

Facility Name & ID Number Franklin Grove Nursing Center

0037168 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 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>25,620</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>51</u>	Intermediate (ICF)	<u>51</u>	<u>18,666</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>44,286</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>1,098</u>	<u>1,573</u>	<u>3,236</u>	<u>5,907</u>	8
9	SNF/PED					9
10	ICF	<u>17,915</u>	<u>12,193</u>		<u>30,108</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>19,013</u>	<u>13,766</u>	<u>3,236</u>	<u>36,015</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.32%

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 04/01/1991

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

YES Date _____ 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 3,236

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number Franklin Grove Nursing Center # 0037168 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	265,213	13,207	4,072	282,492		282,492		282,492		1
2	Food Purchase		244,070		244,070		244,070	(4,417)	239,653		2
3	Housekeeping	193,842	73,852		267,694		267,694	97	267,791		3
4	Laundry	117,280	14,877		132,157		132,157		132,157		4
5	Heat and Other Utilities			183,330	183,330		183,330	947	184,277		5
6	Maintenance	92,020	64,554	6,198	162,772		162,772	2,089	164,861		6
7	Other (specify):*										7
8	TOTAL General Services	668,355	410,560	193,600	1,272,515		1,272,515	(1,284)	1,271,231		8
	B. Health Care and Programs										
9	Medical Director			6,150	6,150		6,150		6,150		9
10	Nursing and Medical Records	1,618,375	38,271	10,770	1,667,416		1,667,416	(1,844)	1,665,572		10
10a	Therapy			320,750	320,750		320,750		320,750		10a
11	Activities	106,275	7,773		114,048		114,048		114,048		11
12	Social Services	29,497			29,497		29,497		29,497		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,754,147	46,044	337,670	2,137,861		2,137,861	(1,844)	2,136,017		16
	C. General Administration										
17	Administrative	129,823		277,625	407,448		407,448	(231,225)	176,223		17
18	Directors Fees										18
19	Professional Services			18,451	18,451		18,451	14,204	32,655		19
20	Dues, Fees, Subscriptions & Promotions			4,820	4,820		4,820	(3,000)	1,820		20
21	Clerical & General Office Expenses	294,818		72,769	367,587		367,587	32,152	399,739		21
22	Employee Benefits & Payroll Taxes			370,300	370,300		370,300	5,599	375,899		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,675	3,675		3,675	(439)	3,236		24
25	Other Admin. Staff Transportation			16,464	16,464		16,464	959	17,423		25
26	Insurance-Prop.Liab.Malpractice			13,333	13,333		13,333	453	13,786		26
27	Other (specify):* Mgmt Alloc of Benefit							12,012	12,012		27
28	TOTAL General Administration	424,641		777,437	1,202,078		1,202,078	(169,285)	1,032,793		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,847,143	456,604	1,308,707	4,612,454		4,612,454	(172,413)	4,440,041		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Franklin Grove Nursing Center

#0037168

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			76,355	76,355		76,355	22,752	99,107			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							113,430	113,430			32
33	Real Estate Taxes			2,000	2,000		2,000	57,207	59,207			33
34	Rent-Facility & Grounds			451,870	451,870		451,870	(451,870)				34
35	Rent-Equipment & Vehicles							840	840			35
36	Other (specify):*											36
37	TOTAL Ownership			530,225	530,225		530,225	(257,641)	272,584			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		79,868		79,868		79,868		79,868			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			66,430	66,430		66,430		66,430			42
43	Other (specify):* Non-allowable cost			28,556	28,556		28,556	(28,556)				43
44	TOTAL Special Cost Centers		79,868	94,986	174,854		174,854	(28,556)	146,298			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,847,143	536,472	1,933,918	5,317,533		5,317,533	(458,610)	4,858,923			45

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(767)	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	(21,899)	30		9
10	Interest and Other Investment Income	(18,420)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(546)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(763)	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	(516)	43		24
25	Fund Raising, Advertising and Promotional	(2,281)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(11,464)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(5,723)	43		28
29	Other-Attach Schedule See Pg. 5A	(16,083)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (78,462)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(380,148)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (380,148)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (458,610)		37

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

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

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

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' COMPILATION REPORT

Franklin Grove Nursing Center

ID# 0037168

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Lab - Part A	\$ (5,426)	43	1
2	X-Ray - Part A	(1,070)	43	2
3	Association Fees	(3,086)	43	3
4	Gain / Loss	(6,501)	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	(16,083)		49

