

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0051599

Facility Name: Franklin Grove Living & Rehabilitation Center, LLC

Address: 502 North State Street Franklin Grove 61031
Number City Zip Code

County: Lee

Telephone Number: (815) 456-2374 Fax #: (815) 456-2250

HFS ID Number:

Date of Initial License for Current Owners: 9/1/11

Type of Ownership:

VOLUNTARY,NON-PROFIT

Charitable Corp.

Trust

IRS Exemption Code

X PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

X Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

In the event there are further questions about this report, please contact:
Name: Michael W. Martin Telephone Number: (217) 258-8888
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the
State of Illinois, for the period from 01/01/11 to 12/31/11
and certify to the best of my knowledge and belief that the said contents
are true, accurate and complete statements in accordance with
applicable instructions. Declaration of preparer (other than provider)
is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information
in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer

(Signed) SEE ACCOUNTANTS' PREPARATION REPORT (Date)
(Print Name and Title)
(Firm Name & Address) McGladrey & Pullen, LLP
20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax #: (847) 517-7067

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone #: (217) 782-1630

Facility Name & ID Number Franklin Grove Living & Rehabilitation Center, LLC

0051599 Report Period Beginning: 01/01/11 Ending: 12/31/11

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>620</u>	<u>188</u>	<u>2,855</u>	<u>3,663</u>	8
9	SNF/PED					9
10	ICF	<u>14,579</u>	<u>15,444</u>		<u>30,023</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>15,199</u>	<u>15,632</u>	<u>2,855</u>	<u>33,686</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.27%

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 2,855

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: 12/31/11 Fiscal Year: 12/31/11
* All facilities other than governmental must report on the accrual basis.

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	A. General Services	1	2	3	4	5	6	7	8			
1	Dietary	274,539	12,264	4,491	291,294		291,294		291,294			1
2	Food Purchase		261,171		261,171		261,171	(4,428)	256,743			2
3	Housekeeping	218,653	57,837		276,490		276,490	91	276,581			3
4	Laundry	105,706	16,030		121,736		121,736		121,736			4
5	Heat and Other Utilities			150,353	150,353		150,353	1,153	151,506			5
6	Maintenance	106,697	54,406	7,906	169,009		169,009	452	169,461			6
7	Other (specify):*											7
8	TOTAL General Services	705,595	401,708	162,750	1,270,053		1,270,053	(2,732)	1,267,321			8
	B. Health Care and Programs											
9	Medical Director			6,775	6,775		6,775		6,775			9
10	Nursing and Medical Records	1,778,352	50,273	2,298	1,830,923		1,830,923	(3,326)	1,827,597			10
10a	Therapy			307,267	307,267		307,267		307,267			10a
11	Activities	93,676	4,778		98,454		98,454		98,454			11
12	Social Services	82,684			82,684		82,684		82,684			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,954,712	55,051	316,340	2,326,103		2,326,103	(3,326)	2,322,777			16
	C. General Administration											
17	Administrative	143,003		322,363	465,366		465,366	(198,197)	267,169			17
18	Directors Fees											18
19	Professional Services			32,146	32,146		32,146	10,372	42,518			19
20	Dues, Fees, Subscriptions & Promotions			21,927	21,927		21,927	97	22,024			20
21	Clerical & General Office Expenses	397,089		55,474	452,563		452,563	45,968	498,531			21
22	Employee Benefits & Payroll Taxes			392,477	392,477		392,477	7,165	399,642			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,610	2,610		2,610	17	2,627			24
25	Other Admin. Staff Transportation			19,561	19,561		19,561	1,800	21,361			25
26	Insurance-Prop.Liab.Malpractice			8,215	8,215		8,215	327	8,542			26
27	Other (specify):* Mgmt Alloc of Benefit							14,314	14,314			27
28	TOTAL General Administration	540,092		854,773	1,394,865		1,394,865	(118,137)	1,276,728			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,200,399	456,759	1,333,863	4,991,021		4,991,021	(124,195)	4,866,826			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			22,570	22,570		22,570	102,256	124,826			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			12,717	12,717		12,717	38,683	51,400			32
33	Real Estate Taxes			12,809	12,809		12,809	6,766	19,575			33
34	Rent-Facility & Grounds			466,329	466,329		466,329	(466,329)				34
35	Rent-Equipment & Vehicles			827	827		827	891	1,718			35
36	Other (specify):*											36
37	TOTAL Ownership			515,252	515,252		515,252	(317,733)	197,519			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		69,519		69,519		69,519		69,519			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			66,203	66,203		66,203		66,203			42
43	Other (specify):* Non-Allow Costs			33,697	33,697		33,697	(33,697)				43
44	TOTAL Special Cost Centers		69,519	99,900	169,419		169,419	(33,697)	135,722			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,200,399	526,278	1,949,015	5,675,692		5,675,692	(475,625)	5,200,067			45

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

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 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	56,920	30		9
10	Interest and Other Investment Income	67,627	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(103)	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	(1,000)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(9,394)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(6,090)	43		24
25	Fund Raising, Advertising and Promotional	(2,779)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(5,321)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(5,334)	43		28
29	Other-Attach Schedule <u>See Pg 5A</u>	15,648	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 110,174		\$	30

BHF USE ONLY							
48		49		50		51	

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 Amount	2 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)	(585,799)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (585,799)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (475,625)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	<u>Gift and Coffee Shops</u>		X			40
41	<u>Barber and Beauty Shops</u>		X			41
42	<u>Laboratory and Radiology</u>		X			42
43	<u>Prescription Drugs</u>		X			43
44						44
45	<u>Other-Attach Schedule</u>		X			45
46	<u>Other-Attach Schedule</u>		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Lab Expense Med A	\$ (8,956)	43	1
2	X Ray Expense Med A	(3,769)	43	2
3	Gain / Loss	28,718	43	3
4	Trust Fees	(295)	43	4
5	COPE Fees		20	5
6	Managed care costs	(50)	43	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
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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	15,648		49

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See PG6-Supp		See PG6-Supp		See PG6-Supp		

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%	\$ 6,084	\$ 6,084	1
2	V	30	Depreciation		Franklin Grove Associates	100.00%	42,352	42,352	2
3	V	32	Interest	80,344	Franklin Grove Associates	100.00%	52,864	(27,480)	3
4	V	32	Amortization		Franklin Grove Associates	100.00%	4,810	4,810	4
5	V	34	Rent Facility and Ground	466,329	Franklin Grove Associates	100.00%		(466,329)	5
6	V	43	Other		Franklin Grove Associates	100.00%	3,902	3,902	6
7	V	43	Other	28,718	Franklin Grove Associates	100.00%		(28,718)	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 575,391			\$ 110,012	\$ * (465,379)	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	Food	\$	SW Management Co. (January-February)	100.00%	\$ 21	\$ 21	15
16	V	3	Housekeeping		SW Management Co. (January-February)	100.00%	12	12	16
17	V	5	Heat and Other Utilities		SW Management Co. (January-February)	100.00%	156	156	17
18	V	6	Maintenance		SW Management Co. (January-February)	100.00%	61	61	18
19	V	17	Administrative	65,400	SW Management Co. (January-February)	100.00%	17,521	(47,879)	19
20	V	19	Professional Services		SW Management Co. (January-February)	100.00%	149	149	20
21	V	20	Dues, Fees, Subs & Promotions		SW Management Co. (January-February)	100.00%	13	13	21
22	V	21	Clerical & General Office Expense		SW Management Co. (January-February)	100.00%	5,471	5,471	22
23	V	24	Travel and Seminar		SW Management Co. (January-February)	100.00%	2	2	23
24	V	25	Other Admin. Staff Transport		SW Management Co. (January-February)	100.00%	244	244	24
25	V	26	Insurance-Prop. Liab Malpractice		SW Management Co. (January-February)	100.00%	44	44	25
26	V	27	Mgmt. Allocation of Benefits		SW Management Co. (January-February)	100.00%	1,940	1,940	26
27	V	30	Depreciation		SW Management Co. (January-February)	100.00%	497	497	27
28	V	32	Interest		SW Management Co. (January-February)	100.00%			28
29	V	33	Real Estate Taxes		SW Management Co. (January-February)	100.00%	388	388	29
30	V	35	Rent-Equipment & Vehicles		SW Management Co. (January-February)	100.00%	121	121	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			\$ 65,400			\$ 26,640	\$ * (38,760)	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	\$ 1,500	S & E Medical Supply Co.	100.00%	\$ 4,084	\$ 2,584	15
16	V	3	Housekeeping	1,208	S & E Medical Supply Co.	100.00%	1,208		16
17	V	10	Medical Supplies	5,414	S & E Medical Supply Co.	100.00%	2,088	(3,326)	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			\$ 8,122			\$ 7,380	\$ * (742)	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.

☒ X

 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%	\$ 12,582	\$ 12,582	15
16	V	32	Interest-Bonds	52,864	SFO Associates	0.00%	46,590	(6,274)	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			\$ 52,864			\$ 59,172	\$ * 6,308	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	\$	SW Management Co. (March)	100.00%	\$ 12	\$ 12	15
16	V	3	Housekeeping		SW Management Co. (March)	100.00%	7	7	16
17	V	5	Heat and Other Utilities		SW Management Co. (March)	100.00%	92	92	17
18	V	6	Maintenance		SW Management Co. (March)	100.00%	36	36	18
19	V	17	Administrative	32,700	SW Management Co. (March)	100.00%	9,244	(23,456)	19
20	V	19	Professional Services		SW Management Co. (March)	100.00%	88	88	20
21	V	20	Dues, Fees, Subs & Promotions		SW Management Co. (March)	100.00%	8	8	21
22	V	21	Clerical & General Office Expense		SW Management Co. (March)	100.00%	3,741	3,741	22
23	V	24	Travel and Seminar		SW Management Co. (March)	100.00%	1	1	23
24	V	25	Other Admin. Staff Transport		SW Management Co. (March)	100.00%	144	144	24
25	V	26	Insurance-Prop. Liab Malpractice		SW Management Co. (March)	100.00%	26	26	25
26	V	27	Mgmt. Allocation of Benefits		SW Management Co. (March)	100.00%	1,143	1,143	26
27	V	30	Depreciation		SW Management Co. (March)	100.00%	248	248	27
28	V	32	Interest		SW Management Co. (March)	100.00%			28
29	V	33	Real Estate Taxes		SW Management Co. (March)	100.00%	229	229	29
30	V	35	Rent-Equipment & Vehicles		SW Management Co. (March)	100.00%	71	71	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			\$ 32,700			\$ 15,090	\$ * (17,610)	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	\$	SW Management Co. (April-June)	100.00%	\$ 40	\$ 40	15
16	V	3	Housekeeping		SW Management Co. (April-June)	100.00%	24	24	16
17	V	5	Heat and Other Utilities		SW Management Co. (April-June)	100.00%	302	302	17
18	V	6	Maintenance		SW Management Co. (April-June)	100.00%	118	118	18
19	V	17	Administrative	98,100	SW Management Co. (April-June)	100.00%	29,181	(68,919)	19
20	V	19	Professional Services		SW Management Co. (April-June)	100.00%	288	288	20
21	V	20	Dues, Fees, Subs & Promotions		SW Management Co. (April-June)	100.00%	25	25	21
22	V	21	Clerical & General Office Expense		SW Management Co. (April-June)	100.00%	12,252	12,252	22
23	V	24	Travel and Seminar		SW Management Co. (April-June)	100.00%	5	5	23
24	V	25	Other Admin. Staff Transport		SW Management Co. (April-June)	100.00%	471	471	24
25	V	26	Insurance-Prop. Liab Malpractice		SW Management Co. (April-June)	100.00%	86	86	25
26	V	27	Mgmt. Allocation of Benefits		SW Management Co. (April-June)	100.00%	3,744	3,744	26
27	V	30	Depreciation		SW Management Co. (April-June)	100.00%	745	745	27
28	V	32	Interest		SW Management Co. (April-June)	100.00%			28
29	V	33	Real Estate Taxes		SW Management Co. (April-June)	100.00%	749	749	29
30	V	35	Rent-Equipment & Vehicles		SW Management Co. (April-June)	100.00%	233	233	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			\$ 98,100			\$ 48,263	\$ * (49,837)	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	\$	SW Management Co. (July-August)	100.00%	\$ 27	\$ 27	15
16	V	3	Housekeeping		SW Management Co. (July-August)	100.00%	16	16	16
17	V	5	Heat and Other Utilities		SW Management Co. (July-August)	100.00%	201	201	17
18	V	6	Maintenance		SW Management Co. (July-August)	100.00%	79	79	18
19	V	17	Administrative	65,400	SW Management Co. (July-August)	100.00%	19,453	(45,947)	19
20	V	19	Professional Services		SW Management Co. (July-August)	100.00%	192	192	20
21	V	20	Dues, Fees, Subs & Promotions		SW Management Co. (July-August)	100.00%	17	17	21
22	V	21	Clerical & General Office Expense		SW Management Co. (July-August)	100.00%	8,168	8,168	22
23	V	24	Travel and Seminar		SW Management Co. (July-August)	100.00%	3	3	23
24	V	25	Other Admin. Staff Transport		SW Management Co. (July-August)	100.00%	314	314	24
25	V	26	Insurance-Prop. Liab Malpractice		SW Management Co. (July-August)	100.00%	57	57	25
26	V	27	Mgmt. Allocation of Benefits		SW Management Co. (July-August)	100.00%	2,496	2,496	26
27	V	30	Depreciation		SW Management Co. (July-August)	100.00%	497	497	27
28	V	32	Interest		SW Management Co. (July-August)	100.00%			28
29	V	33	Real Estate Taxes		SW Management Co. (July-August)	100.00%	499	499	29
30	V	35	Rent-Equipment & Vehicles		SW Management Co. (July-August)	100.00%	155	155	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			\$ 65,400			\$ 32,174	\$ * (33,226)	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	\$	SW Management Co. (September-December)	100.00%	\$ 53	\$ 53	15
16	V	3	Housekeeping		SW Management Co. (September-December)	100.00%	32	32	16
17	V	5	Heat and Other Utilities		SW Management Co. (September-December)	100.00%	402	402	17
18	V	6	Maintenance		SW Management Co. (September-December)	100.00%	158	158	18
19	V	17	Administrative	18,763	SW Management Co. (September-December)	100.00%	6,767	(11,996)	19
20	V	19	Professional Services		SW Management Co. (September-December)	100.00%	383	383	20
21	V	20	Dues, Fees, Subs & Promotions		SW Management Co. (September-December)	100.00%	34	34	21
22	V	21	Clerical & General Office Expense		SW Management Co. (September-December)	100.00%	16,336	16,336	22
23	V	24	Travel and Seminar		SW Management Co. (September-December)	100.00%	6	6	23
24	V	25	Other Admin. Staff Transport		SW Management Co. (September-December)	100.00%	627	627	24
25	V	26	Insurance-Prop. Liab Malpractice		SW Management Co. (September-December)	100.00%	114	114	25
26	V	27	Mgmt. Allocation of Benefits		SW Management Co. (September-December)	100.00%	4,991	4,991	26
27	V	30	Depreciation		SW Management Co. (September-December)	100.00%	997	997	27
28	V	32	Interest		SW Management Co. (September-December)	100.00%			28
29	V	33	Real Estate Taxes		SW Management Co. (September-December)	100.00%	999	999	29
30	V	35	Rent-Equipment & Vehicles		SW Management Co. (September-December)	100.00%	311	311	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			\$ 18,763			\$ 32,210	\$ * 13,447	39

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

VII. RELATED PARTIES
A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Moshe Herman	50.00%	Oregon Living & Rehabilitation Center, LLC	Oregon	S.W. Management Co.	Skokie	Bookkeeping /	1
2	Stuart Milstein	7.33%	Beauvais Manor Healthcare & Rehab	St. Louis, MO			Management Co.	2
3	Ari Milstein	7.33%	Hillside Manor Healthcare & Rehab	St. Louis, MO	*SFO Associates	Finance Company	Finance Company	3
4	Elana Minkove	7.33%	Rancho Manor Healthcare & Rehab	Florissant, MO				4
5	Amanda Bachrach	4.40%	Rosewood Health & Rehab Center	Independence, MO	* This entity only relates to Shabbona Healthcare Center,			5
6	Yedida Wolfe	4.40%			Franklin Grove Living and Rehab, and Oregon Living			6
7	James Wolfe	4.40%			and Rehab			7
8	Neil Wolfe	4.40%						8
9	Richard Wolfe	4.40%			S&E Medical Supply	Skokie	Medical Supplies	9
10	Robin Krystal	4.00%			Momentum	Skokie	Management	10
11	David Zuckerman	2.00%			Healthcare		Company	11
12								12
13					Groves Community	Independence, MO	Hospice	13
14					Hospice			14
15					Forest View Senior	Independence, MO	Independent	15
16					Residences		Living	16
17					White Oak Living	Independence, MO	Residential	17
18					Center		Care	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

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	Moshe Herman	Owner	Administrative	50.00	175,333	20	50.00	Salary	\$ 42,000	L17, C3	1
2											2
3	Sheldon Wolfe **	President	Administrative	31.65	See Sch 7A	3	0.07	Salary	14,500	L17,C7	3
4	Ronnie Klein **	Shareholder	Administrative	2.48	See Sch 7B	15	0.38	Salary & Fees	76,125	17,3 & 17,7	4
5	Moshe Herman **	CFO	Administrative	15.83	See Sch 7C	3	0.07	Salary	14,500	L17,C7	5
6											6
7											7
8	** This compensation if for the time period of 1/1/11-8/31/11										8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 147,125		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**

Facility Name & ID Number Franklin Grove Living & Rehabilitation Center, LLC # 0051599 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

	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	124,018	12	\$ 358	\$	7,139	\$ 21	1
2	3	Housekeeping	Bed Days Available	124,018	12	213		7,139	12	2
3	5	Heat and Other Utilities	Bed Days Available	124,018	12	2,716		7,139	156	3
4	6	Maintenance	Bed Days Available	124,018	12	1,066		7,139	61	4
5	19	Professional Services	Bed Days Available	124,018	12	2,591		7,139	149	5
6	20	Dues, Fees, Subs & Promotions	Bed Days Available	124,018	12	229		7,139	13	6
7	21	Clerical & General Office Exp	Bed Days Available	124,018	12	95,042	95,042	7,139	5,471	7
8	24	Travel and Seminar	Bed Days Available	124,018	12	42		7,139	2	8
9	25	Other Admin. Staff Transport	Bed Days Available	124,018	12	4,236		7,139	244	9
10	26	Insurance-Prop., Liab & Malp.	Bed Days Available	124,018	12	772		7,139	44	10
11	27	Mgmt. Allocation of Benefits	Bed Days Available	124,018	12	33,703		7,139	1,940	11
12	32	Interest	Bed Days Available	124,018	12			7,139	0	12
13	33	Real Estate Taxes	Bed Days Available	124,018	12	6,744		7,139	388	13
14	35	Rent-Equipment & Vehicles	Bed Days Available	124,018	12	2,099		7,139	121	14
15										15
16	17	Administrative	Avg. Hours Worked	42	12	33,833	33,833	3	2,417	16
17	17	Administrative	Avg. Hours Worked	42	12	33,833	33,833	3	2,417	17
18	17	Administrative	Avg. Hours Worked	40	12	33,833	33,833	15	12,687	18
19	30	Depreciation	Direct Cost	6,938	12				497	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 251,310	\$ 196,541		\$ 26,640	25

Facility Name & ID Number Franklin Grove Living & Rehabilitation Center, LLC # 0051599 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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 ()

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.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food	Direct Cost			\$	\$		\$ 4,084	1
2	3	Housekeeping	Direct Cost						1,208	2
3	10	Medical Supplies	Direct Cost						2,088	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					\$	\$		\$ 7,380	25

Facility Name & ID Number Franklin Grove Living & Rehabilitation Center, LLC # 0051599 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Professional Services	Note Receivable	6,500,000	3	\$ 29,209	\$	2,800,000	\$ 12,582	1
2	32	Interest-Bonds	Note Receivable	6,500,000	3	108,156		2,800,000	46,590	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					\$ 137,365	\$		\$ 59,172	25

Facility Name & ID Number Franklin Grove Living & Rehabilitation Center, LLC # 0051599 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	2	Food	Bed Days Available	55,304	11	\$ 179	\$	3,751	\$ 12	1
2	3	Housekeeping	Bed Days Available	55,304	11	106		3,751	7	2
3	5	Heat and Other Utilities	Bed Days Available	55,304	11	1,358		3,751	92	3
4	6	Maintenance	Bed Days Available	55,304	11	532		3,751	36	4
5	19	Professional Services	Bed Days Available	55,304	11	1,294		3,751	88	5
6	20	Dues, Fees, Subs & Promotions	Bed Days Available	55,304	11	115		3,751	8	6
7	21	Clerical & General Office Exp	Bed Days Available	55,304	11	55,153	47,522	3,751	3,741	7
8	24	Travel and Seminar	Bed Days Available	55,304	11	22		3,751	1	8
9	25	Other Admin. Staff Transport	Bed Days Available	55,304	11	2,118		3,751	144	9
10	26	Insurance-Prop., Liab & Malp.	Bed Days Available	55,304	11	386		3,751	26	10
11	27	Mgmt. Allocation of Benefits	Bed Days Available	55,304	11	16,851		3,751	1,143	11
12	32	Interest	Bed Days Available	55,304	11			3,751		12
13	33	Real Estate Taxes	Bed Days Available	55,304	11	3,372		3,751	229	13
14	35	Rent-Equipment & Vehicles	Bed Days Available	55,304	11	1,050		3,751	71	14
15										15
16	17	Administrative	Avg. Hours Worked	35	11	16,917	16,917	3	1,450	16
17	17	Administrative	Avg. Hours Worked	35	11	16,917	16,917	3	1,450	17
18	17	Administrative	Avg. Hours Worked	40	3	16,917	16,917	15	6,344	18
19	30	Depreciation	Direct Cost	3,469					248	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 133,287	\$ 98,273		\$ 15,090	25

Facility Name & ID Number Franklin Grove Living & Rehabilitation Center, LLC # 0051599 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

	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	148,694	10	\$ 537	\$	11,011	\$ 40	1
2	3	Housekeeping	Bed Days Available	148,694	10	320		11,011	24	2
3	5	Heat and Other Utilities	Bed Days Available	148,694	10	4,074		11,011	302	3
4	6	Maintenance	Bed Days Available	148,694	10	1,599		11,011	118	4
5	19	Professional Services	Bed Days Available	148,694	10	3,886		11,011	288	5
6	20	Dues, Fees, Subs & Promotions	Bed Days Available	148,694	10	344		11,011	25	6
7	21	Clerical & General Office Exp	Bed Days Available	148,694	10	165,455	142,564	11,011	12,252	7
8	24	Travel and Seminar	Bed Days Available	148,694	10	64		11,011	5	8
9	25	Other Admin. Staff Transport	Bed Days Available	148,694	10	6,354		11,011	471	9
10	26	Insurance-Prop., Liab & Malp.	Bed Days Available	148,694	10	1,158		11,011	86	10
11	27	Mgmt. Allocation of Benefits	Bed Days Available	148,694	10	50,553		11,011	3,744	11
12	32	Interest	Bed Days Available	148,694	10			11,011		12
13	33	Real Estate Taxes	Bed Days Available	148,694	10	10,116		11,011	749	13
14	35	Rent-Equipment & Vehicles	Bed Days Available	148,694	10	3,149		11,011	233	14
15										15
16	17	Administrative	Avg. Hours Worked	30	10	50,750	50,750	3	5,075	16
17	17	Administrative	Avg. Hours Worked	30	10	50,750	50,750	3	5,075	17
18	17	Administrative	Avg. Hours Worked	40	3	50,750	50,750	15	19,031	18
19	30	Depreciation	Direct Cost	10,408					745	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 399,859	\$ 294,814		\$ 48,263	25

Facility Name & ID Number Franklin Grove Living & Rehabilitation Center, LLC # 0051599 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	2	Food	Bed Days Available	101,308	10	\$ 358	\$	7,502	\$ 27	1
2	3	Housekeeping	Bed Days Available	101,308	10	213		7,502	16	2
3	5	Heat and Other Utilities	Bed Days Available	101,308	10	2,716		7,502	201	3
4	6	Maintenance	Bed Days Available	101,308	10	1,066		7,502	79	4
5	19	Professional Services	Bed Days Available	101,308	10	2,591		7,502	192	5
6	20	Dues, Fees, Subs & Promotions	Bed Days Available	101,308	10	229		7,502	17	6
7	21	Clerical & General Office Exp	Bed Days Available	101,308	10	110,303	95,042	7,502	8,168	7
8	24	Travel and Seminar	Bed Days Available	101,308	10	42		7,502	3	8
9	25	Other Admin. Staff Transport	Bed Days Available	101,308	10	4,236		7,502	314	9
10	26	Insurance-Prop., Liab & Malp.	Bed Days Available	101,308	10	772		7,502	57	10
11	27	Mgmt. Allocation of Benefits	Bed Days Available	101,308	10	33,703		7,502	2,496	11
12	32	Interest	Bed Days Available	101,308	10			7,502		12
13	33	Real Estate Taxes	Bed Days Available	101,308	10	6,744		7,502	499	13
14	35	Rent-Equipment & Vehicles	Bed Days Available	101,308	10	2,099		7,502	155	14
15										15
16	17	Administrative	Avg. Hours Worked	30	10	33,833	33,833	3	3,383	16
17	17	Administrative	Avg. Hours Worked	30	10	33,833	33,833	3	3,383	17
18	17	Administrative	Avg. Hours Worked	40	3	33,833	33,833	15	12,687	18
19	30	Depreciation	Direct Cost	10,408					497	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 266,571	\$ 196,541		\$ 32,174	25

Facility Name & ID Number Franklin Grove Living & Rehabilitation Center, LLC # 0051599 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

	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	199,348	10	\$ 716	\$	14,762	\$ 53	1
2	3	Housekeeping	Bed Days Available	199,348	10	426		14,762	32	2
3	5	Heat and Other Utilities	Bed Days Available	199,348	10	5,432		14,762	402	3
4	6	Maintenance	Bed Days Available	199,348	10	2,131		14,762	158	4
5	19	Professional Services	Bed Days Available	199,348	10	5,181		14,762	383	5
6	20	Dues, Fees, Subs & Promotions	Bed Days Available	199,348	10	458		14,762	34	6
7	21	Clerical & General Office Exp	Bed Days Available	199,348	10	220,606	190,085	14,762	16,336	7
8	24	Travel and Seminar	Bed Days Available	199,348	10	86		14,762	6	8
9	25	Other Admin. Staff Transport	Bed Days Available	199,348	10	8,472		14,762	627	9
10	26	Insurance-Prop., Liab & Malp.	Bed Days Available	199,348	10	1,543		14,762	114	10
11	27	Mgmt. Allocation of Benefits	Bed Days Available	199,348	10	67,405		14,762	4,991	11
12	32	Interest	Bed Days Available	199,348	10			14,762		12
13	33	Real Estate Taxes	Bed Days Available	199,348	10	13,488		14,762	999	13
14	35	Rent-Equipment & Vehicles	Bed Days Available	199,348	10	4,198		14,762	311	14
15										15
16	17	Administrative	Avg. Hours Worked	30	10	67,667	67,667	3	6,767	16
17	17	Administrative	Avg. Hours Worked	30	10					17
18	17	Administrative	Avg. Hours Worked	15	1	67,667	67,667			18
19	30	Depreciation	Direct Cost	13,877					997	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 465,476	\$ 325,419		\$ 32,210	25

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	\$ 646,154	8/15/14	Variable	\$ 109,354
2	(Loan Payable-SFO Assoc)				\$129,231.00						
3											
4											
5											
	Working Capital										
6	Sheldon Wolfe		X	Working Capital		9/1/11	250,000	250,000	8/31/14	1.6900	1,408
7	Albert Milstein		X	Working Capital		9/1/11	250,000	250,000	8/31/14	1.6900	1,409
8											
9	TOTAL Facility Related				\$129,231.00		\$ 3,300,000	\$ 1,146,154			\$ 112,171
	B. Non-Facility Related*										
10								Amortization of loan cost			4,810
11								Interest Income Offset			(65,581)
12											
13											
14	TOTAL Non-Facility Related						\$	\$			\$ (60,771)
15	TOTALS (line 9+line14)						\$ 3,300,000	\$ 1,146,154			\$ 51,400

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A 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.)

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

HFS 3745 (N-4-99)

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 2010 report.							\$	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.)	2010						\$ 16,711	2
3. Under or (over) accrual (line 2 minus line 1).							\$ 16,711	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)							\$	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
	Allocated from Management Co.						2,864	
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.							\$ 19,575	7
Real Estate Tax History:								
Real Estate Tax Bill for Calendar Year:	2006	52,663	8	FOR BHF USE ONLY				
	2007	54,385	9					
	2008	54,449	10					
	2009	54,450	11					
	2010	16,711	12					
This facility does not accrue real estate taxes as it is part of the lease agreement.				13	FROM R. E. TAX STATEMENT FOR 2010 \$			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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Franklin Grove Living & Rehabilitation Center, LLC

COUNTY

Lee

FACILITY IDPH LICENSE NUMBER

0051599

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 2010 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 2010.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>06-03-36-351-07</u>	<u>Long Term Care Property</u>	\$ <u>40,304.00</u>	\$ <u>16,711.00</u>
2. <u>10-28-412-049-0000</u>	<u>SW Management Allocation</u>	\$ <u>33,410.00</u>	\$ <u>2,330.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>73,714.00</u></u>	\$ <u><u>19,041.00</u></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 and 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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 38,868

B. General Construction Type: Exterior BrickFrame Concrete & SteelNumber 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: N/A

2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A

4. Dates Incurred: N/A

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.					
	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care		1991	\$ 36,205	1
2					2
3	TOTALS			\$ 36,205	3

Facility Name & ID Number Franklin Grove Living & Rehabilitation Center, LLC

0051599

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	121		1991		\$ 1,334,101	\$	31.5	\$ 42,352	\$ 42,352	\$ 868,223	4
5											5
6	Mgmt. Alloc				31,019			886	886	14,761	6
7											7
8											8
	Improvement Type**										
9	Various			1991	6,392		20	287	287	6,392	9
10	Various			1992	29,415		20	1,471	1,471	28,806	10
11	Various			1993	47,511		20	2,381	2,381	45,732	11
12	Various			1994	17,652		20	883	883	15,648	12
13	Various			1995	10,809		20	540	540	8,973	13
14	Various			1997	55,791		20	2,790	2,790	42,179	14
15	Various			1998	87,964		20	4,398	4,398	56,532	15
16	Various			1999	24,113		20	1,206	1,206	14,995	16
17	Retroaire Chassis			2000	2,321		20	116	116	1,276	17
18	Water Main Line			2001	3,294		20	165	165	1,771	18
19	Walk In Freezer			2001	8,947		20	447	447	4,659	19
20	Wiring To Kitchen			2001	12,250		20	613	613	6,586	20
21	Kitchen Labor			2001	3,163		20	158	158	1,607	21
22	Kitchen Labor			2001	1,532		20	77	77	779	22
23	Carpeting			2002	16,211		5			16,211	23
24	Bathroom and Tub			2002	3,700		10	370	370	3,423	24
25	Bath			2002	7,972		10	797	797	7,241	25
26	Glass Blocks			2002	1,649		10	165	165	1,539	26
27	Voice Alarm			2003	948		20	47	47	474	27
28	Code Alert			2003	3,887		20	194	194	1,813	28
29	Magnetic Door Holders			2003	1,652		20	83	83	826	29
30	Air Conditioners			2003	4,244		20	212	212	2,121	30
31	Tub & Lift			2003	8,738		20	437	437	4,514	31
32	3 Air Conditioners			2003	478		20	24	24	239	32
33	Boiler Repair			2003	1,683		20	84	84	750	33
34	Shower - Glass, Bars			2003	550		20	28	28	246	34
35	Carpet			2003	599		20	30	30	247	35
36	Gutters & Down Spouts			2003	10,759		20	538	538	4,663	36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number Franklin Grove Living & Rehabilitation Center, LLC

0051599

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 Aluminum Soffit	2003	\$ 1,864	\$	20	\$ 93	\$ 93	\$ 792	37
38 Painting (24 Rooms)	2004	5,520		20	276	276	2,070	38
39 Nurses station	2004	18,750		20	938	938	7,032	39
40 Dining Area	2004	2,400		20	120	120	900	40
41 New Windows	2004	6,335		20	317	317	2,376	41
42 Bathroom Plumbing and Electrical	2004	12,600		20	630	630	4,725	42
43 Kitchen and Dining Room	2004	16,369		20	818	818	6,137	43
44 Remodel Shower and Flooring	2004	10,595		20	530	530	3,974	44
45 Display Case - Nurses Station	2004	3,800		20	190	190	1,425	45
46 Dining Room Windows	2004	9,614		20	481	481	3,606	46
47 Glass Block Shower Windows	2004	1,427		20	71	71	535	47
48 Remodel Glass and Shower	2004	3,100		20	155	155	1,163	48
49 Carpet	2004	2,660		20	133	133	998	49
50 Windows	2005	34,060		20	1,703	1,703	11,070	50
51 Remodel Wall	2005	6,518		20	326	326	2,119	51
52 Outside Soffit	2005	6,268		20	313	313	2,037	52
53 Install Valves	2005	4,500		20	225	225	1,463	53
54 Tiles and Flooring	2006	15,604		20	780	780	4,291	54
55 Exterior and Resident Doors	2006	21,725		20	1,086	1,086	5,974	55
56 Kick Plates	2006	5,533		20	277	277	1,522	56
57 Windows	2006	58,240		20	2,912	2,912	16,016	57
58 Siding	2006	2,080		20	104	104	572	58
59 Paving	2006	7,517		20	376	376	2,067	59
60 Wallpaper	2006	3,078		20	154	154	847	60
61 Air Conditioners	2006	20,183		20	1,009	1,009	5,550	61
62 Water Heater	2006	9,984		20	499	499	2,745	62
63								63
64 Glue Down Carpet	2007	3,036		20	152	152	684	64
65								65
66 New Doors	2008	41,645		20	2,082	2,082	7,288	66
67 Wiring-Kitchen Ansul System to Fire Alarm	2008	5,571		20	279	279	975	67
68 Lighting Insulation	2008	12,804		20	640	640	2,241	68
69 New Ceiling-Laundry	2008	3,755		20	188	188	657	69
70 TOTAL (lines 4 thru 69)		\$ 2,096,479	\$		\$ 79,636	\$ 79,636	\$ 1,267,075	70

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

Facility Name & ID Number Franklin Grove Living & Rehabilitation Center, LLC

0051599

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12A, Carried Forward		\$ 2,096,479	\$		\$ 79,636	\$ 79,636	\$ 1,267,075	1
2 South Porch Remodel	2008	4,175		20	209	209	731	2
3 Wallpaper & Installation	2008	8,467		20	423	423	1,481	3
4 Steel studs & drywall on outside walls, retrim windows, and	2008	101,179		20	5,059	5,059	17,706	4
5 extend electrical boxes in 36 rooms								5
6 Gas Water heater	2008	4,399		20	220	220	770	6
7 Painting	2008	9,395		20	470	470	1,644	7
8 Replace Boiler Sections	2008	12,164		20	608	608	2,129	8
9 Vinyl Flooring	2008	83,058		20	4,153	4,153	14,535	9
10 Landscaping	2008	14,896		15	993	993	3,476	10
11 New Sprinkler System	2009	155,270		20	7,764	7,764	19,410	11
12 New Water Line for Sprinkler System	2009	14,936		20	747	747	1,867	12
13 Fire Alarm Interface-Sprinkler System	2009	3,000		20	150	150	375	13
14 Laminate Flooring	2009	2,946		20	147	147	368	14
15 Repave parking lots	2010	36,093		20	1,805	1,805	2,707	15
16 Replace concrete for front sidewalk	2010	4,653		20	233	233	349	16
17 Water heater	2010	8,047		20	402	402	603	17
18 Remodel Kitchen	2011	25,348		20	634	634	634	18
19 Remodel Laundry Room	2011	11,100		20	278	278	278	19
20 Dining Room Floor	2011	9,658		20	241	241	241	20
21 Carpet & Installation	2011	3,705		20	93	93	93	21
22 Front Entrance Soffit	2011	2,100		20	53	53	53	22
23 Parking lot Seal coating	2011	8,400	8,400	20	70	(8,330)	70	23
24 SW Management Allocation-Leasehold Improvements	1995	3,471			174	174	3,127	24
25 SW Management Allocation-Leasehold Improvements	1996	578			29	29	449	25
26 SW Management Allocation-Leasehold Improvements	1997	670			33	33	569	26
27 SW Management Allocation-Leasehold Improvements	1998	573			29	29	394	27
28 SW Management Allocation-Leasehold Improvements	1999	1,591			80	80	961	28
29 SW Management Allocation-Leasehold Improvements	2005	3,291			165	165	1,070	29
30 SW Management Allocation-Leasehold Improvements	2007	1,864			93	93	419	30
31 SW Management Allocation-Leasehold Improvements	2009	3,890			194	194	487	31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 2,635,396	\$ 8,400		\$ 105,184	\$ 96,784	\$ 1,344,071	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 173,760	\$	\$ 16,806	\$ 16,806	10	\$ 74,551	71
72	Current Year Purchases	40,289	14,170	1,536	(12,634)	10	1,542	72
73	Fully Depreciated Assets	522,988					522,988	73
74	Mgmt. Co.	9,795		198	198	10	7,775	74
75	TOTALS	\$ 746,832	\$ 14,170	\$ 18,540	\$ 4,370		\$ 606,856	75

D. Vehicle Costs. (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	2010 Infiniti	2010	\$ 5,511	\$	\$ 1,102	\$ 1,102	5	\$ 1,654	76
77										77
78										78
79										79
80	TOTALS			\$ 5,511	\$	\$ 1,102	\$ 1,102		\$ 1,654	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$ 3,423,944	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 22,570	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 124,826	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 102,256	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,952,581	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

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

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

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

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:				\$ N/A			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .
-

9. Option to Buy: YES NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? YES NO
16. Rental Amount for movable equipment: \$ N/A Description: N/A
(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	Facility	Acura	\$ 827.36	\$ 827	17
18	Allocated from Management Co.			891	18
19					19
20					20
21	TOTAL		\$ 827.36	\$ 1,718	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 EndingAnnual Rent
12. /2012 \$
13. /2013 \$
14. /2014 \$

* 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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

		ALLOCATION OF COSTS (d)			
		1	2	3	4
		Facility			
		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.

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

	Service	Schedule V Line & Column Reference	2	3	4		6	7	8	
			Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
					Units	Cost				
1	Licensed Occupational Therapist	L10A, C3	hrs	\$	1,235	\$ 138,308	\$	1,235	\$	138,308
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		627	28,824		627		28,824
3	Licensed Recreational Therapist		hrs							
4	Licensed Physical Therapist	L10A, C3	hrs		1,341	139,433		1,341		139,433
5	Physician Care		visits							
6	Dental Care		visits							
7	Work Related Program		hrs							
8	Habilitation		hrs							
9	Pharmacy	L39, C2	# of prescripts				69,519			69,519
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
11	Academic Education		hrs							
12	Other (specify):									
13	Other (specify):									
14	TOTAL			\$	3,203	\$ 306,565	\$ 69,519	3,203	\$	376,084

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.

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	\$ 108,319	\$ 108,319	1
2	Cash-Patient Deposits	100	100	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	784,875	784,875	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,665	2,665	6
7	Other Prepaid Expenses		464	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Schedule 17A	9,350	2,053,519	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 905,309	\$ 2,949,942	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		1,365,120	14
15	Leasehold Improvements, at Historical Cost	8,400	1,270,276	15
16	Equipment, at Historical Cost	14,170	752,343	16
17	Accumulated Depreciation (book methods)	(22,570)	(1,952,581)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe See Schedule 17A		163,513	22
23	Other(specify): Due fr. FOM Prop - Dep Option	190,000	190,000	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 190,000	\$ 1,824,876	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,095,309	\$ 4,774,818	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 40,491	\$ 40,491	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	100	100	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	94,374	94,374	30
	Accrued Taxes Payable (excluding real estate taxes)	8,322	8,322	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	2,817	2,817	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	275,666	465,666	36
37	Due From Franklin Grove, Inc.		(734,807)	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 421,770	\$ (123,037)	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	500,000	1,146,154	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Prior Owner Balance	18,854	18,854	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 518,854	\$ 1,165,008	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 940,624	\$ 1,041,971	46
47	TOTAL EQUITY(page 18, line 24)	\$ 154,685	\$ 3,732,847	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,095,309	\$ 4,774,818	48

*(See instructions.)

Franklin Grove Living & Rehabilitation Center, LLC
0051599
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Schedule 17A

XV. BALANCE SHEET -

Other Current Assets (specify):	Operating	After Consolidation
Employee Payroll Advance	364	364
Reimbursement Due	7,751	7,751
Short Term Loan Exchange	1,235	1,235
Due from Florissant Properties	-	358,893
RE Due to/from SFO Associates		1,685,276
Total Line 9 - Other Current Assets (specify):	9,350	2,053,519

Other Long-Term Assets (specify):	Operating	After Consolidation
Investment in SFO Associate	-	103,483
Loan Costs	-	144,309
Amortization - Loan Costs	-	(84,279)
Total Line 22 - Other Long-Term Assets (specify):	-	163,513

Other Current Liabilities (specify):	Operating	After Consolidation
Insurance Premiums Payable	762	762
Retirement (From P/R)	550	550
Accrued Expenses	123,854	123,854
Option Deposit		190,000
Short Term Loan Exchange	150,500	150,500
Total Line 36 - Other Current Liabilities (specify):	275,666	465,666

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 95,000	1
2	Restatements (describe):		2
3	Prior Owner Adjustment	(4,610)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 90,390	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	254,295	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	(190,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 64,295	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)	\$ 154,685	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Franklin Grove Living & Rehabilitation Center, LI # 0051599 Report Period Beginning: 01/01/11Ending: 12/31/11**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	\$ 5,753,264	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,753,264	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	134,174	6
7	Oxygen	14,211	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 148,385	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	4,775	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 4,775	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	23,657	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 23,657	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	<u>Other income</u>	(94)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (94)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,929,987	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,270,053	31
32	Health Care	2,326,103	32
33	General Administration	1,394,865	33
	B. Capital Expense		
34	Ownership	515,252	34
	C. Ancillary Expense		
35	Special Cost Centers	103,216	35
36	Provider Participation Fee	66,203	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,675,692	40
41	Income before Income Taxes (line 30 minus line 40)**	254,295	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 254,295	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.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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	1,720	1,800	\$ 52,785	\$ 29.33	1
2	Assistant Director of Nursing	823	823	24,156	29.37	2
3	Registered Nurses	7,401	7,752	187,826	24.23	3
4	Licensed Practical Nurses	19,643	20,821	477,007	22.91	4
5	CNAs & Orderlies	92,808	94,653	987,231	10.43	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,564	4,639	49,347	10.64	8
9	Activity Director					9
10	Activity Assistants	7,502	7,803	93,676	12.01	10
11	Social Service Workers	5,555	5,705	82,684	14.49	11
12	Dietician					12
13	Food Service Supervisor	2,738	2,960	50,655	17.11	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,652	23,644	223,884	9.47	15
16	Dishwashers					16
17	Maintenance Workers	6,448	6,870	106,697	15.53	17
18	Housekeepers	22,375	23,512	218,653	9.30	18
19	Laundry	10,850	11,557	105,706	9.15	19
20	Administrator	2,080	2,080	143,003	68.75	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	18,468	19,281	397,089	20.59	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)	225,623	233,899	\$ 3,200,399 *	\$ 13.68	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	\$ 4,491	L1, C3	35
36	Medical Director	Monthly	6,775	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,298	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	Monthly	702	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)		\$ 14,266		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

XIX. SUPPORT SCHEDULES

[illegible]

*** Attach copy of IMRF notifications**

****See instructions.**

Franklin Grove Living & Rehabilitation Center, LLC
0051599
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Schedule 21A

XIX. Support Schedule
C. Professional Services

Total (agree to Schedule V, line 19, column 3) 32,146

Disallow Non-Allowable Legal Fees:
Williams McCarthy LLP (340)
Stephen N.Sher PC (5,904)

Allocated from Franklin Grove Associates:
Legal 3,150
Accounting-RSM McGladrey, Inc. 2,934
Non-Allowable Legal (3,150)

Allocated from SW Management Compnay:
Legal 138
Accounting-RSM McGladrey, Inc. 962

Allocated from SFO Associates
Accounting-RSM McGladrey, Inc. 12,582

Total (agree to Schedule V, line 19, column 8) 42,518

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3									N/A				
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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-\$10,935
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (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. \$ 8,500 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 X NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
Franklin Grove Nursing Center, Inc. / #0037168 / September 1, 2011
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 66,203
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 benefit: on Schedule V. \$ 7,165 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? N/A
Attach invoices and a summary of services for all architect and appraisal fees