	22,674	37,020		19
20	Dues, Fees, Subscriptions & Promotions			7,175	7,175		7,175	(1,721)	5,454		20
21	Clerical & General Office Expenses	201,218		39,925	241,143		241,143	52,497	293,640		21
22	Employee Benefits & Payroll Taxes			326,024	326,024		326,024	4,368	330,392		22
23	Inservice Training & Education										23
24	Travel and Seminar			219	219		219	1	220		24
25	Other Admin. Staff Transportation			12,479	12,479		12,479	414	12,893		25
26	Insurance-Prop.Liab.Malpractice			13,356	13,356		13,356	580	13,936		26
27	Other (specify):* <b>Mgmt. Allc. Benefits</b>							12,463	12,463		27
28	<b>TOTAL General Administration</b>	321,321		694,254	1,015,575		1,015,575	(155,834)	859,741		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,561,625	357,900	992,913	3,912,438		3,912,438	(157,892)	3,754,546		29

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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

Facility Name & ID Number Franklin Grove Nursing Center

#0037168

Report Period Beginning:

01/01/06

Ending:

12/31/06

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			59,876	59,876		59,876	29,817	89,693			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							8,587	8,587			32
33	Real Estate Taxes			50,968	50,968		50,968	2,803	53,771			33
34	Rent-Facility & Grounds			397,485	397,485		397,485	(397,485)				34
35	Rent-Equipment & Vehicles			1,011	1,011		1,011	903	1,914			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			509,340	509,340		509,340	(355,375)	153,965			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		33,768		33,768		33,768		33,768			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			66,248	66,248		66,248		66,248			42
43	Other (specify):* <b>Nonallowable Cost</b>			28,620	28,620		28,620	(28,620)				43
44	<b>TOTAL Special Cost Centers</b>		33,768	94,868	128,636		128,636	(28,620)	100,016			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,561,625	391,668	1,597,121	4,550,414		4,550,414	(541,887)	4,008,527			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 Franklin Grove Nursing Center

# 0037168

Report Period Beginning:

01/01/06

Ending:

12/31/06

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(4,396)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(15,106)	30		9
10	Interest and Other Investment Income	(39,173)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(603)	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	(31)	43		18
19	Entertainment				19
20	Contributions	(1,610)	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				24
25	Fund Raising, Advertising and Promotional	(2,051)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(18,172)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,809)	43		28
29	Other-Attach Schedule See Sch 5A	(117,634)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (200,585)</b>		<b>\$</b>	<b>30</b>

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(341,302)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (341,302)</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (541,887)</b>		<b>37</b>

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>		<b>47</b>

BHF USE ONLY					
48	49	50	51	52	

SEE ACCOUNTANTS' COMPILATION REPORT

Franklin Grove Nursing Center  
Provider #: 0037168  
1/1/2006 to 12/31/2006

Schedule 5A

VI. Adjustment Detail  
Line 29 - Other

<u>Non-allowable expenses</u>	<u>Amount</u>	<u>Reference</u>
Disallow Part A Lab	(3,162)	43
Disallow Part A X-ray	(1,388)	43
Disallow Dues	(1,847)	20
Adjust Management fees	(108,220)	17
Adjust Management fees	(3,017)	21
<b>Total</b>	<b>(117,634)</b>	

**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 Services	\$	Franklin Grove Associates	100.00%	\$ 1,875	\$ 1,875	1
2	V	30 Depreciation		Franklin Grove Associates	100.00%	42,352	42,352	2
3	V	32 Interest		Franklin Grove Associates	100.00%	131,457	131,457	3
4	V	32 Interest Income-Intercompany	160,409	Franklin Grove Associates	100.00%		(160,409)	4
5	V	32 Amortization		Franklin Grove Associates	100.00%	4,810	4,810	5
6	V	34 Rent Facility and Ground	397,485	Franklin Grove Associates	100.00%		(397,485)	6
7	V	43 Other		Franklin Grove Associates	100.00%	4,602	4,602	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 557,894			\$ 185,096	\$ * (372,798)	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	2 Food	\$	SW Management Co.	100.00%	\$ 6	\$	6	15
16	V	3 Housekeeping		SW Management Co.	100.00%	291		291	16
17	V	5 Heat and Other Utilities		SW Management Co.	100.00%	1,412		1,412	17
18	V	6 Maintenance		SW Management Co.	100.00%	1,117		1,117	18
19	V	17 Administrative	190,730	SW Management Co.	100.00%	51,840		(138,890)	19
20	V	19 Professional Services		SW Management Co.	100.00%	7,356		7,356	20
21	V	20 Dues, Fees, Subs & Promotions		SW Management Co.	100.00%	126		126	21
22	V	21 Clerical & General Office Expense		SW Management Co.	100.00%	55,514		55,514	22
23	V	24 Travel and Seminar		SW Management Co.	100.00%	1		1	23
24	V	25 Other Admin. Staff Transport		SW Management Co.	100.00%	414		414	24
25	V	26 Insurance-Prop. Liab Malpractice		SW Management Co.	100.00%	580		580	25
26	V	27 Mgmt. Allocation of Benefits		SW Management Co.	100.00%	12,463		12,463	26
27	V	30 Depreciation		SW Management Co.	100.00%	2,571		2,571	27
28	V	32 Interest		SW Management Co.	100.00%	1,321		1,321	28
29	V	33 Real Estate Taxes		SW Management Co.	100.00%	2,803		2,803	29
30	V	35 Rent-Equipment & Vehicles		SW Management Co.	100.00%	903		903	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		\$ 190,730			\$ 138,718	\$ *	(52,012)	39

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

**VII. RELATED PARTIES (continued)**

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	2 Food	\$ 2,459	S & E Medical Supply Co.	100.00%	\$ 1,923	\$ (536)	15	
16	V	3 Housekeeping	1,289	S & E Medical Supply Co.	100.00%	1,289		16	
17	V	10 Medical Supplies	1,325	S & E Medical Supply Co.	100.00%	1,345	20	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	<b>Total</b>		\$ 5,073			\$ 4,557	\$ *	(516)	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	19 Professional Services	\$	SFO Associates	100.00%	\$ 13,443	\$	13,443	15
16	V	32 Interest-Bonds	110,003	SFO Associates	100.00%	103,021		(6,982)	16
17	V	32 Interest-Intercompany		SFO Associates	100.00%	77,563		77,563	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		\$ 110,003			\$ 194,027	\$ *	84,024	39

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

Schedule 6B

VII Related Parties - Page 6

Related Nursing Homes

City

In-State:

Cahokia Nursing and Rehab	Cahokia
Caseyville Nursing and 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 and Rehab	East St. Louis

Out-of-State:

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

Facility Name &amp; ID Number

Franklin Grove Nursing Center

# 0037168

Report Period Beginning:

01/01/06

Ending:

12/31/06

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Sheldon Wolfe	President	Administrative	31.74	See Schedule 7A	3	7.00	Salary	\$ 11,745	L17, C7	1
2	Ronnie Klein	Shareholder	Administrative	15.83	See Schedule 7B	5	13.00	Salary&Fees	21,875	17,3 & 21,7	2
3	Moshe Herman	CFO	Administrative	2.48	See Schedule 7C	3.4	8.00	Salary	13,311	L21, C7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 46,931		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 Franklin Grove Nursing Center

# 0037168

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	2	Food	Bed Days Available	608,840	11	\$ 89	44,165	\$ 6	1	
2	3	Housekeeping	Bed Days Available	608,840	11	4,018	44,165	291	2	
3	5	Heat and Other Utilities	Bed Days Available	608,840	11	19,472	44,165	1,412	3	
4	6	Maintenance	Bed Days Available	608,840	11	15,398	44,165	1,117	4	
5	19	Professional Services	Bed Days Available	608,840	11	101,398	44,165	7,356	5	
6	20	Dues, Fees, Subs & Promotions	Bed Days Available	608,840	11	1,732	44,165	126	6	
7	21	Clerical & General Office Exp	Bed Days Available	608,840	11	765,293	711,669	55,514	7	
8	24	Travel and Seminar	Bed Days Available	608,840	11	15	44,165	1	8	
9	25	Other Admin. Staff Transport	Bed Days Available	608,840	11	5,704	44,165	414	9	
10	26	Insurance-Prop., Liab. & Malp.	Bed Days Available	608,840	11	8,000	44,165	580	10	
11	27	Mgmt. Allocation of Benefits	Bed Days Available	608,840	11	171,812	44,165	12,463	11	
12	32	Interest	Bed Days Available	608,840	11	18,211	44,165	1,321	12	
13	33	Real Estate Taxes	Bed Days Available	608,840	11	38,636	44,165	2,803	13	
14	35	Rent - Equipment & Vehicles	Bed Days Available	608,840	11	12,454	44,165	903	14	
15									15	
16	17	Administrative	Avg. Hours Worked	43	11	743,036	743,036	3	51,840	16
17									17	
18									18	
19	30	Depreciation	Direct Cost					2,571	19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 1,905,268	\$ 1,454,705	\$ 138,718	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Franklin Grove Nursing Center

# 0037168

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

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

Name of Related Organization S & E Medical Supply Co.  
 Street Address 3100 Commercial Avenue  
 City / State / Zip Code Northbrook, IL 60062  
 Phone Number ( 847) 982-9300  
 Fax Number ( )

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	2	Food	Direct Cost		\$	\$		1,923	1
2	3	Housekeeping	Direct Cost					1,289	2
3	10	Medical Supplies	Direct Cost					1,345	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				\$	\$		4,557	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Franklin Grove Nursing Center

# 0037168 Report Period Beginning: 01/01/06 Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

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

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

1 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	\$ 31,207	\$ 2,800,000	\$ 13,443	1
2	32	Interest - Bonds	Note Receivable	6,500,000	3	239,155	2,800,000	103,021	2
3									3
4	32	Interest - Intercompany	Direct Cost					77,563	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 270,362	\$	\$ 194,027	25

SEE ACCOUNTANTS' COMPILATION REPORT

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Franklin Grove Assoc.	X		Bonds	Annual	7/1/94	\$ 2,800,000	\$ 1,507,692	8/15/14	0.0665	\$ 103,021	1								
2	(Loan Payable-SFO Assoc)				\$129,231.00							2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6												6								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>				\$129,231.00		\$ 2,800,000	\$ 1,507,692			\$ 103,021	9								
<b>B. Non-Facility Related*</b>																				
10							Amortization of loan costs				4,810	10								
11							Interest income offset net of intercompany interest				(100,565)	11								
12							SW Management Allocation-mortgage				1,321	12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (94,434)	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 2,800,000	\$ 1,507,692			\$ 8,587	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.)



**IMPORTANT NOTICE**

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

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

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

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

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

FACILITY NAME Franklin Grove Nursing Center COUNTY Lee

FACILITY IDPH LICENSE NUMBER 0037168

CONTACT PERSON REGARDING THIS REPORT Sheldon Wolfe

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

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

Enter the tax index number and real estate tax assessed for 2005 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>06-03-36-351-07</u>	<u>Long Term Care Property</u>	\$ <u>50,968.46</u>	\$ <u>50,968.46</u>
2. <u>10-28-412-049-0000</u>	<u>SW Management Allocation</u>	\$ <u>39,720.37</u>	\$ <u>2,803.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>90,688.83</u>	\$ <u>53,771.46</u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?        YES   X   NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

Facility Name & ID Number Franklin Grove Nursing Center

# 0037168

Report Period Beginning:

01/01/06

Ending:

12/31/06

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 38,868 B. General Construction Type: Exterior Brick Frame Concrete & 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).  
Meadows of Franklin Grove, Assisted living, 45 units.

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>1991</u>	<u>\$ 36,205</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>			<b>\$ 36,205</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Franklin Grove Nursing Center

# 0037168

Report Period Beginning:

01/01/06

Ending:

12/31/06

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	121	1991		\$ 1,334,101	\$	31.5	\$ 42,352	\$ 42,352	\$ 543,955	4
5										5
6	Mgmt. Alloc	1995		31,780		39	908	908	10,583	6
7										7
8										8
	Improvement Type**									
9	Various		1991	6,395	203	20	320	117	4,827	9
10	Various		1992	29,415	1,737	20	1,471	(266)	21,452	10
11	Various		1993	47,512		20	2,376	2,376	33,854	11
12	Various		1994	17,652	297	20	883	586	11,224	12
13	Various		1995	10,809	164	20	541	377	6,273	13
14	Various		1997	55,791	1,266	20	2,792	1,526	28,238	14
15	Various		1998	87,964	2,200	20	4,399	2,199	34,544	15
16	Various		1999	24,113	538	20	1,205	667	8,965	16
17	Retroaire Chassis		2000	2,321		20	116	116	696	17
18	Water Main Line		2001	3,294	84	20	165	81	948	18
19	Walk In Freezer		2001	8,947		20	447	447	2,422	19
20	Wiring To Kitchen		2001	12,250		20	613	613	3,524	20
21	Kitchen Labor		2001	3,163		20	158	158	816	21
22	Kitchen Labor		2001	1,532		20	77	77	397	22
23	Carpeting		2002	16,211		5	3,242	3,242	16,210	23
24	Bathroom and Tub		2002	3,700	95	10	370	275	1,573	24
25	Bath		2002	7,972	204	10	797	593	3,255	25
26	Glass Blocks		2002	1,649	42	10	165	123	715	26
27	Voice Alarm		2003	948		20	47	47	236	27
28	Code Alert		2003	3,885		20	194	194	841	28
29	Magnetic Door Holders		2003	1,652		20	83	83	414	29
30	Air Conditioners		2003	4,244		20	212	212	1,060	30
31	Tub & Lift		2003	8,738		20	437	437	2,330	31
32	3 Air Conditioners		2003	478		20	24	24	120	32
33	Boiler Repair		2003	1,683		20	84	84	329	33
34	Shower - Glass, Bars		2003	550		20	28	28	109	34
35	Carpet		2003	599		20	30	30	97	35
36	Gutters & Down Spouts		2003	10,759	276	20	538	262	1,973	36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Franklin Grove Nursing Center

# 0037168

Report Period Beginning:

01/01/06

Ending:

12/31/06

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Aluminum Soffit	2003	\$ 1,864	\$ 48	20	\$ 89	\$ 41	\$ 327	37
38	Painting (24 Rooms)	2004	5,520	201	20	276	75	690	38
39	Nurses station	2004	18,750	682	20	938	256	2,345	39
40	Dining Area	2004	2,400	87	20	120	33	300	40
41	New Windows	2004	6,335	230	20	317	87	792	41
42	Bathroom Plumbing and Electrical	2004	12,600	458	20	630	172	1,575	42
43	Kitchen and Dining Room	2004	16,369	595	20	818	223	2,045	43
44	Remodel Shower and Flooring	2004	10,595	385	20	530	145	1,325	44
45	Display Case - Nurses Station	2004	3,800	138	20	190	52	475	45
46	Dining Room Windows	2004	9,614	350	20	481	131	1,202	46
47	Glass Block Shower Windows	2004	1,427	52	20	71	19	178	47
48	Remodel Glass and Shower	2004	3,100	113	20	155	42	388	48
49	Carpet	2004	2,660	98	20	133	35	332	49
50	Windows	2005	34,060	1,239	20	1,703	464	2,554	50
51	Remodel Wall	2005	6,518	237	20	326	89	489	51
52	Outside Soffit	2005	6,268	228	20	313	85	469	52
53	Install Valves	2005	4,500	164	20	225	61	337	53
54	Tiles and Flooring	2006	15,604	479	20	390	(89)	390	54
55	Exterior and Resident Doors	2006	21,725	18	20	543	525	543	55
56	Kick Plates	2006	5,533	112	20	138	26	138	56
57	Windows	2006	58,240	1,825	20	1,456	(369)	1,456	57
58	Siding	2006	2,080		20	52	52	52	58
59	Paving	2006	7,517	376	20	188	(188)	188	59
60	Wallpaper	2006	3,078	33	20	77	44	77	60
61	Air Conditioners	2006	20,183	20,183	20	505	(19,678)	505	61
62	Water Heater	2006	9,984	257	20	249	(8)	249	62
63									63
64	SW Management Allocation-Leasehold Improvements	1995	3,390		20	170	170	2,215	64
65	SW Management Allocation-Leasehold Improvements	1996	592		20	30	30	313	65
66	SW Management Allocation-Leasehold Improvements	1997	853		20	43	43	510	66
67	SW Management Allocation-Leasehold Improvements	1998	587		20	29	29	257	67
68	SW Management Allocation-Leasehold Improvements	1999	1,630		20	81	81	577	68
69	SW Management Allocation-Leasehold Improvements	2005	3,372		20	169	169	253	69
70	TOTAL (lines 4 thru 69)		\$ 2,040,854	\$ 35,694		\$ 76,509	\$ 40,815	\$ 765,526	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Franklin Grove Nursing Center

# 0037168

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	\$ 85,508	\$ 741	\$ 10,871	\$ 10,130	10	\$ 36,276	71
72	Current Year Purchases	23,441	23,441	1,172	(22,269)	10	1,172	72
73	Fully Depreciated Assets	483,600					483,600	73
74	Allocation from Management Co	8,578		290	290	10	8,120	74
75	TOTALS	\$ 601,127	\$ 24,182	\$ 12,333	\$ (11,849)		\$ 529,168	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				\$	\$	\$	\$		\$	76
77										77
78	Allocation from Mgmt. Co	2004 Cadillac	2004	4,256		851	851	5	2,128	78
79										79
80	TOTALS			\$ 4,256	\$	\$ 851	\$ 851		\$ 2,128	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,682,442	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 59,876	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 89,693	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 29,817	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,296,822	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	Bill Nigue 1995	\$ 4,200	\$ 210	\$ 2,432	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 4,200	\$ 210	\$ 2,432	91

G. Construction-in-Progress

	Description	Cost	
92		\$	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: \$ 1,011 Description: Dietary equipment rented for picnic - \$1,011

(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>Management Allocation</u>		\$	\$ <u>903</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$ <u>903</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. \_\_\_\_\_ /2007 \$ \_\_\_\_\_

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

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

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

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

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	\$	3,792	\$ 64,466	\$	3,792	\$ 64,466	1
2	Licensed Speech and Language Development Therapist	L10A,C3	hrs		192	4,042		192	4,042	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A,C3	hrs		4,347	69,545		4,347	69,545	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39,C2	# of prescripts				33,768		33,768	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	<b>TOTAL</b>			\$	8,331	\$ 138,054	\$ 33,768	8,331	\$ 171,822	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 Franklin Grove Nursing Center

# 0037168

Report Period Beginning: 01/01/06

Ending:

12/31/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/06

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 189,761	\$ 189,761	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	624,715	624,715	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	3,866	3,866	6
7	Other Prepaid Expenses		1,059	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Schedule 17A	302,313	2,752,845	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,120,655	\$ 3,572,246	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		36,205	13
14	Buildings, at Historical Cost		1,365,881	14
15	Leasehold Improvements, at Historical Cost	512,840	674,973	15
16	Equipment, at Historical Cost	582,749	605,383	16
17	Accumulated Depreciation (book methods)	(692,595)	(1,296,822)	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):		130,750	22
23	Other(specify): See Schedule 17A		1,768	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 402,994	\$ 1,518,138	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,523,649	\$ 5,090,384	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 43,653	\$ 43,653	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	106,026	106,026	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,784	10,784	31
32	Accrued Real Estate Taxes(Sch.IX-B)	53,500	53,500	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	See Schedule 17A	41,306	41,306	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 255,269	\$ 255,269	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable		1,507,692	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 1,507,692	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 255,269	\$ 1,762,961	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,268,380	\$ 3,327,423	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,523,649	\$ 5,090,384	48

Franklin Grove Nursing Center  
 Provider #: 0037168  
 12/31/2006

Schedule 17A

XV. BALANCE SHEET -

<b>Other Current Assets (specify):</b>	<b>Operating</b>	<b>After Consolidation</b>
Due from State-Interest	8,181	8,181
Due from GR Associates	294,132	0
RE Due to/from Florissant	0	1,432,938
RE Due to/from SFO Associates	0	1,311,726
<b>Total Line 9 - Other Current Assets (specify):</b>	<b><u>302,313</u></b>	<b><u>2,752,845</u></b>

<b>Other Current Liabilities (specify):</b>	<b>Operating</b>	<b>After Consolidation</b>
Short Term Loan Exchange	(5,770)	(5,770)
Insurance Premiums Payable	1,060	1,060
Accrued Expenses	46,016	46,016
<b>Total Line 36 - Other Current Liabilities (specify):</b>	<b><u>41,306</u></b>	<b><u>41,306</u></b>

<b>Other Long-Term Assets (specify):</b>	<b>Operating</b>	<b>After Consolidation</b>
Investment in SFO Associate	0	46,670
Loan Costs	0	144,309
Amortization - Loan	0	(60,229)
<b>Total Line 22 - Other Long-Term Assets (specify):</b>	<b><u>0</u></b>	<b><u>130,750</u></b>

<b>Other (specify):</b>	<b>Operating</b>	<b>After Consolidation</b>
Non-care asset		1,768
<b>Total Line 23 - Other (specify):</b>	<b><u>0</u></b>	<b><u>1,768</u></b>

See Accountants' Compilation Report

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,260,271</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Prior Period Adjustment</b>	<b>190</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>1,260,461</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>673,419</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(665,500)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>7,919</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,268,380</b>	<b>24</b> *

Operating Entity Only

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

SEE ACCOUNTANTS' COMPILATION REPORT

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

1

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 5,056,077	1
2	Discounts and Allowances for all Levels		2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,056,077	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	97,147	6
7	Oxygen	28,192	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 125,339	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	200	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 200	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	39,173	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 39,173	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Misc Income</u>	3,044	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 3,044	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,223,833	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,046,231	31
32	Health Care	1,850,632	32
33	General Administration	1,015,575	33
	<b>B. Capital Expense</b>		
34	Ownership	509,340	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	62,388	35
36	Provider Participation Fee	66,248	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,550,414	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	673,419	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 673,419	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 Franklin Grove Nursing Center

# 0037168

Report Period Beginning:

01/01/06

Ending:

12/31/06

**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,080	2,080	\$ 71,029	\$ 34.15	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,493	5,791	123,194	21.27	3
4	Licensed Practical Nurses	22,571	23,765	481,258	20.25	4
5	CNAs & Orderlies	77,275	79,066	811,392	10.26	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,953	4,171	48,049	11.52	8
9	Activity Director					9
10	Activity Assistants	8,760	9,079	101,113	11.14	10
11	Social Service Workers	1,992	2,123	28,184	13.28	11
12	Dietician					12
13	Food Service Supervisor	3,474	3,634	41,893	11.53	13
14	Head Cook					14
15	Cook Helpers/Assistants	23,155	24,386	190,077	7.79	15
16	Dishwashers					16
17	Maintenance Workers	5,632	6,010	84,560	14.07	17
18	Housekeepers	18,953	20,175	163,169	8.09	18
19	Laundry	11,100	11,704	96,386	8.24	19
20	Administrator	2,080	2,080	120,103	57.74	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,280	11,744	201,218	17.13	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)	197,798	205,808	\$ 2,561,625 *	\$ 12.45	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	\$ 3,168	L1, C3	35
36	Medical Director	Monthly	6,950	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	14,479	L10,C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	Monthly	200	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)		\$ 24,797		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$ N/A		50
51	Licensed Practical Nurses				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	
Jill Gee	Administrator	0	\$ 120,103	Workers' Compensation Insurance	\$ 52,578	IDPH License Fee	\$ 350	
				Unemployment Compensation Insurance	23,677	Advertising: Employee Recruitment		
				FICA Taxes	194,359	Health Care Worker Background Check		
				Employee Health Insurance	46,735	(Indicate # of checks performed <u>142</u> )	1,705	
				Employee Meals	4,368	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		IL Council on Long Term Care	3,267	
				Misc. Employee Benefits/Disability	8,280	Miscellaneous Dues, Subscriptions, Permits	1,753	
				Holiday Expense	395	Miscellaneous Inspections & Licenses	100	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 120,103			Allocated from Home Office	126	
B. Administrative - Other						Less: Non-Allowable Dues	(1,847)	
Description			Amount			Less: Public Relations Expense	( )	
SW Management - Home Office and Management Fees			\$ 190,730			Non-allowable advertising	( )	
Ronnie Klein - Management Fees			90,000			Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 280,730	TOTAL (agree to Schedule V, line 22, col.8)	\$ 330,392	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 5,454	
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
Winston & Strawn	Legal		\$ 145	N/A			Out-of-State Travel	\$
RSM McGladrey, Inc.	Accounting		14,201				In-State Travel	
							Seminar Expense	219
							Allocated from Home Office	1
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 14,346	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 220

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

\*\*See instructions.

Franklin Grove Nursing Center, Inc.  
Provider #: 0037168  
12/31/2005

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3) 14,346

Allocated from Franklin Grove Associates:

Accounting - RSM McGladrey, Inc. 1,875

Allocated from SW Management Company:

Legal 6,060

Accounting - RSM McGladrey, Inc. 1,296

Allocated from SFO Associates

Accounting - RSM McGladrey, Inc. 13,443

Total (agree to Schedule V, line 19, column 8) 37,020

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Franklin Grove Nursing Center# 0037168

Report Period Beginning:

01/01/06

Ending:

12/31/06**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. Illinois Council on Long Term Care- \$1420
- (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 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 13,966 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. \$ 66,248  
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. \$ 4,368 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients?
- 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. \$ None**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? No  
Attach invoices and a summary of services for all architect and appraisal fees