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%	\$ 600	\$ 600	1
2	V	30 Depreciation		Franklin Grove Associates	100.00%	42,352	42,352	2
3	V	32 Interest		Franklin Grove Associates	100.00%	130,009	130,009	3
4	V	32 Amortization		Franklin Grove Associates	100.00%	4,810	4,810	4
5	V	34 Rent Facility and Ground	451,870	Franklin Grove Associates	100.00%		(451,870)	5
6	V	43 Other		Franklin Grove Associates	100.00%	6,501	6,501	6
7	V	33 Real Estate Taxes		Franklin Grove Associates	100.00%	54,385	54,385	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 451,870			\$ 238,657	\$ * (213,213)	14

* 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:

Beauvais Manor Healthcare and Rehab	St. Louis, MO
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.

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%	\$ 7	\$	7	15
16	V	3 Housekeeping		SW Management Co.	100.00%	97		97	16
17	V	5 Heat and Other Utilities		SW Management Co.	100.00%	947		947	17
18	V	6 Maintenance		SW Management Co.	100.00%	2,089		2,089	18
19	V	17 Administrative	277,625	SW Management Co.	100.00%	46,400		(231,225)	19
20	V	19 Professional Services		SW Management Co.	100.00%	3,117		3,117	20
21	V	20 Dues, Fees, Subs & Promotions		SW Management Co.	100.00%	86		86	21
22	V	21 Clerical & General Office Expense		SW Management Co.	100.00%	32,152		32,152	22
23	V	24 Travel and Seminar		SW Management Co.	100.00%	11		11	23
24	V	25 Other Admin. Staff Transport		SW Management Co.	100.00%	959		959	24
25	V	26 Insurance-Prop. Liab Malpractice		SW Management Co.	100.00%	453		453	25
26	V	27 Mgmt. Allocation of Benefits		SW Management Co.	100.00%	12,012		12,012	26
27	V	30 Depreciation		SW Management Co.	100.00%	2,299		2,299	27
28	V	33 Real Estate Taxes		SW Management Co.	100.00%	2,822		2,822	28
29	V	35 Rent-Equipment & Vehicles		SW Management Co.	100.00%	840		840	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		\$ 277,625			\$ 104,291	\$ *	(173,334)	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	\$ 1,108	S & E Medical Supply Co.	100.00%	\$ 2,283	\$ 1,175	15
16	V	10 Medical Supplies	3,412	S & E Medical Supply Co.	100.00%	1,568	(1,844)	16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 4,520			\$ 3,851	\$ *	(669) 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%	\$ 10,037	\$ 10,037	15
16	V	32 Interest-Bonds	130,009	SFO Associates	100.00%	127,040	(2,969)	16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 130,009			\$ 137,077	\$ * 7,068	39

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

Facility Name & ID Number Franklin Grove Nursing Center # 0037168 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Sheldon Wolfe	President	Administrative		See Schedule 7A	3	7.50	Salary	\$ 13,920	L17, C7	1
2	Ronnie Klein	Shareholder	Administrative		See Schedule 7B	5	12.50	Salary & Fees	18,560	17,3 & 17, 7	2
3	Moshe Herman	CFO	Administrative		See Schedule 7C	3	7.50	Salary	13,920	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	\$ 46,400		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: 01/01/2008

Ending: 12/31/2008

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	2	Food	Bed Days Available	657,492	12	\$ 98	\$ 44,286	\$ 7	1	
2	3	Housekeeping	Bed Days Available	657,492	12	1,440	44,286	97	2	
3	5	Heat and Other Utilities	Bed Days Available	657,492	12	14,061	44,286	947	3	
4	6	Maintenance	Bed Days Available	657,492	12	31,014	44,286	2,089	4	
5	19	Professional Services	Bed Days Available	657,492	12	46,281	44,286	3,117	5	
6	20	Dues, Fees, Subs & Promotions	Bed Days Available	657,492	12	1,278	44,286	86	6	
7	21	Clerical & General Office Exp	Bed Days Available	657,492	12	477,338	410,633	32,152	7	
8	24	Travel and Seminar	Bed Days Available	657,492	12	157	44,286	11	8	
9	25	Other Admin. Staff Transport	Bed Days Available	657,492	12	14,238	44,286	959	9	
10	26	Insurance-Prop., Liab & Malp.	Bed Days Available	657,492	12	6,729	44,286	453	10	
11	27	Mgmt. Allocation of Benefits	Bed Days Available	657,492	12	178,342	44,286	12,012	11	
12	33	Real Estate Taxes	Bed Days Available	657,492	12	41,904	44,286	2,822	12	
13	35	Rent-Equipment & Vehicles	Bed Days Available	657,492	12	12,467	44,286	840	13	
14									14	
15									15	
16	17	Administrative	Avg. Hours Worked	40	11	371,200	371,200	3	27,840	16
17	17	Administrative	Avg. Hours Worked	50	6	185,600	185,600	5	18,560	17
18									18	
19	30	Depreciation	Direct Cost					2,299	19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 1,382,147	\$ 967,433	\$ 104,291	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Franklin Grove Nursing Center

0037168

Report Period Beginning:

01/01/2008

Ending: 12/31/2008

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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	Direct Cost		\$	\$		\$ 2,283	1
2	10	Medical Supplies	Direct Cost					1,568	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				\$	\$		\$ 3,851	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Franklin Grove Nursing Center

0037168

Report Period Beginning:

01/01/2008

Ending: 12/31/2008

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	Professional Services	Note Receivable	6,500,000	3	\$ 23,300	\$ 2,800,000	\$ 10,037	1
2	32	Interest-Bonds	Note Receivable	6,500,000	3	294,915	2,800,000	127,040	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 318,215	\$	\$ 137,077	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Franklin Grove Nursing Center

0037168

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	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			
A. Directly Facility Related																				
Long-Term																				
1	Franklin Grove Assoc.	X		Bonds	Annual	7/1/94	\$ 2,800,000	\$ 1,163,077	8/15/14		\$ 127,040	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	\$ 1,163,077			\$ 127,040	9								
B. Non-Facility Related*																				
10							Amortization of loan cost				4,810	10								
11							Interest Income Offset				(18,420)	11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ (13,610)	14								
15	TOTALS (line 9+line14)						\$ 2,800,000	\$ 1,163,077			\$ 113,430	15								

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

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2007 report.		\$	54,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2007	\$	54,385	2
3. Under or (over) accrual (line 2 minus line 1).		\$	385	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	56,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
	Allocation from Management Co		2,822	
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.		\$	59,207	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2003	49,904	8	
	2004	49,199	9	
	2005	50,968	10	
	2006	52,663	11	
	2007	54,385	12	
2007 real estate tax bill * 103% = 56,017. Use 56,000				
				FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2007	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2008 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME 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 2007 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>06-03-36-351-07</u>	<u>Long Term Care Property</u>	\$ <u>54,384.54</u>	\$ <u>54,384.54</u>
2. <u>10-28-412-049-0000</u>	<u>SW Management Allocation</u>	\$ <u>43,500.34</u>	\$ <u>2,822.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>97,884.88</u>	\$ <u>57,206.54</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Franklin Grove Nursing Center

0037168

Report Period Beginning:

01/01/2008 Ending:

12/31/2008

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:

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	121	1991		\$ 1,334,100	\$	31.5	\$ 42,352	\$ 42,352	\$ 741,167	4
5										5
6	Mgmt. Alloc	1995		29,153		31.5	833	833	10,541	6
7										7
8										8
	Improvement Type**									
9	Various		1991	6,395	203	20	320	117	5466	9
10	Various		1992	29,415		20	1,471	1,471	24393	10
11	Various		1993	47,511	297	20	2,375	2,078	38605	11
12	Various		1994	17,652		20	883	883	13000	12
13	Various		1995	10,809	272	20	541	269	7352	13
14	Various		1997	55,791	1,081	20	2,792	1,711	33811	14
15	Various		1998	87,964	2,200	20	4,399	2,199	43338	15
16	Various		1999	24,113	538	20	1,205	667	12478	16
17	Retroaire Chassis		2000	2,321		20	116	116	928	17
18	Water Main Line		2001	3,294	84	20	165	81	1277	18
19	Walk In Freezer		2001	8,947		20	447	447	3318	19
20	Wiring To Kitchen		2001	12,250		20	613	613	4748	20
21	Kitchen Labor		2001	3,163		20	158	158	33	21
22	Kitchen Labor		2001	1,532		20	77	77	549	22
23	Carpeting		2002	16,211		5			16211	23
24	Bathroom and Tub		2002	3,700	95	10	370	275	2313	24
25	Bath		2002	7,972	204	10	797	593	4850	25
26	Glass Blocks		2002	1,649	42	10	165	123	1045	26
27	Voice Alarm		2003	948		20	47	47	332	27
28	Code Alert		2003	3,887		20	194	194	1230	28
29	Magnetic Door Holders		2003	1,652		20	83	83	578	29
30	Air Conditioners		2003	4,244		20	212	212	1485	30
31	Tub & Lift		2003	8,738		20	437	437	3204	31
32	3 Air Conditioners		2003	478		20	24	24	168	32
33	Boiler Repair		2003	1,683		20	84	84	498	33
34	Shower - Glass, Bars		2003	550		20	28	28	163	34
35	Carpet		2003	599		20	30	30	157	35
36	Gutters & Down Spouts		2003	10,759	276	20	538		3049	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:

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Aluminum Soffit	2003	\$ 1,864	\$ 48	20	\$ 89	\$ 41	\$ 513	37
38	Painting (24 Rooms)	2004	5,520	201	20	276	75	1,242	38
39	Nurses station	2004	18,750	682	20	938	256	4,219	39
40	Dining Area	2004	2,400	87	20	120	33	540	40
41	New Windows	2004	6,335	230	20	317	87	1,425	41
42	Bathroom Plumbing and Electrical	2004	12,600	458	20	630	172	2,835	42
43	Kitchen and Dining Room	2004	16,369	595	20	818	223	3,683	43
44	Remodel Shower and Flooring	2004	10,595	385	20	530	145	2,384	44
45	Display Case - Nurses Station	2004	3,800	138	20	190	52	855	45
46	Dining Room Windows	2004	9,614	350	20	481	131	2,163	46
47	Glass Block Shower Windows	2004	1,427	78	20	71	(7)	321	47
48	Remodel Glass and Shower	2004	3,100	165	20	155	(10)	698	48
49	Carpet	2004	2,660	98	20	133	35	599	49
50	Windows	2005	34,060	1,239	20	1,703	464	5,961	50
51	Remodel Wall	2005	6,518	237	20	326	89	1,141	51
52	Outside Soffit	2005	6,268	228	20	313	85	1,097	52
53	Install Valves	2005	4,500	164	20	225	61	788	53
54	Tiles and Flooring	2006	15,604	547	20	780	233	1,951	54
55	Exterior and Resident Doors	2006	21,725		20	1,086	1,086	2,716	55
56	Kick Plates	2006	5,533	141	20	277	136	692	56
57	Windows	2006	58,240	3,063	20	2,912	(151)	7,280	57
58	Siding	2006	2,080		20	104	104	260	58
59	Paving	2006	7,517	643	20	376	(267)	940	59
60	Wallpaper	2006	3,078	112	20	154	42	385	60
61	Air Conditioners	2006	20,183		20	1,009	1,009	2,523	61
62	Water Heater	2006	9,984	363	20	499	136	1,248	62
63									63
64	Glue Down Carpet	2007	3,036		20	152	152	228	64
65									65
66	New Doors	2008	41,645	1,199	20	1,041	(158)	1,041	66
67	Wiring-Kitchen Ansul System to Fire Alarm	2008	5,571	144	20	139	(5)	139	67
68	Lighting Insulation	2008	12,804	291	20	320	29	320	68
69	New Ceiling-Laundry	2008	3,755	85	20	94	9	94	69
70	TOTAL (lines 4 thru 69)		\$ 2,094,615	\$ 17,263		\$ 78,014	\$ 60,489	\$ 1,026,559	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	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	
1	Totals from Page 12A, Carried Forward		\$ 2,094,615	\$ 17,263		\$ 78,014	\$ 60,751	\$ 1,026,559	1
2	South Porch Remodel	2008	4,175	95	20	104	9	104	2
3	Wallpaper & Installation	2008	8,467	167	20	212	45	212	3
4	Remodel Resident Rooms	2008	101,178	1,993	20	2,529	536	2,529	4
5	Gas Water heater	2008	4,399	73	20	110	37	110	5
6	painting	2008	9,395	128	20	235	107	235	6
7	Replace Boiler Sections	2008	12,164	166	20	304	138	304	7
8	Vinyl Flooring	2008	83,058	881	20	2,077	1,196	2,076	8
9	Landscaping	2008	14,896	7,821	15	497	(7,324)	497	9
10									10
11	SW Management Allocation-Leasehold Improvements	1995	3,111		20	155	155	2,344	11
12	SW Management Allocation-Leasehold Improvements	1996	543		20	27	27	341	12
13	SW Management Allocation-Leasehold Improvements	1997	782		20	39	39	546	13
14	SW Management Allocation-Leasehold Improvements	1998	539		20	27	27	290	14
15	SW Management Allocation-Leasehold Improvements	1999	1,495		20	75	75	679	15
16	SW Management Allocation-Leasehold Improvements	2005	3,093		20	155	155	541	16
17	SW Management Allocation-Leasehold Improvements	2007	1,751		20	88	88	131	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	TOTAL (lines 1 thru 33)		\$ 2,343,661	\$ 28,587		\$ 84,648	\$ 56,061	\$ 1,037,499	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 112,396	\$ 256	\$ 11,183	\$ 10,927	10	\$ 40,085	71
72	Current Year Purchases	47,512	47,512	2,375	(45,137)	10	2,376	72
73	Fully Depreciated Assets	506,036					506,036	73
74	Allocation from Mgmt. Co.	9,205		120	120	10	6,747	74
75	TOTALS	\$ 675,149	\$ 47,768	\$ 13,678	\$ (34,090)		\$ 555,244	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	Allocation from Mgmt. Co.	2004 Cadillac	2004	\$ 3,904	\$	\$ 781	\$ 781	5	\$ 3,514	76
77										77
78										78
79										79
80	TOTALS			\$ 3,904	\$	\$ 781	\$ 781		\$ 3,514	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)	\$ 3,058,919	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 76,355	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 99,107	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 22,752	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,596,257	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	\$ 2,852	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 4,200	\$ 210	\$ 2,852	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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:				\$ _____			3
4	Additions				N/A			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: \$ N/A Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	SW Management Co. Allocation		\$ _____	\$ 840	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ 840	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. _____ /2009 \$ _____

13. _____ /2010 \$ _____

14. _____ /2011 \$ _____

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10A, C3	hrs	\$	2,257	\$ 126,359	\$	2,257	\$ 126,359	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		197	8,935		197	8,935	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		3,515	182,799		3,515	182,799	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				79,868		79,868	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	TOTAL			\$	5,969	\$ 318,093	\$ 79,868	5,969	\$ 397,961	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: 01/01/2008

Ending:

12/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 232,125	\$ 232,125	1
2	Cash-Patient Deposits	3,462	3,462	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 2,027)	1,052,472	1,052,472	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	3,704	3,704	6
7	Other Prepaid Expenses		861	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Sch 17A	216,612	3,423,751	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,508,375	\$ 4,716,375	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		1,363,255	14
15	Leasehold Improvements, at Historical Cost	817,381	980,406	15
16	Equipment, at Historical Cost	651,944	674,853	16
17	Accumulated Depreciation (book methods)	(810,578)	(1,593,405)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): See Sch 17A		106,297	22
23	Other(specify): See Sch 17A		1,348	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 658,747	\$ 1,568,959	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,167,122	\$ 6,285,334	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 113,842	\$ 113,842	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,618	1,618	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	137,907	137,907	30
31	Accrued Taxes Payable (excluding real estate taxes)	13,444	13,444	31
32	Accrued Real Estate Taxes(Sch.IX-B)	56,000	56,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Sch 17A	162,069	372,388	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 484,880	\$ 695,199	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		1,163,077	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)	\$	\$ 1,163,077	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 484,880	\$ 1,858,276	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,682,242	\$ 4,427,058	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,167,122	\$ 6,285,334	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Franklin Grove Nursing Center, Inc.
 Provider #: 0037168
 12/31/2008

Schedule 17A

XV. BALANCE SHEET -

Other Current Assets (specify):	Operating	After Consolidation
Due from State-Interest	5,636	5,636
Employee Payroll advance	657	657
RE Due to/from Florissant	0	1,614,194
Due to Franklin Grove Associates	210,319	210,319
RE Due to/from SFO Associates	0	1,592,945
Total Line 9 - Other Current Assets (specify):	216,612	3,423,751

Other Long-Term Assets (specify):	Operating	After Consolidation
Investment in SFO Associate	0	31,837
Loan Costs	0	144,309
Amortization - Loan Costs	0	(69,849)
Total Line 22 - Other Long-Term Assets (specify):	0	106,297

Other (specify):	Operating	After Consolidation
Non-care asset	-	1,348
Total Line 23 - Other (specify):	0	1,348

Other Current Liabilities (specify):	Operating	After Consolidation
Reimbursement Due	5,559	5,559
Insurance Premiums Payable	16,084	16,084
Retirement (From P/R)	648	648
Accrued Expenses	139,778	139,778
Due to Public Aid	-	-
Due from Franklin Grove	-	210,319
Total Line 36 - Other Current Liabilities (specify):	162,069	372,388

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,488,859	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,488,859	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	393,384	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	(200,000)	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)	\$ 193,383	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)	\$ 1,682,242	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	\$ 5,487,258	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,487,258	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	184,018	6
7	Oxygen	20,538	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 204,556	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	300	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 300	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	18,420	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 18,420	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	383	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 383	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,710,917	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,272,515	31
32	Health Care	2,137,861	32
33	General Administration	1,202,078	33
	B. Capital Expense		
34	Ownership	530,225	34
	C. Ancillary Expense		
35	Special Cost Centers	108,424	35
36	Provider Participation Fee	66,430	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,317,533	40
41	Income before Income Taxes (line 30 minus line 40)**	393,384	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 393,384	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: 01/01/2008

Ending: 12/31/2008

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,000	2,000	\$ 72,102	\$ 36.05	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,044	8,344	202,119	24.22	3
4	Licensed Practical Nurses	19,037	20,062	445,649	22.21	4
5	CNAs & Orderlies	80,344	82,020	860,439	10.49	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,430	3,645	38,066	10.44	8
9	Activity Director					9
10	Activity Assistants	7,616	7,807	106,275	13.61	10
11	Social Service Workers	1,962	2,126	29,497	13.87	11
12	Dietician					12
13	Food Service Supervisor	3,904	4,053	62,275	15.37	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,689	21,601	202,938	9.39	15
16	Dishwashers					16
17	Maintenance Workers	5,790	6,161	92,020	14.94	17
18	Housekeepers	21,938	22,983	193,842	8.43	18
19	Laundry	12,587	13,363	117,280	8.78	19
20	Administrator	2,080	2,080	129,823	62.41	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,506	14,268	294,818	20.66	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)	202,927	210,513	\$ 2,847,143 *	\$ 13.52	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly \$ 4,072	L1, C3	35
36	Medical Director	Monthly 6,150	L9, C3	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 10,770	L10, C3	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant	Monthly 2,657	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)	\$ 23,649		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Jill Gee	Administrator	0	\$ 129,823	Workers' Compensation Insurance	\$ 66,383	IDPH License Fee	\$	
				Unemployment Compensation Insurance	24,012	Advertising: Employee Recruitment		
				FICA Taxes	216,082	Health Care Worker Background Check		
				Employee Health Insurance	60,386	(Indicate # of checks performed)		
				Employee Meals	5,599	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		IL Council on Long Term Care	4,235	
				Miscellaneous Employee Benefits	1,481	Miscellaneous Dues & Permits	55	
				Holiday Expense	1,956	Miscellaneous Inspections & Licenses	530	
						Allocation from Mgmt. Co.	86	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 129,823			Less: Non-Allowable Dues	(3,086)	
B. Administrative - Other						Less: Public Relations Expense	()	
Description			Amount			Non-allowable advertising	()	
SW Management-Home Office and Management Fees			\$ 97,625			Yellow page advertising	()	
Ronnie Klein - Management Fees			180,000					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 277,625	TOTAL (agree to Schedule V, line 22, col.8)	\$ 375,899	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 1,820	
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
McGladrey & Pullen, LLP	Accounting		\$ 18,361	N/A		\$	Out-of-State Travel	\$
FR&R Healthcare Consulting	Accounting		90					
							In-State Travel	
							Seminar Expense	3,225
							Allocation from Mgmt. Co.	11
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 18,451	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 3,236

* Attach copy of IMRF notifications
 SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Franklin Grove Nursing Center, Inc.

Provider # 0037168

12/31/2008

Schedule 21A

XIX. Support Schedule

C. Professional Services

Total (agree to Schedule V, line 19, column 3)	18,451
Reclassified from Education & Seminar	450
Allocated from Franklin Grove Associates:	
Accounting-RSM McGladrey, Inc.	600
Allocated from SW Management Company:	
Legal	2,444
Accounting-RSM McGladrey, Inc.	673
Allocated from SFO Associates	
Accounting-RSM McGladrey, Inc.	10,037
Total (agree to Schedule V, line 19, column 8)	<u>32,655</u>

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Franklin Grove Nursing Center# 0037168Report Period Beginning: 01/01/2008Ending: 12/31/2008**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Council on Long Term Care \$4235
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 13,128 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. \$ 66,430
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. \$ 5,599 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. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees