

Facility Name & ID Number Franklin Grove Nursing Center

0037168 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>70</u>	Skilled (SNF)	<u>70</u>	<u>25,550</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>51</u>	Intermediate (ICF)	<u>51</u>	<u>18,615</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>121</u>	TOTALS	<u>121</u>	<u>44,165</u>	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	<u>1,180</u>	<u>1,736</u>	<u>2,786</u>	<u>5,702</u>	8
9	SNF/PED					9
10	ICF	<u>19,353</u>	<u>13,430</u>		<u>32,783</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>20,533</u>	<u>15,166</u>	<u>2,786</u>	<u>38,485</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.14%

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 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 2,786

Medicare Intermediary Wisconsin Physicians Service

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/07 Fiscal Year: 12/31/07

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Franklin Grove Nursing Center # 0037168 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	258,608	13,709	3,620	275,937		275,937		275,937	1	
2	Food Purchase		233,636		233,636		233,636	(5,206)	228,430	2	
3	Housekeeping	179,727	68,018		247,745		247,745	131	247,876	3	
4	Laundry	106,835	9,513		116,348		116,348		116,348	4	
5	Heat and Other Utilities			174,118	174,118		174,118	1,211	175,329	5	
6	Maintenance	86,645	41,046	6,303	133,994		133,994	1,559	135,553	6	
7	Other (specify):*									7	
8	TOTAL General Services	631,815	365,922	184,041	1,181,778		1,181,778	(2,305)	1,179,473	8	
	B. Health Care and Programs										
9	Medical Director			6,400	6,400		6,400		6,400	9	
10	Nursing and Medical Records	1,588,359	21,083	13,293	1,622,735		1,622,735	9	1,622,744	10	
10a	Therapy			249,585	249,585		249,585		249,585	10a	
11	Activities	100,519	2,815		103,334		103,334		103,334	11	
12	Social Services	36,013			36,013		36,013		36,013	12	
13	CNA Training									13	
14	Program Transportation									14	
15	Other (specify):*									15	
16	TOTAL Health Care and Programs	1,724,891	23,898	269,278	2,018,067		2,018,067	9	2,018,076	16	
	C. General Administration										
17	Administrative	123,917		277,625	401,542		401,542	(234,201)	167,341	17	
18	Directors Fees									18	
19	Professional Services			19,257	19,257		19,257	20,131	39,388	19	
20	Dues, Fees, Subscriptions & Promotions			10,485	10,485		10,485	(479)	10,006	20	
21	Clerical & General Office Expenses	306,840		59,396	366,236		366,236	28,925	395,161	21	
22	Employee Benefits & Payroll Taxes			348,463	348,463		348,463	5,030	353,493	22	
23	Inservice Training & Education									23	
24	Travel and Seminar			1,769	1,769		1,769	43	1,812	24	
25	Other Admin. Staff Transportation			14,301	14,301		14,301	541	14,842	25	
26	Insurance-Prop.Liab.Malpractice			14,254	14,254		14,254	509	14,763	26	
27	Other (specify):*							10,119	10,119	27	
28	TOTAL General Administration	430,757		745,550	1,176,307		1,176,307	(169,382)	1,006,925	28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,787,463	389,820	1,198,869	4,376,152		4,376,152	(171,678)	4,204,474	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.

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			41,628	41,628		41,628	46,935	88,563			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							60,234	60,234			32
33	Real Estate Taxes			53,163	53,163		53,163	2,829	55,992			33
34	Rent-Facility & Grounds			397,485	397,485		397,485	(397,485)				34
35	Rent-Equipment & Vehicles			1,043	1,043		1,043	852	1,895			35
36	Other (specify):*											36
37	TOTAL Ownership			493,319	493,319		493,319	(286,635)	206,684			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		47,016		47,016		47,016		47,016			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):* Non-allowable Cos			31,861	31,861		31,861	(31,861)				43
44	TOTAL Special Cost Centers		47,016	98,109	145,125		145,125	(31,861)	113,264			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,787,463	436,836	1,790,297	5,014,596		5,014,596	(490,174)	4,524,422			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:

01/01/2007

Ending:

12/31/2007

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(4,533)	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	2,359	30		9
10	Interest and Other Investment Income	(36,846)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(516)	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	(1,170)	43		18
19	Entertainment				19
20	Contributions	(1,700)	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	(247)	43		24
25	Fund Raising, Advertising and Promotional	(2,246)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(15,091)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,810)	43		28
29	Other-Attach Schedule See Pg. 5A	(12,301)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (75,101)		\$	30

BHF USE ONLY					
48		49		50	
				51	
					52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(415,073)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (415,073)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (490,174)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Franklin Grove Nursing Center

ID# 0037168

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Disallow Part A Lab	\$ (6,898)	43	1
2	Disallow Part A X-ray	(1,741)	43	2
3	Disallow Dues	(537)	20	3
4	Gains & Losses	(3,125)	43	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				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	(12,301)		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 Services	\$	Franklin Grove Associates	100.00%	\$ 1,950	\$ 1,950	1
2	V	30 Depreciation		Franklin Grove Associates	100.00%	42,352	42,352	2
3	V	32 Interest		Franklin Grove Associates	100.00%	114,796	114,796	3
4	V	32 Amortization		Franklin Grove Associates	100.00%	4,810	4,810	4
5	V	34 Rent Facility and Ground	397,485	Franklin Grove Associates	100.00%		(397,485)	5
6	V	43 Other		Franklin Grove Associates	100.00%	8,216	8,216	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 397,485			\$ 172,124	\$ * (225,361)	14

* 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 <u>Food</u>	\$	<u>SW Management Co.</u>	100.00%	\$ 22	\$	22	15
16	V	3 <u>Housekeeping</u>		<u>SW Management Co.</u>	100.00%	131		131	16
17	V	5 <u>Heat and Other Utilities</u>		<u>SW Management Co.</u>	100.00%	1,211		1,211	17
18	V	6 <u>Maintenance</u>		<u>SW Management Co.</u>	100.00%	1,559		1,559	18
19	V	17 <u>Administrative</u>	277,625	<u>SW Management Co.</u>	100.00%	43,424		(234,201)	19
20	V	19 <u>Professional Services</u>		<u>SW Management Co.</u>	100.00%	7,382		7,382	20
21	V	20 <u>Dues, Fees, Subs & Promotions</u>		<u>SW Management Co.</u>	100.00%	58		58	21
22	V	21 <u>Clerical & General Office Expense</u>		<u>SW Management Co.</u>	100.00%	28,925		28,925	22
23	V	24 <u>Travel and Seminar</u>		<u>SW Management Co.</u>	100.00%	43		43	23
24	V	25 <u>Other Admin. Staff Transport</u>		<u>SW Management Co.</u>	100.00%	541		541	24
25	V	26 <u>Insurance-Prop. Liab Malpractice</u>		<u>SW Management Co.</u>	100.00%	509		509	25
26	V	27 <u>Mgmt. Allocation of Benefits</u>		<u>SW Management Co.</u>	100.00%	10,119		10,119	26
27	V	30 <u>Depreciation</u>		<u>SW Management Co.</u>	100.00%	2,224		2,224	27
28	V	32 <u>Interest</u>		<u>SW Management Co.</u>	100.00%	1,177		1,177	28
29	V	33 <u>Real Estate Taxes</u>		<u>SW Management Co.</u>	100.00%	2,829		2,829	29
30	V	35 <u>Rent-Equipment & Vehicles</u>		<u>SW Management Co.</u>	100.00%	852		852	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		\$ 277,625			\$ 101,006	\$ *	(176,619)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	2 Food	\$ 1,992	S & E Medical Supply Co.	100.00%	\$ 1,794	\$ (198)
16	V	3 Housekeeping	360	S & E Medical Supply Co.	100.00%	360	
17	V	10 Medical Supplies	44	S & E Medical Supply Co.	100.00%	53	9
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		\$ 2,396			\$ 2,207	\$ * (189)

* 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	100.00%	\$ 10,799	\$ 10,799
16	V	32 Interest-Bonds	101,096	SFO Associates	100.00%	91,093	(10,003)
17	V	32 Interest-Intercompany	13,700	SFO Associates	100.00%		(13,700)
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		\$ 114,796			\$ 101,892	\$ * (12,904)

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Franklin Grove Nursing Center # 0037168 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Sheldon Wolfe	President	Administrative		See Schedule 7A	3	7.00	Salary	\$ 13,519	L17, C7	1
2	Ronnie Klein	Shareholder	Administrative		See Schedule 7B	5	13.00	Salary & Fees	16,386	17,3 & 17, 7	2
3	Moshe Herman	CFO	Administrative		See Schedule 7C	3	8.00	Salary	13,519	L17, C7	3
4											4
5											5
6											6
7											7
8											8
9			Note: All individuals work in excess of 40 hours per week.								9
10											10
11											11
12											12
13								TOTAL	\$ 43,424		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:

01/01/2007

Ending: 2/31/2007

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	2	Food	Bed Days Available	645,320	11	\$ 319	\$ 44,165	\$ 22	1	
2	3	Housekeeping	Bed Days Available	645,320	11	1,918	44,165	131	2	
3	5	Heat and Other Utilities	Bed Days Available	645,320	11	17,688	44,165	1,211	3	
4	6	Maintenance	Bed Days Available	645,320	11	22,780	44,165	1,559	4	
5	19	Professional Services	Bed Days Available	645,320	11	107,864	44,165	7,382	5	
6	20	Dues, Fees, Subs & Promotions	Bed Days Available	645,320	11	844	44,165	58	6	
7	21	Clerical & General Office Exp	Bed Days Available	645,320	11	422,637	373,471	28,925	7	
8	24	Travel and Seminar	Bed Days Available	645,320	11	625	44,165	43	8	
9	25	Other Admin. Staff Transport	Bed Days Available	645,320	11	7,906	44,165	541	9	
10	26	Insurance-Prop., Liab & Malp.	Bed Days Available	645,320	11	7,442	44,165	509	10	
11	27	Mgmt. Allocation of Benefits	Bed Days Available	645,320	11	147,860	44,165	10,119	11	
12	32	Interest	Bed Days Available	645,320	11	17,198	44,165	1,177	12	
13	33	Real Estate Taxes	Bed Days Available	645,320	11	41,339	44,165	2,829	13	
14	35	Rent-Equipment & Vehicles	Bed Days Available	645,320	11	12,453	44,165	852	14	
15									15	
16	17	Administrative	Avg. Hours Worked	40	11	360,500	360,500	3	27,038	16
17	17	Administrative	Avg. Hours Worked	55	11	180,250	180,250	5	16,386	17
18									18	
19	30	Depreciation	Direct Cost			32,495		2,224	19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 1,382,118	\$ 914,221	\$ 101,006	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Franklin Grove Nursing Center

0037168

Report Period Beginning:

01/01/2007

Ending: 2/31/2007

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	2	Food	Direct Cost		\$	\$		\$ 1,794	1
2	3	Housekeeping	Direct Cost					360	2
3	10	Medical Supplies	Direct Cost					53	3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 2,207	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Franklin Grove Nursing Center

0037168

Report Period Beginning:

01/01/2007

Ending: 2/31/2007

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Professional Services	Note Receivable	6,500,000	3	\$ 25,069	\$ 2,800,000	\$ 10,799	1
2	32	Interest-Bonds	Note Receivable	6,500,000	3	211,466	2,800,000	91,093	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 236,535	\$	\$ 101,892	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Franklin Grove Nursing Center

0037168

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10					
		Related**					Monthly Payment Required	Date of Note					Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
A. Directly Facility Related																	
Long-Term																	
1	Franklin Grove Assoc.	X		Bonds	Annual	7/1/94	\$ 2,800,000	\$ 1,335,385	8/15/14		\$ 91,093	1					
2	(Loan Payable-SFO Assoc)				\$129,231.00							2					
3												3					
4												4					
5												5					
Working Capital																	
6												6					
7												7					
8												8					
9	TOTAL Facility Related				\$129,231.00		\$ 2,800,000	\$ 1,335,385			\$ 91,093	9					
B. Non-Facility Related*																	
10							Amortization of loan cost				4,810	10					
11							Disallow nonallowable interest expense				(36,846)	11					
12							Allocated from Management Co.				1,177	12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$ (30,859)	14					
15	TOTALS (line 9+line14)						\$ 2,800,000	\$ 1,335,385			\$ 60,234	15					

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

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2006 report.		\$	53,500	1
	Allocated from Management Co.		2,829	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2006	\$	52,663	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(837)	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	54,000	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
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.		\$	55,992	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2002	46,432	8	
	2003	49,904	9	
	2004	49,199	10	
	2005	50,968	11	
	2006	52,663	12	
2006 real estate tax bill * 103% = 54,243. Use 54,000				
FOR BHF USE ONLY				
	13	FROM R. E. TAX STATEMENT FOR 2006	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2007 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME 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 2006 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2006.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>06-03-36-351-07</u>	<u>Long Term Care Property</u>	\$ <u>52,663.00</u>	\$ <u>52,663.00</u>
2. <u>10-28-412-049-0000</u>	<u>SW Management Allocation</u>	\$ <u>42,503.98</u>	\$ <u>2,829.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>95,166.98</u>	\$ <u>55,492.00</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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

Facility Name & ID Number Franklin Grove Nursing Center

0037168

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

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	TOTALS			\$ 36,205	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Franklin Grove Nursing Center

0037168

Report Period Beginning:

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

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	121	1991		\$ 1,334,100	\$	31.5	\$ 42,352	\$ 42,352	\$ 698,814	4
5										5
6	Mgmt. Alloc	1995		29,623		39	846	846	10,711	6
7										7
8										8
	Improvement Type**									
9	Various		1991	6,395	203	20	320	117	5,147	9
10	Various		1992	29,415	869	20	1,471	602	22,922	10
11	Various		1993	47,511	297	20	2,375	2,078	36,229	11
12	Various		1994	17,652		20	883	883	12,117	12
13	Various		1995	10,809	272	20	541	269	6,814	13
14	Various		1997	55,791	1,158	20	2,792	1,634	31,021	14
15	Various		1998	87,964	2,200	20	4,399	2,199	38,943	15
16	Various		1999	24,113	538	20	1,205	667	10,170	16
17	Retroaire Chassis		2000	2,321		20	116	116	812	17
18	Water Main Line		2001	3,294	84	20	165	81	1,113	18
19	Walk In Freezer		2001	8,947		20	447	447	2,869	19
20	Wiring To Kitchen		2001	12,250		20	613	613	4,137	20
21	Kitchen Labor		2001	3,163		20	158	158	974	21
22	Kitchen Labor		2001	1,532		20	77	77	474	22
23	Carpeting		2002	16,211		5			16,210	23
24	Bathroom and Tub		2002	3,700	95	10	370	275	1,943	24
25	Bath		2002	7,972	204	10	797	593	4,052	25
26	Glass Blocks		2002	1,649	42	10	165	123	880	26
27	Voice Alarm		2003	948		20	47	47	283	27
28	Code Alert		2003	3,887		20	194	194	1,035	28
29	Magnetic Door Holders		2003	1,652		20	83	83	497	29
30	Air Conditioners		2003	4,244		20	212	212	1,272	30
31	Tub & Lift		2003	8,738		20	437	437	2,767	31
32	3 Air Conditioners		2003	478		20	24	24	144	32
33	Boiler Repair		2003	1,683		20	84	84	413	33
34	Shower - Glass, Bars		2003	550		20	28	28	137	34
35	Carpet		2003	599		20	30	30	127	35
36	Gutters & Down Spouts		2003	10,759	276	20	538		2,511	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 Franklin Grove Nursing Center

0037168

Report Period Beginning:

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Aluminum Soffit	2003	\$ 1,864	\$ 48	20	\$ 89	\$ 41	\$ 416	37
38	Painting (24 Rooms)	2004	5,520	201	20	276	75	966	38
39	Nurses station	2004	18,750	682	20	938	256	3,283	39
40	Dining Area	2004	2,400	87	20	120	33	420	40
41	New Windows	2004	6,335	230	20	317	87	1,109	41
42	Bathroom Plumbing and Electrical	2004	12,600	458	20	630	172	2,205	42
43	Kitchen and Dining Room	2004	16,369	595	20	818	223	2,863	43
44	Remodel Shower and Flooring	2004	10,595	385	20	530	145	1,855	44
45	Display Case - Nurses Station	2004	3,800	138	20	190	52	665	45
46	Dining Room Windows	2004	9,614	350	20	481	131	1,683	46
47	Glass Block Shower Windows	2004	1,427	52	20	71	19	249	47
48	Remodel Glass and Shower	2004	3,100	113	20	155	42	543	48
49	Carpet	2004	2,660	98	20	133	35	465	49
50	Windows	2005	34,060	1,239	20	1,703	464	4,257	50
51	Remodel Wall	2005	6,518	237	20	326	89	815	51
52	Outside Soffit	2005	6,268	228	20	313	85	782	52
53	Install Valves	2005	4,500	164	20	225	61	562	53
54	Tiles and Flooring	2006	15,604	547	20	780	233	1,170	54
55	Exterior and Resident Doors	2006	21,725		20	1,086	1,086	1,629	55
56	Kick Plates	2006	5,533	141	20	277	136	415	56
57	Windows	2006	58,240	3,063	20	2,912	(151)	4,368	57
58	Siding	2006	2,080		20	104	104	156	58
59	Paving	2006	7,517	714	20	376	(338)	564	59
60	Wallpaper	2006	3,078	112	20	154	42	231	60
61	Air Conditioners	2006	20,183		20	1,009	1,009	1,514	61
62	Water Heater	2006	9,984	363	20	499	136	748	62
63									63
64	Glue Down Carpet	2007	3,036	3,036	20	76	(2,960)	76	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,031,310	\$ 19,519		\$ 76,357	\$ 56,576	\$ 949,547	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 2,031,310	\$ 19,519		\$ 76,357	\$ 56,838	\$ 949,547	1
2								2
3								3
4								4
5	1995	3,160		20	158	158	2,223	5
6	1996	552		20	28	28	319	6
7	1997	795		20	40	40	515	7
8	1998	547		20	27	27	267	8
9	1999	1,519		20	76	76	614	9
10	2005	3,143		20	157	157	393	10
11	2007	1,779		20	44	44	44	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		\$ 2,042,805	\$ 19,519		\$ 76,887	\$ 57,368	\$ 953,922	34

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:

01/01/2007

Ending:

12/31/2007

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	\$ 108,949	\$ 426	\$ 9,955	\$ 9,529	10	\$ 47,403	71
72	Current Year Purchases	21,683	21,683	1,084	(20,599)	10	1,084	72
73	Fully Depreciated Assets	483,600					483,600	73
74	Allocation from Management Co.	7,991		54	54		6,730	74
75	TOTALS	\$ 622,223	\$ 22,109	\$ 11,093	\$ (11,016)		\$ 538,817	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	Allocation from Mgmt. Co.	2004 Cadillac	2004	3,965		793	793	5	2,775	77
78										78
79										79
80	TOTALS			\$ 3,965	\$	\$ 793	\$ 793		\$ 2,775	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)	\$ 2,705,198	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 41,628	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 88,773	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 47,145	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,495,514	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	\$ 2,642	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 4,200	\$ 210	\$ 2,642	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		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: \$ 1,043 Description: Dietary equipment- \$1,043

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18	<u>Management Allocation</u>			<u>852</u>	18
19					19
20					20
21	TOTAL		\$	\$ 852	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. _____ /2008 \$ _____

13. _____ /2009 \$ _____

14. _____ /2010 \$ _____

* 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	\$	4,364	\$ 122,190	\$	4,364	\$ 122,190	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		145	8,985		145	8,985	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A,C3	hrs		4,539	118,014		4,539	118,014	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				47,016		47,016	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	9,048	\$ 249,189	\$ 47,016	9,048	\$ 296,205	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: 01/01/2007

Ending: 12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 405,081	\$ 405,081	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>-0-</u>)	886,690	886,690	3
4	Supply Inventory (priced at <u> </u>)			4
5	Short-Term Investments			5
6	Prepaid Insurance	4,234	4,234	6
7	Other Prepaid Expenses		1,002	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Schedule 17A</u>	183,726	2,906,505	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,479,731	\$ 4,203,512	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		36,205	13
14	Buildings, at Historical Cost		1,363,724	14
15	Leasehold Improvements, at Historical Cost	515,876	679,081	15
16	Equipment, at Historical Cost	604,431	621,988	16
17	Accumulated Depreciation (book methods)	(734,223)	(1,492,872)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): <u>See Schedule 17A</u>		117,608	22
23	Other(specify): <u>See Schedule 17A</u>		1,558	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 386,084	\$ 1,327,292	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,865,815	\$ 5,530,804	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 96,240	\$ 96,240	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	370	370	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	120,889	120,889	30
31	Accrued Taxes Payable (excluding real estate taxes)	12,214	12,214	31
32	Accrued Real Estate Taxes(Sch.IX-B)	54,000	54,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Schedule 17A</u>	93,243	93,243	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 376,956	\$ 376,956	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		1,335,385	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)	\$	\$ 1,335,385	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 376,956	\$ 1,712,341	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,488,859	\$ 3,818,463	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,865,815	\$ 5,530,804	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

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

Schedule 17A

XV. BALANCE SHEET -

Other Current Assets (specify):	Operating	After Consolidation
Due from State-Interest	8,460	8,460
Employee Payroll advance	570	570
Due from GR Associates	0	(174,696)
RE Due to/from Florissant	0	1,520,868
Due to Franklin Grove Associates	174,696	174,696
RE Due to/from SFO Associates	0	1,376,607
Total Line 9 - Other Current Assets (specify):	183,726	2,906,505

Other Long-Term Assets (specify):	Operating	After Consolidation
Investment in SFO Associate	0	38,338
Loan Costs	0	144,309
Amortization - Loan Costs	0	(65,039)
Total Line 22 - Other Long-Term Assets (specify):	0	117,608

Other (specify):	Operating	After Consolidation
Non-care asset		1,558
Total Line 23 - Other (specify):	0	1,558

Other Current Liabilities (specify):	Operating	After Consolidation
Retirement (From P/R)	460	460
Due to Public Aid	(11,932)	(11,932)
Accrued Expenses	(81,771)	(81,771)
Total Line 36 - Other Current Liabilities (specify):	(93,243)	(93,243)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,268,380	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,268,380	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	583,478	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	(363,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Rounding	1	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 220,479	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)	\$ 1,488,859	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	\$ 5,336,568	1
2		Discounts and Allowances for all Levels		2
3		SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,336,568	3
B. Ancillary Revenue				
4		Day Care		4
5		Other Care for Outpatients		5
6		Therapy	188,917	6
7		Oxygen	32,414	7
8		SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 221,331	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	960	21
22		Laundry		22
23		SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 960	23
D. Non-Operating Revenue				
24		Contributions		24
25		Interest and Other Investment Income***	36,846	25
26		SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 36,846	26
E. Other Revenue (specify):****				
27		Settlement Income (Insurance, Legal, Etc.)		27
28		<u>Miscellaneous Revenue</u>	2,369	28
28a				28a
29		SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,369	29
30		TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,598,074	30

2		Expenses	Amount	
A. Operating Expenses				
31		General Services	1,181,778	31
32		Health Care	2,018,067	32
33		General Administration	1,176,307	33
B. Capital Expense				
34		Ownership	493,319	34
C. Ancillary Expense				
35		Special Cost Centers	78,877	35
36		Provider Participation Fee	66,248	36
D. Other Expenses (specify):				
37				37
38				38
39				39
40		TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,014,596	40
41		Income before Income Taxes (line 30 minus line 40)**	583,478	41
42		Income Taxes		42
43		NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 583,478	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: 01/01/2007

Ending: 12/31/2007

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,080	2,080	\$ 75,073	\$ 36.09	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,421	7,678	182,160	23.72	3
4	Licensed Practical Nurses	20,070	20,989	445,580	21.23	4
5	CNAs & Orderlies	77,839	79,633	818,151	10.27	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,023	6,298	67,395	10.70	8
9	Activity Director					9
10	Activity Assistants	7,579	7,804	100,519	12.88	10
11	Social Service Workers	2,674	2,858	36,013	12.60	11
12	Dietician					12
13	Food Service Supervisor	4,460	4,694	68,314	14.55	13
14	Head Cook					14
15	Cook Helpers/Assistants	21,674	22,581	190,294	8.43	15
16	Dishwashers					16
17	Maintenance Workers	5,637	6,025	86,645	14.38	17
18	Housekeepers	19,629	20,988	179,727	8.56	18
19	Laundry	11,804	12,415	106,835	8.61	19
20	Administrator	2,080	2,080	123,917	59.58	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,270	14,913	306,840	20.58	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)	203,240	211,036	\$ 2,787,463 *	\$ 13.21	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	\$ 3,620	L1,C3	35
36	Medical Director	Monthly	6,400	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	13,293	L10,C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	Monthly	396	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)		\$ 23,709		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

Facility Name & ID Number Franklin Grove Nursing Center

0037168

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

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	\$ 123,917	Workers' Compensation Insurance	\$ 37,134	IDPH License Fee	\$ 2,540		
				Unemployment Compensation Insurance	26,112	Advertising: Employee Recruitment			
				FICA Taxes	211,611	Health Care Worker Background Check			
				Employee Health Insurance	62,599	(Indicate # of checks performed <u>12</u>)	140		
				Employee Meals	5,030	Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		IL Council on Long Term Care	7,369		
				Misc. Employee Benefits/Disability	5,112	Miscellaneous Dues & Permits	285		
				Holiday Expense	5,807	Miscellaneous Inspections & Licenses	151		
				Uniforms	88	Allocated from management Co.	58		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 123,917	TOTAL (agree to Schedule V, line 22, col.8)		\$ 353,493	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 10,006
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
SW Management-Home office and Management Fees			\$ 187,625	N/A		\$	Out-of-State Travel	\$	
Ronnie Klein-Management Fees			90,000						
(Eliminated in Sch. V, Col. 7)							In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 277,625				Seminar Expense	1,769	
							Allocated from Home Office	43	
C. Professional Services				TOTAL			Entertainment Expense (agree to Sch. V, line 24, col. 8)		
Vendor/Payee	Type		Amount	\$			TOTAL		
RSM McGladrey, Inc.	Accounting		\$ 19,257				\$ 1,812		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 19,257						

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Franklin Grove Nursing Center, Inc.

Provider # 0037168

12/31/2007

Schedule 21A

XIX. Support Schedule

C. Professional Services

Total (agree to Schedule V, line 19, column 3) 19,257

Allocated from Franklin Grove Associates: 1,950
Accounting-RSM McGladrey, Inc.

Allocated from SW Management Compnay:
Legal 5,382
Accounting-RSM McGladrey, Inc. 2,000

Allocated from SFO Associates
Accounting-RSM McGladrey, Inc. 10,799

Total (agree to Schedule V, line 19, column 8) 39,388

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								
					FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Franklin Grove Nursing Center# 0037168Report Period Beginning: 01/01/2007Ending: 12/31/2007**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Council on Long Term Care- \$6,832
- (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? 10yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 13,609 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. \$ 5,030 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? 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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees