

Facility Name & ID Number Franklin Grove Nursing Center

0037168 Report Period Beginning: 01/01/09 Ending: 12/31/09

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	Private Pay	4 Other	Total	
8	SNF	827	1,303	3,941	6,071	8
9	SNF/PED					9
10	ICF	16,624	12,743	28	29,395	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,451	14,046	3,969	35,466	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.30%

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 04/01/91

J. Was the facility purchased or leased after January 1, 1978?
YES Date 04/01/91 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 70 and days of care provided 3,941

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/09 Fiscal Year: 12/31/09

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

Facility Name & ID Number Franklin Grove Nursing Center # 0037168 Report Period Beginning: 01/01/09 Ending: 12/31/09

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	269,280	14,648	4,135	288,063		288,063		288,063		1
2	Food Purchase		248,643		248,643		248,643	(4,204)	244,439		2
3	Housekeeping	200,705	65,448		266,153		266,153	202	266,355		3
4	Laundry	118,867	14,350		133,217		133,217		133,217		4
5	Heat and Other Utilities			160,748	160,748		160,748	1,174	161,922		5
6	Maintenance	100,026	55,185	7,400	162,611		162,611	584	163,195		6
7	Other (specify):*										7
8	TOTAL General Services	688,878	398,274	172,283	1,259,435		1,259,435	(2,244)	1,257,191		8
	B. Health Care and Programs										
9	Medical Director			6,875	6,875		6,875		6,875		9
10	Nursing and Medical Records	1,695,039	45,343	14,694	1,755,076		1,755,076	(3,005)	1,752,071		10
10a	Therapy			402,033	402,033		402,033		402,033		10a
11	Activities	122,149	9,030		131,179		131,179		131,179		11
12	Social Services	32,143			32,143		32,143		32,143		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,849,331	54,373	423,602	2,327,306		2,327,306	(3,005)	2,324,301		16
	C. General Administration										
17	Administrative	135,235		267,825	403,060		403,060	(220,025)	183,035		17
18	Directors Fees										18
19	Professional Services			26,774	26,774		26,774	18,932	45,706		19
20	Dues, Fees, Subscriptions & Promotions			17,403	17,403		17,403	108	17,511		20
21	Clerical & General Office Expenses	319,293		68,039	387,332		387,332	32,703	420,035		21
22	Employee Benefits & Payroll Taxes			373,060	373,060		373,060	6,351	379,411		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,476	2,476		2,476	13	2,489		24
25	Other Admin. Staff Transportation			9,056	9,056		9,056	988	10,044		25
26	Insurance-Prop.Liab.Malpractice			11,342	11,342		11,342	402	11,744		26
27	Other (specify):* Mgmt Alloc of Benefit							12,286	12,286		27
28	TOTAL General Administration	454,528		775,975	1,230,503		1,230,503	(148,242)	1,082,261		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,992,737	452,647	1,371,860	4,817,244		4,817,244	(153,491)	4,663,753		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

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Ending:

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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			53,362	53,362		53,362	59,524	112,886			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			24,500	24,500		24,500	58,266	82,766			32
33	Real Estate Taxes			54,449	54,449		54,449	2,831	57,280			33
34	Rent-Facility & Grounds			397,485	397,485		397,485	(397,485)				34
35	Rent-Equipment & Vehicles			1,072	1,072		1,072	843	1,915			35
36	Other (specify):*											36
37	TOTAL Ownership			530,868	530,868		530,868	(276,021)	254,847			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		113,750		113,750		113,750		113,750			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 cost			25,763	25,763		25,763	(25,763)				43
44	TOTAL Special Cost Centers		113,750	92,011	205,761		205,761	(25,763)	179,998			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,992,737	566,397	1,994,739	5,553,873		5,553,873	(455,275)	5,098,598			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

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VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	15,111	30		9
10	Interest and Other Investment Income	123,271	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(633)	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	(400)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(4,376)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(10,923)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG5A	46,121	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 168,171		\$	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)	(623,446)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (623,446)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (455,275)		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	52

SEE ACCOUNTANTS' COMPILATION REPORT

Franklin Grove Nursing Center

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Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Lab Expense Med A	\$ (7,314)	43	1
2	X Ray Expense Med A	(7,632)	43	2
3	Gain / Loss	61,067	43	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
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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	46,121		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:	
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)	
1	V	19 Professional Services	\$	Franklin Grove Associates	100.00%	\$ 2,625	\$ 2,625	1
2	V	30 Depreciation		Franklin Grove Associates	100.00%	42,352	42,352	2
3	V	32 Interest	147,771	Franklin Grove Associates	100.00%	117,104	(30,667)	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%	5,515	5,515	6
7	V	43 Other		Franklin Grove Associates	100.00%	(27,408)	(27,408)	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 545,256			\$ 144,998	\$ * (400,258)	14

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

Franklin Grove Nursing Center Inc
0037168
12/31/2009

VII Related Parties - Page 6

Schedule 6A

Share Number	Shareholder Name	Beginning Shares	Ownership Percentage
1	Albert Milstein	384	31.73
2	Sheldon Wolfe	383	31.65
3	Ronnie Klein as Trustee	30	2.48
4	Wanda Bowling	30	2.48
5	Kenneth Klein	191.5	15.83
6	Moshe Herman	191.5	15.83

SEE ACCOUNTANTS' COMPILATION REPORT

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

Other Related Business Entities

Shabbona Supportive Living Center, LLC	Shabbona	Supportive Living Facility
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%	\$ 12	\$	12	15
16	V	3 Housekeeping		SW Management Co.	100.00%	202		202	16
17	V	5 Heat and Other Utilities		SW Management Co.	100.00%	1,174		1,174	17
18	V	6 Maintenance		SW Management Co.	100.00%	584		584	18
19	V	17 Administrative	267,825	SW Management Co.	100.00%	47,800		(220,025)	19
20	V	19 Professional Services		SW Management Co.	100.00%	3,316		3,316	20
21	V	20 Dues, Fees, Subs & Promotions		SW Management Co.	100.00%	108		108	21
22	V	21 Clerical & General Office Expense		SW Management Co.	100.00%	32,594		32,594	22
23	V	24 Travel and Seminar		SW Management Co.	100.00%	13		13	23
24	V	25 Other Admin. Staff Transport		SW Management Co.	100.00%	988		988	24
25	V	26 Insurance-Prop. Liab Malpractice		SW Management Co.	100.00%	402		402	25
26	V	27 Mgmt. Allocation of Benefits		SW Management Co.	100.00%	12,286		12,286	26
27	V	30 Depreciation		SW Management Co.	100.00%	2,061		2,061	27
28	V	32 Interest		SW Management Co.	100.00%				28
29	V	33 Real Estate Taxes		SW Management Co.	100.00%	2,831		2,831	29
30	V	35 Rent-Equipment & Vehicles		SW Management Co.	100.00%	843		843	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		\$ 267,825			\$ 105,214	\$ *	(162,611)	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	\$ 1,525	S & E Medical Supply Co.	100.00%	\$ 3,660	\$ 2,135	15
16	V	10 Medical Supplies	4,386	S & E Medical Supply Co.	100.00%	1,381	(3,005)	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		\$ 5,911			\$ 5,041	\$ * (870)	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	0.00%	\$ 12,991	\$	12,991	15
16	V	21 Clerical & General Office		SFO Associates	0.00%	109		109	16
17	V	32 Interest-Bonds	117,104	SFO Associates	0.00%	77,956		(39,148)	17
18	V	43 Other		SFO Associates	0.00%	(33,659)		(33,659)	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		\$ 117,104			\$ 57,397	\$ *	(59,707)	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: 01/01/09 Ending: 12/31/09

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	\$ 14,340	L17, C7	1
2	Ronnie Klein	Shareholder	Administrative		See Schedule 7B	5	12.50	Salary & Fees	19,120	17,3 & 17, 7	2
3	Moshe Herman	CFO	Administrative		See Schedule 7C	3	7.50	Salary	14,340	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	\$ 47,800		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

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0037168

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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 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

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	657,730	11	\$ 177	\$ 44,165	\$ 12	1	
2	3	Housekeeping	Bed Days Available	657,730	11	3,004	44,165	202	2	
3	5	Heat and Other Utilities	Bed Days Available	657,730	11	17,488	44,165	1,174	3	
4	6	Maintenance	Bed Days Available	657,730	11	8,697	44,165	584	4	
5	19	Professional Services	Bed Days Available	657,730	11	49,378	44,165	3,316	5	
6	20	Dues, Fees, Subs & Promotions	Bed Days Available	657,730	11	1,616	44,165	109	6	
7	21	Clerical & General Office Exp	Bed Days Available	657,730	11	485,405	432,056	44,165	32,594	7
8	24	Travel and Seminar	Bed Days Available	657,730	11	186	44,165	12	8	
9	25	Other Admin. Staff Transport	Bed Days Available	657,730	11	14,707	44,165	988	9	
10	26	Insurance-Prop., Liab & Malp.	Bed Days Available	657,730	11	5,991	44,165	402	10	
11	27	Mgmt. Allocation of Benefits	Bed Days Available	657,730	11	182,974	44,165	12,286	11	
12	32	Interest	Bed Days Available	657,730	11		44,165	0	12	
13	33	Real Estate Taxes	Bed Days Available	657,730	11	42,159	44,165	2,831	13	
14	35	Rent-Equipment & Vehicles	Bed Days Available	657,730	11	12,559	44,165	843	14	
15									15	
16	17	Administrative	Avg. Hours Worked	40	11	382,400	382,400	3	28,680	16
17	17	Administrative	Avg. Hours Worked	50	6	191,200	191,200	5	19,120	17
18									18	
19	30	Depreciation	Direct Cost						2,061	19
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 1,397,941	\$ 1,005,656	\$ 105,214	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Franklin Grove Nursing Center

0037168

Report Period Beginning:

01/01/09

Ending: 12/31/09

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		\$	\$		\$ 3,660	1
2	10	Medical Supplies	Direct Cost					1,381	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				\$	\$		\$ 5,041	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Franklin Grove Nursing Center

0037168

Report Period Beginning:

01/01/09

Ending: 12/31/09

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	\$ 30,158	\$ 2,800,000	\$ 12,991	1
2	21	Clerical & General Office	Note Receivable	6,500,000	3	253	2,800,000	109	2
3	32	Interest-Bonds	Note Receivable	6,500,000	3	180,969	2,800,000	77,956	3
4	43	Other	Note Receivable	6,500,000	3	(78,136)	2,800,000	(33,659)	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					\$ 133,244	\$	\$ 57,397	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Franklin Grove Nursing Center

0037168

Report Period Beginning:

01/01/09

Ending:

12/31/09

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										
										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	Interest Only	7/1/94	\$ 2,800,000	\$ 990,769	8/15/14	Variable	\$ 77,956	1							
2	(Loan Payable-SFO Assoc)											2							
3												3							
4												4							
5												5							
Working Capital																			
6												6							
7												7							
8												8							
9	TOTAL Facility Related						\$ 2,800,000	\$ 990,769			\$ 77,956	9							
B. Non-Facility Related*																			
10								Amortization of loan cost			4,810	10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$ 4,810	14							
15	TOTALS (line 9+line14)						\$ 2,800,000	\$ 990,769			\$ 82,766	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.)

Facility Name & ID Number Franklin Grove Nursing Center

0037168

Report Period Beginning:

01/01/09

Ending:

12/31/09

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).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>		<u>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:

01/01/09

Ending:

12/31/09

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	\$ 783,519	4
5											5
6	Mgmt. Alloc		1995		29,060		31.5	830	830	12,169	6
7											7
8											8
	Improvement Type**										
9	Various		1991		6,395	203	20	320	117	5786	9
10	Various		1992		29,415		20	1,471	1,471	25864	10
11	Various		1993		47,511	297	20	2,376	2,079	40981	11
12	Various		1994		17,652		20	883	883	13883	12
13	Various		1995		10,809	272	20	540	268	7893	13
14	Various		1997		55,791	1,158	20	2,790	1,632	36600	14
15	Various		1998		87,964	2,200	20	4,398	2,198	47736	15
16	Various		1999		24,113	538	20	1,206	668	12584	16
17	Retroaire Chassis		2000		2,321		20	116	116	1044	17
18	Water Main Line		2001		3,294	84	20	165	81	1441	18
19	Walk In Freezer		2001		8,947		20	447	447	3765	19
20	Wiring To Kitchen		2001		12,250		20	613	613	5360	20
21	Kitchen Labor		2001		3,163		20	158	158	1291	21
22	Kitchen Labor		2001		1,532		20	77	77	626	22
23	Carpeting		2002		16,211		5			16211	23
24	Bathroom and Tub		2002		3,700	95	10	370	275	2683	24
25	Bath		2002		7,972	204	10	797	593	5647	25
26	Glass Blocks		2002		1,649	42	10	165	123	1209	26
27	Voice Alarm		2003		948		20	47	47	379	27
28	Code Alert		2003		3,887		20	194	194	1425	28
29	Magnetic Door Holders		2003		1,652		20	83	83	661	29
30	Air Conditioners		2003		4,244		20	212	212	1697	30
31	Tub & Lift		2003		8,738		20	437	437	3640	31
32	3 Air Conditioners		2003		478		20	24	24	191	32
33	Boiler Repair		2003		1,683		20	84	84	582	33
34	Shower - Glass, Bars		2003		550		20	28	28	190	34
35	Carpet		2003		599		20	30	30	187	35
36	Gutters & Down Spouts		2003		10,759	276	20	538		3587	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:

01/01/09

Ending:

12/31/09

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	\$ 93	\$ 45	\$ 606	37
38	Painting (24 Rooms)	2004	5,520	201	20	276	75	1,518	38
39	Nurses station	2004	18,750	682	20	938	256	5,156	39
40	Dining Area	2004	2,400	87	20	120	33	660	40
41	New Windows	2004	6,335	230	20	317	87	1,742	41
42	Bathroom Plumbing and Electrical	2004	12,600	458	20	630	172	3,465	42
43	Kitchen and Dining Room	2004	16,369	595	20	818	223	4,501	43
44	Remodel Shower and Flooring	2004	10,595	385	20	530	145	2,914	44
45	Display Case - Nurses Station	2004	3,800	138	20	190	52	1,045	45
46	Dining Room Windows	2004	9,614	350	20	481	131	2,644	46
47	Glass Block Shower Windows	2004	1,427	52	20	71	19	392	47
48	Remodel Glass and Shower	2004	3,100	113	20	155	42	853	48
49	Carpet	2004	2,660	98	20	133	35	732	49
50	Windows	2005	34,060	1,239	20	1,703	464	7,664	50
51	Remodel Wall	2005	6,518	237	20	326	89	1,467	51
52	Outside Soffit	2005	6,268	228	20	313	85	1,410	52
53	Install Valves	2005	4,500	164	20	225	61	1,013	53
54	Tiles and Flooring	2006	15,604	547	20	780	233	2,731	54
55	Exterior and Resident Doors	2006	21,725		20	1,086	1,086	3,802	55
56	Kick Plates	2006	5,533	141	20	277	136	968	56
57	Windows	2006	58,240	3,063	20	2,912	(151)	10,192	57
58	Siding	2006	2,080		20	104	104	364	58
59	Paving	2006	7,517	579	20	376	(203)	1,315	59
60	Wallpaper	2006	3,078	112	20	154	42	539	60
61	Air Conditioners	2006	20,183		20	1,009	1,009	3,532	61
62	Water Heater	2006	9,984	363	20	499	136	1,747	62
63									63
64	Glue Down Carpet	2007	3,036		20	152	152	380	64
65									65
66	New Doors	2008	41,645	1,514	20	2,082	568	3,123	66
67	Wiring-Kitchen Ansul System to Fire Alarm	2008	5,571	203	20	279	76	418	67
68	Lighting Insulation	2008	12,804	466	20	640	174	960	68
69	New Ceiling-Laundry	2008	3,755	137	20	188	51	282	69
70	TOTAL (lines 4 thru 69)		\$ 2,094,522	\$ 17,799		\$ 79,607	\$ 61,546	\$ 1,106,962	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Franklin Grove Nursing Center

0037168

Report Period Beginning:

01/01/09

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12/31/09

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		\$ 2,094,522	\$ 17,799		\$ 79,607	\$ 61,808	\$ 1,106,962	1
2	South Porch Remodel	2008	4,175	152	20	209	57	313	2
3	Wallpaper & Installation	2008	8,467	308	20	423	115	635	3
4	Steel studs & drywall on outside walls, retrim windows, and	2008	101,178	3,679	20	5,059	1,380	7,588	4
5	extend electrical boxes in 36 rooms								5
6	Gas Water heater	2008	4,399	160	20	220	60	330	6
7	Painting	2008	9,395	342	20	470	128	705	7
8	Replace Boiler Sections	2008	12,164	442	20	608	166	912	8
9	Vinyl Flooring	2008	83,058	3,020	20	4,153	1,133	6,229	9
10	Landscaping	2008	14,896	708	15	993	285	1,490	10
11	New Sprinkler System	2009	155,270	5,411	20	3,882	(1,529)	3,882	11
12	New Water Line for Sprinkler System	2009	14,936	339	20	373	34	373	12
13	Fire Alarm Interface-Sprinkler System	2009	3,000	59	20	75	16	75	13
14	Laminate Flooring	2009	2,946	2,946	20	74	(2,872)	74	14
15									15
16									16
17									17
18	SW Management Allocation-Leasehold Improvements	1995	3,101		20	155	155	2,491	18
19	SW Management Allocation-Leasehold Improvements	1996	542		20	27	27	367	19
20	SW Management Allocation-Leasehold Improvements	1997	780		20	39	39	584	20
21	SW Management Allocation-Leasehold Improvements	1998	537		20	27	27	316	21
22	SW Management Allocation-Leasehold Improvements	1999	1,491		20	75	75	752	22
23	SW Management Allocation-Leasehold Improvements	2005	3,084		20	154	154	694	23
24	SW Management Allocation-Leasehold Improvements	2007	1,746		20	87	87	218	24
25	SW Management Allocation-Leasehold Improvements	2009	3,645		20	91	91	91	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,523,332	\$ 35,365		\$ 96,801	\$ 61,436	\$ 1,135,081	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:

01/01/09

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12/31/09

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	\$ 206,722	\$ 205	\$ 14,621	\$ 14,416		\$ 104,106	71
72	Current Year Purchases	17,792	17,792	889	(16,903)		889	72
73	Fully Depreciated Assets	459,222					459,222	73
74	Allocation from Management Co.	9,181		186	186		6,912	74
75	TOTALS	\$ 692,917	\$ 17,997	\$ 15,696	\$ (2,301)		\$ 571,129	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 Management	2004 Cadillac	2004	\$ 3,892	\$	\$ 389	\$ 389		\$ 3,892	76
77										77
78										78
79										79
80	TOTALS			\$ 3,892	\$	\$ 389	\$ 389		\$ 3,892	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)	\$ 3,256,346	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 53,362	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 112,886	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 59,524	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,710,102	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	\$	\$ 3,062	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 4,200	\$	\$ 3,062	91

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			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: \$ 1,072 Description: Special Occasions-Party Rental-\$1072

(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	Allocated from Management Co.		\$	\$ 843	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 843	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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* 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	\$	1,552	\$ 173,773	\$	1,552	\$ 173,773	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		245	11,291		245	11,291	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		2,038	211,920		2,038	211,920	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				113,750		113,750	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	TOTAL			\$	3,835	\$ 396,984	\$ 113,750	3,835	\$ 510,734	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: 01/01/09

Ending:

12/31/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 354,043	\$ 354,043	1
2	Cash-Patient Deposits	1,618	1,618	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 3,539)	711,614	711,614	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	3,472	3,472	6
7	Other Prepaid Expenses		861	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Schedule 17A	14,972	2,031,277	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,085,719	\$ 3,102,885	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		1,363,164	14
15	Leasehold Improvements, at Historical Cost	993,533	1,160,168	15
16	Equipment, at Historical Cost	669,736	692,609	16
17	Accumulated Depreciation (book methods)	(863,940)	(1,707,040)	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 (spe See Sch 17A		128,895	22
23	Other(specify): See Schedule 17A		4,200	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 799,329	\$ 1,678,201	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,885,048	\$ 4,781,086	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 45,432	\$ 45,432	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	41,884	41,884	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,731	5,731	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 Schedule 17A	340,542	112,323	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 489,589	\$ 261,370	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable		990,769	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 990,769	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 489,589	\$ 1,252,139	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,395,459	\$ 3,528,947	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,885,048	\$ 4,781,086	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Franklin Grove Nursing Center, Inc.
 Provider #: 0037168
 12/31/2009

Schedule 17A

XV. BALANCE SHEET -

<u>Other Current Assets (specify):</u>	<u>Operating</u>	<u>After Consolidation</u>
Due from State-Interest	14,972	14,972
RE Due to/from Florissant	0	429,381
RE Due to/from SFO Associates	0	1,586,924
Total Line 9 - Other Current Assets (specify):	<u>14,972</u>	<u>2,031,277</u>

<u>Other Long-Term Assets (specify):</u>	<u>Operating</u>	<u>After Consolidation</u>
Investment in SFO Associate	0	59,245
Loan Costs	0	144,309
Amortization - Loan Costs	0	(74,659)
Total Line 22 - Other Long-Term Assets (specify):	<u>0</u>	<u>128,895</u>

<u>Other (specify):</u>	<u>Operating</u>	<u>After Consolidation</u>
Non-care asset	-	4,200
Total Line 23 - Other (specify):	<u>0</u>	<u>4,200</u>

<u>Other Current Liabilities (specify):</u>	<u>Operating</u>	<u>After Consolidation</u>
Due to State	(22,442)	(22,442)
Due to Franklin Grove Associates	(228,219)	(228,219)
Insurance Premiums Payable	(955)	(955)
Retirement (From P/R)	(598)	(598)
Accrued Expenses	(88,407)	(88,407)
Due to Public Aid	79	79
Due from Franklin Grove	-	228,219
Total Line 36 - Other Current Liabilities (specify):	<u>(340,542)</u>	<u>(112,323)</u>

SEE ACCOUNTANTS' COMPILATION REPORT

XVI. STATEMENT OF CHANGES IN EQUITY

		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,682,242	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,682,242	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	560,216	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	(847,000)	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)	\$ (286,783)	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)	\$ 1,395,459	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Franklin Grove Nursing Center

0037168

Report Period Beginning: 01/01/09

Ending: 12/31/09

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	\$ 5,867,582	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,867,582	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	204,863	6
7	Oxygen	18,779	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 223,642	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	3,522	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 3,522	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	19,343	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 19,343	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,114,089	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,259,435	31
32	Health Care	2,327,306	32
33	General Administration	1,230,503	33
B. Capital Expense			
34	Ownership	530,868	34
C. Ancillary Expense			
35	Special Cost Centers	139,513	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)*	\$ 5,553,873	40
41	Income before Income Taxes (line 30 minus line 40)**	560,216	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 560,216	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:

01/01/09

Ending:

12/31/09

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,692	1,732	\$ 58,324	\$ 33.67	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,615	8,018	192,348	23.99	3
4	Licensed Practical Nurses	21,030	22,275	481,349	21.61	4
5	CNAs & Orderlies	90,597	92,734	919,642	9.92	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,462	4,535	43,376	9.56	8
9	Activity Director					9
10	Activity Assistants	9,535	9,776	122,149	12.49	10
11	Social Service Workers	2,222	2,366	32,143	13.59	11
12	Dietician					12
13	Food Service Supervisor	4,098	4,375	66,398	15.18	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,194	23,197	202,882	8.75	15
16	Dishwashers					16
17	Maintenance Workers	6,479	6,926	100,026	14.44	17
18	Housekeepers	22,983	24,121	200,705	8.32	18
19	Laundry	12,746	13,635	118,867	8.72	19
20	Administrator	2,160	2,160	135,235	62.61	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,286	15,857	319,293	20.14	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)	223,099	231,707	\$ 2,992,737 *	\$ 12.92	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	\$ 4,135	L1, C3	35
36	Medical Director	Monthly	6,875	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	14,694	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	Monthly	5,049	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)		\$ 30,753		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

Facility Name & ID Number Franklin Grove Nursing Center

0037168

Report Period Beginning: 01/01/09

Ending: 12/31/09

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	\$ 135,235	Workers' Compensation Insurance	\$ 45,470	IDPH License Fee	\$ 1,990		
				Unemployment Compensation Insurance	20,163	Advertising: Employee Recruitment			
				FICA Taxes	227,182	Health Care Worker Background Check			
				Employee Health Insurance	70,651	(Indicate # of checks performed _____)			
				Employee Meals	6,351	<u>Patient Background Checks</u>			
				Illinois Municipal Retirement Fund (IMRF)*		Illinois Council on Long Term Care	13,388		
				Other Employee Benefits	6,687	Miscellaneous Dues & Permits	1,925		
				Holiday Expense	2,907	Miscellaneous Inspections & Licenses	100		
						Allocated from Management Co.	108		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 135,235						
B. Administrative - Other									
Description			Amount						
SW Management-Home Office and Management Fees			\$ 87,825						
Ronnie Klein - Management Fees (Eliminated on Schedule V, Column 7)			180,000						
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 267,825	TOTAL (agree to Schedule V, line 22, col.8)			\$ 379,411	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 17,511
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	
Michigan Peer Review Org.	Peer Review		\$ 360	N/A			Out-of-State Travel	\$	
Honkamp Krueger & Co., P.C.	Accounting		2,162						
McGladrey & Pullen, LLP	Accounting		17,946				In-State Travel		
K&L Gates	Legal		6,306						
							Seminar Expense	2,476	
							Allocated from Management Co.	13	
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 26,774	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 2,489	

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Franklin Grove Nursing Center, Inc.

Provider # 0037168

12/31/2009

Schedule 21A

XIX. Support Schedule

C. Professional Services

Total (agree to Schedule V, line 19, column 3) 26,774

Allocated from Franklin Grove Associates:

Accounting-RSM McGladrey, Inc. 2,625

Allocated from SW Management Compnay:

Legal 2,100

Accounting-RSM McGladrey, Inc. 1,216

Allocated from SFO Associates

Accounting-RSM McGladrey, Inc. 12,991

Total (agree to Schedule V, line 19, column 8) 45,706

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

SEE ACCOUNTANTS' COMPILATION REPORT

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-\$13,388
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 7,894 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.

- (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. \$ 6,351 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
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT