FOR BHF USE

LL1

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.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

I. IDPH License ID Number: 0051599

Facility Name: Franklin Grove Lvg & Rehab

Address: 502 North State St (Number) | Franklin Grove (City) | 61031 (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	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Amanda Springborn **Telephone Number:** (314) 925-3838
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 01/01/14 to 12/31/14 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) Moshe Herman
(Title) Member

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address) McGladrey 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 Lvg & Rehab # 0051599 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,708	390	3,950	6,048	8
9	SNF/PED					9
10	ICF	13,829	13,239	2,826	29,894	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,537	13,629	6,776	35,942	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.38%

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 [X] 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 [X]

I. On what date did you start providing long term care at this location?
Date started 9/1/11

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 9/1/11 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 70 and days of care provided 3,830

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/14 Fiscal Year: 12/31/14

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

Facility Name & ID Number Franklin Grove Lvg & Rehab # 0051599 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	290,951	23,667	7,612	322,230		322,230		322,230			1
2	Food Purchase		296,964		296,964		296,964	(8,657)	288,307			2
3	Housekeeping	247,752	74,262		322,014		322,014	29	322,043			3
4	Laundry	81,044	7,030		88,074		88,074		88,074			4
5	Heat and Other Utilities			148,384	148,384		148,384	1,059	149,443			5
6	Maintenance	125,015	64,077	8,571	197,663		197,663	237	197,900			6
7	Other (specify):*											7
8	**TOTAL General Services**	744,762	466,000	164,567	1,375,329		1,375,329	(7,332)	1,367,997			8
	B. Health Care and Programs											
9	Medical Director			9,300	9,300		9,300		9,300			9
10	Nursing and Medical Records	1,932,286	77,519	9,809	2,019,614		2,019,614		2,019,614			10
10a	Therapy											10a
11	Activities	92,041	1,090		93,131		93,131		93,131			11
12	Social Services	78,638			78,638		78,638		78,638			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,102,965	78,609	19,109	2,200,683		2,200,683		2,200,683			16
	C. General Administration											
17	Administrative	141,437		201,054	342,491		342,491	(109,206)	233,285			17
18	Directors Fees											18
19	Professional Services			39,560	39,560		39,560	(6,133)	33,427			19
20	Dues, Fees, Subscriptions & Promotions			22,515	22,515		22,515	(5,967)	16,548			20
21	Clerical & General Office Expenses	344,930		49,513	394,443		394,443	40,731	435,174			21
22	Employee Benefits & Payroll Taxes			502,275	502,275		502,275	7,557	509,832			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,297	4,297		4,297	112	4,409			24
25	Other Admin. Staff Transportation			35,334	35,334		35,334	1,453	36,787			25
26	Insurance-Prop.Liab.Malpractice			14,898	14,898		14,898	32,103	47,001			26
27	Other (specify):* Mgmt Alloc of Benefi							13,879	13,879			27
28	**TOTAL General Administration**	486,367		869,446	1,355,813		1,355,813	(25,471)	1,330,342			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,334,094	544,609	1,053,122	4,931,825		4,931,825	(32,803)	4,899,022			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.

Facility Name & ID Number Franklin Grove Lvg & Rehab #0051599 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			18,062	18,062		18,062	124,827	142,889			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			196,143	196,143		196,143	201,977	398,120			32
33	Real Estate Taxes							44,834	44,834			33
34	Rent-Facility & Grounds			588,000	588,000		588,000	(588,000)				34
35	Rent-Equipment & Vehicles			850	850		850	800	1,650			35
36	Other (specify):* Insurance - MIP							52,791	52,791			36
37	**TOTAL Ownership**			803,055	803,055		803,055	(162,771)	640,284			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		105,582	557,987	663,569		663,569		663,569			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			263,423	263,423		263,423		263,423			42
43	Other (specify):* Non-Allowable Cos			90,038	90,038		90,038	(90,038)				43
44	**TOTAL Special Cost Centers**		105,582	911,448	1,017,030		1,017,030	(90,038)	926,992			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,334,094	650,191	2,767,625	6,751,910		6,751,910	(285,612)	6,466,298			45

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

Facility Name & ID Number Franklin Grove Lvg & Rehab # 0051599 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	(139,556)	30		9
10	Interest and Other Investment Income	(20,698)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(483)	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				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(8,236)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(10,475)	43		24
25	Fund Raising, Advertising and Promotional	(371)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,594)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(7,777)	43		28
29	Other-Attach Schedule See Page 5A	(118,385)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (308,575)		$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 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)	22,963		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 22,963		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (285,612)		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	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

Franklin Grove Lvg & Rehab

ID# 0051599

Report Period Beginning: 01/01/14

Ending: 12/31/14

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Lab Expense Med A	$ (5,896)	43	1
2	X Ray Expense Med A	(2,485)	43	2
3	Miscellaneous Income Offset	(4,218)	21	3
4	Nonallowable Lobbying	(4,098)	20	4
5	Non Allowable Chamber of Commerce	(699)	20	5
6	Managed Care Costs	(59,957)	43	6
7	Non Allowable Management Fees	(41,032)	17	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(118,385)		49

Facility Name & ID Number Franklin Grove Lvg & Rehab # 0051599 Report Period Beginning: 01/01/14 Ending: 12/31/14

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. [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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	Bank Charges	$ 88	FOM Property LLC	100.00%	$	$ (88)	1
2	V	26	Insurance		FOM Property LLC	100.00%	31,293	31,293	2
3	V	30	Depreciation		FOM Property LLC	100.00%	261,784	261,784	3
4	V	32	Interest	1,193	FOM Property LLC	100.00%	219,558	218,365	4
5	V	32	Amortization		FOM Property LLC	100.00%	4,310	4,310	5
6	V	33	Real Estate Taxes		FOM Property LLC	100.00%	42,058	42,058	6
7	V	34	Rent Facility and Ground	588,000	FOM Property LLC	100.00%		(588,000)	7
8	V	36	Insurance - MIP		FOM Property LLC	100.00%	52,791	52,791	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 589,281			$ 611,794	$ * 22,513	14

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

Facility Name & ID Number Franklin Grove Lvg & Rehab # 0051599 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	Food	$	SW Financial Services Company	100.00%	$ 180	$ 180	15
16	V	3	Housekeeping		SW Financial Services Company	100.00%	29	29	16
17	V	5	Utilities		SW Financial Services Company	100.00%	1,059	1,059	17
18	V	6	Maintenance		SW Financial Services Company	100.00%	237	237	18
19	V	17	Administrative	75,054	SW Financial Services Company	100.00%	6,880	(68,174)	19
20	V	19	Professional Services		SW Financial Services Company	100.00%	1,179	1,179	20
21	V	20	Dues, Fees, Subs. & Promotions		SW Financial Services Company	100.00%	169	169	21
22	V	21	Clerical & General Office Expenses		SW Financial Services Company	100.00%	44,622	44,622	22
23	V	24	Travel & Seminar		SW Financial Services Company	100.00%	112	112	23
24	V	25	Other Admin. Staff Transportation		SW Financial Services Company	100.00%	1,453	1,453	24
25	V	26	Insurance-Prop, Liab & Malpractice		SW Financial Services Company	100.00%	810	810	25
26	V	27	Other		SW Financial Services Company	100.00%	13,879	13,879	26
27	V	30	Depreciation		SW Financial Services Company	100.00%	2,599	2,599	27
28	V	33	Real Estate Taxes		SW Financial Services Company	100.00%	2,776	2,776	28
29	V	35	Rent - Equipment & Vehicles		SW Financial Services Company	100.00%	800	800	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			$ 75,054			$ 76,784	$ * 1,730	39

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

Facility Name & ID Number Franklin Grove Lvg & Rehab # 0051599 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	Food	$ 14,084	S & E Medical Supply Co.	100.00%	$ 12,804	$ (1,280)	15
16	V								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			$ 14,084			$ 12,804	$ * (1,280)	39

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

Facility Name & ID Number Franklin Grove Lvg & Rehab # 0051599 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	57.30%	Cahokia Nursing and Rehab	Cahokia	Prairie Crossing	Shabbona	Supportive Living	1
2	Stuart Milstein	4.90%	Caseyville Nursing and Rehab	Caseyville	Assisted Living		Facility	2
3	Ari Milstein	4.90%	Green Acres Healthcare & Rehab Center LLC	Amboy	SW Financial	Skokie	Bookkeeping/	3
4	Elana Minkove	4.90%			Services Co.		Management Comp.	4
5	Amanda Bachrach	4.40%	Franklin Grove Living & Rehabilitation, LLC	Franklin Grove	S&E Medical Supply C	Skokie	Medical Supplies	5
6	Yedida Wolfe	4.40%	Oregon Living & Rehabilitation, LLC	Oregon				6
7	James Wolfe	4.40%	Prairie Crossing Living & Rehab Center, LLC	Shabbona				7
8	Neil Wolfe	4.40%	Tower Hill Rehabilitation, LLC	South Elgin, IL				8
9	Richard Wolfe	4.40%						9
10	Robin Krystal	4.00%	Beauvais Manor Healthcare and Rehab	St. Louis, MO				10
11	David Zuckerman	2.00%	Hillside Manor Healthcare and Rehab	St. Louis, MO	Groves Community	Independence, MO	Hospice	11
12			Rancho Manor Healthcare and Rehab	Florissant, MO	Hospice			12
13			Rosewood Health & Rehab	Independence, MO	Forest View Senior	Independence, MO	Independent	13
14			Seasons Care Center	Kansas City, MO	Residences		Living	14
15			Carriage Square	St. Joseph, MO	White Oak Living	Independence, MO	Residential	15
16					Center		Care	16
17								17
18					Seasons Day Services	Kansas City, MO	Adult Day Care	18
19					Program LLC			19
20								20
21					Cahokia Building LLC	Cahokia	Real Estae	21
22					Caseyville Property LL	Caseyville	Real Estate	22
23					Green Acres Property	Amboy	Real Estate	23
24								24
25								25
26					FOM Property LLC	Franklin Grove	Real Estate	26
27					Oregon Property LLC	Oregon	Real Estate	27
28					Shabbona Building	Shabbona	Real Estate	28
29					Associates LLC			29
30					Tower Hill Property L	South Elgin	Real Estate	30

Facility Name & ID Number Franklin Grove Lvg & Rehab # 0051599 Report Period Beginning: 01/01/14 Ending: 12/31/14

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					Beauvais Manor	St. Louis, MO	Real Estate	1
2					Property LLC			2
3								3
4					Hillside Manor	St. Louis, MO	Real Estate	4
5					Real Estate &			5
6					Development			6
7								7
8					Rancho Manor	Florissant, MO	Real Estate	8
9					Property, LLC			9
10								10
11					The Groves &	Independence, MO	Real Estate	11
12					Rest Haven			12
13					Property LLC			13
14								14
15					Seasons Property LLC	Kansas City, MO	Real Estate	15
16								16
17					Carriage Square Prop	St. Joseph, MO	Real Estate	17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Franklin Grove Lvg & Rehab # 0051599 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Moshe Herman	Owner	Administrative	57.30	See SCH 7A	13.33	33.33	Guar. Pmts	$ 84,968	17,3 & 17,7	1
2	David Zuckerman	Owner	Administrative	2.00	See SCH 7B	1	2.22	Salary	3,247	17(7)	2
3	Sheldon Wolfe	Administrative	Administrative	22.00	See SCH 7C	1	2.22	Salary	3,247	17(7)	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 91,462		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 Lvg & Rehab # 0051599 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food	Bed Days Available	663,601	13	$ 2,712	$	44,165	$ 180	1
2	3	Housekeeping	Bed Days Available	663,601	13	434		44,165	29	2
3	5	Utilities	Bed Days Available	663,601	13	15,908		44,165	1,059	3
4	6	Maintenance	Bed Days Available	663,601	13	3,567		44,165	237	4
5	19	Professional Services-Legal	Bed Days Available	663,601	13	1,827		44,165	122	5
6	19	Professional Services-Other	Bed Days Available	663,601	13	15,885		44,165	1,057	6
7	20	Dues, Fees, Subscriptions & Prom	Bed Days Available	663,601	13	2,546		44,165	169	7
8	21	Clerical & General Office Expens	Bed Days Available	663,601	13	549,341	549,341	44,165	36,561	8
9	21	Clerical & General Office Expens	Bed Days Available	663,601	13	121,114		44,165	8,061	9
10	24	Travel & Seminar	Bed Days Available	663,601	13	1,687		44,165	112	10
11	25	Other Admin. Staff Transportion	Bed Days Available	663,601	13	21,838		44,165	1,453	11
12	26	Insurance-Prop, Liab & Malpract	Bed Days Available	663,601	13	12,166		44,165	810	12
13	27	Other - Mgmt Allocation of Benef	Bed Days Available	663,601	13	208,541		44,165	13,879	13
14	33	Real Estate Taxes	Bed Days Available	663,601	13	41,712		44,165	2,776	14
15	35	Rent - Equipment & Vehicles	Bed Days Available	663,601	13	12,022		44,165	800	15
16										16
17	17	Administrative	Avg. Hours Worked	45	13	163,500	163,500	1	3,633	17
18	17	Administrative	Avg. Hours Worked	45	13	146,104	146,104	1	3,247	18
19	30	Depreciation	Direct Cost	39,045					2,599	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,320,904	$ 858,945		$ 76,784	25

Facility Name & ID Number Franklin Grove Lvg & Rehab # 0051599 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 [X] 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 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			$	$		$ 12,804	1
2										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					$	$		$ 12,804	25

Facility Name & ID Number Franklin Grove Lvg & Rehab # 0051599 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	Lancaster Pollard Mortgage Co		X	Mortgage	$37,669.35	12/1/13	$ 4,971,254	$ 4,889,338	12/1/43	0.0438	$ 219,558	1
2												2
3	Amortization of Loan Costs										101,550	3
4												4
5												5
	Working Capital											
6	Sheldon Wolfe	X		Working Capital	$250,000.00	9/1/11	250,000	100,000	8/31/15	0.0128	1,361	6
7	Albert Milstein	X		Working Capital	$250,000.00	9/1/11	250,000	100,000	8/31/15	0.0128	1,361	7
8	See Schedule 9A			Working Capital			2,208,598	1,351,509			96,182	8
9	TOTAL Facility Related				$537,669.35		$ 7,679,852	$ 6,440,847			$ 420,012	9
	B. Non-Facility Related*											
10												10
11												11
12								Interest Income			(21,891)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (21,891)	14
15	TOTALS (line 9+line14)						$ 7,679,852	$ 6,440,847			$ 398,120	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 52,791 Line # 36

* 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.)

Facility Name: Franklin Grove Lvg & Rehab
IDPH License ID N 0051599
Fiscal Year End: 12/31/14

Schedule 9A

IX. Interest Expense and Real Estate Tax Expense

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related* YES	Related* NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Franklin Grove Associates	X		Working Capital	Varies	12/1/13	1,458,598	1,351,509	12/1/43	0.0650	94,660	6
7	MB Financial Bank		X	Working Capital	Interest Only	2/10/14	750,000		2/10/15	0.0425	1,522	7
8												8
9	TOTAL Facility Related				$0.00		$ 2,208,598	$ 1,351,509			$ 96,182	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related				$0.00		$ 0	$ 0			$ 0	14

Facility Name & ID Number Franklin Grove Lvg & Rehab # 0051599 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 42,300	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.)	**2013**	$ 41,558	2
3. Under or (over) accrual (line 2 minus line 1).		$ (742)	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 42,800	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 Managment Co.	2,776	
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.		$ 44,834	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	54,450	8
	2010	16,711	9
	2011	40,660	10
	2012	41,070	11
	2013	41,558	12

2014 Tax accrual= 41,558 * 1.03 = 42,805

Will use 42,800

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Franklin Grove Lvg & Rehab COUNTY Lee

FACILITY IDPH LICENSE NUMBER 0051599

CONTACT PERSON REGARDING THIS REPORT Moshe Herman

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 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-03-36-351-07	Long Term Care Property	$ 41,558.18	$ 41,558.18
2.	10-28-412-049-0000	SW Financial Services Co. Allocation	$ 39,795.50	$ 2,776.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 81,353.68	$ 44,334.18

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

Facility Name & ID Number Franklin Grove Lvg & Rehab # 0051599 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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 [X] 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 Lvg & Rehab # 0051599 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 995,279	4
5											5
6	Mgmt. Alloc		1995		27,047		39	773	773	15,189	6
7											7
8											8
	Improvement Type**										
9	Various			1991	6,392		20			6,392	9
10	Various			1992	29,415		20			29,415	10
11	Various			1993	47,511		20			47,511	11
12	Various			1994	17,652		20	238	238	17,652	12
13	Various			1995	10,809		20	540	540	10,594	13
14	Various			1997	55,791		20	2,790	2,790	50,548	14
15	Various			1998	87,964		20	4,398	4,398	69,727	15
16	Various			1999	24,113		20	1,206	1,206	18,612	16
17	Retroaire Chassis			2000	2,321		20	116	116	1,624	17
18	Water Main Line			2001	3,294		20	165	165	2,266	18
19	Walk In Freezer			2001	8,947		20	447	447	6,000	19
20	Wiring To Kitchen			2001	12,250		20	613	613	8,425	20
21	Kitchen Labor			2001	3,163		20	158	158	2,081	21
22	Kitchen Labor			2001	1,532		20	77	77	1,010	22
23	Carpeting			2002	16,211		5			16,211	23
24	Bathroom and Tub			2002	3,700		10			3,700	24
25	Bath			2002	7,972		10			7,972	25
26	Glass Blocks			2002	1,649		10			1,649	26
27	Voice Alarm			2003	948		20	47	47	615	27
28	Code Alert			2003	3,887		20	194	194	2,395	28
29	Magnetic Door Holders			2003	1,652		20	83	83	1,075	29
30	Air Conditioners			2003	4,244		20	212	212	2,757	30
31	Tub & Lift			2003	8,738		20	437	437	5,825	31
32	3 Air Conditioners			2003	478		20	24	24	311	32
33	Boiler Repair			2003	1,683		20	84	84	1,002	33
34	Shower - Glass, Bars			2003	550		20	28	28	330	34
35	Carpet			2003	599		20	30	30	337	35
36	Gutters & Down Spouts			2003	10,759		20	538		6,277	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

Facility Name & ID Number Franklin Grove Lvg & Rehab # 0051599 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Aluminum Soffit	2003	$ 1,864	$	20	$ 93	$ 93	$ 1,072	37
38	Painting (24 Rooms)	2004	5,520		20	276	276	2,898	38
39	Nurses station	2004	18,750		20	938	938	9,846	39
40	Dining Area	2004	2,400		20	120	120	1,260	40
41	New Windows	2004	6,335		20	317	317	3,327	41
42	Bathroom Plumbing and Electrical	2004	12,600		20	630	630	6,615	42
43	Kitchen and Dining Room	2004	16,369		20	818	818	8,591	43
44	Remodel Shower and Flooring	2004	10,595		20	530	530	5,564	44
45	Display Case - Nurses Station	2004	3,800		20	190	190	1,995	45
46	Dining Room Windows	2004	9,614		20	481	481	5,049	46
47	Glass Block Shower Windows	2004	1,427		20	71	71	748	47
48	Remodel Glass and Shower	2004	3,100		20	155	155	1,628	48
49	Carpet	2004	2,660		20	133	133	1,397	49
50	Windows	2005	34,060		20	1,703	1,703	16,179	50
51	Remodel Wall	2005	6,518		20	326	326	3,097	51
52	Outside Soffit	2005	6,268		20	313	313	2,976	52
53	Install Valves	2005	4,500		20	225	225	2,138	53
54	Tiles and Flooring	2006	15,604		20	780	780	6,631	54
55	Exterior and Resident Doors	2006	21,725		20	1,086	1,086	9,232	55
56	Kick Plates	2006	5,533		20	277	277	2,353	56
57	Windows	2006	58,240		20	2,912	2,912	24,752	57
58	Siding	2006	2,080		20	104	104	884	58
59	Paving	2006	7,517		20	376	376	3,195	59
60	Wallpaper	2006	3,078		20	154	154	1,309	60
61	Air Conditioners	2006	20,183		20	1,009	1,009	8,577	61
62	Water Heater	2006	9,984		20	499	499	4,242	62
63									63
64	Glue Down Carpet	2007	3,036		20	152	152	1,140	64
65									65
66	New Doors	2008	41,645		20	2,082	2,082	13,535	66
67	Wiring-Kitchen Ansul System to Fire Alarm	2008	5,571		20	279	279	1,811	67
68	Lighting Insulation	2008	12,804		20	640	640	4,162	68
69	New Ceiling-Laundry	2008	3,755		20	188	188	1,220	69
70	TOTAL (lines 4 thru 69)		$ 2,092,507	$		$ 73,407	$ 72,869	$ 1,490,202	70

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

Facility Name & ID Number Franklin Grove Lvg & Rehab # 0051599 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,092,507	$		$ 73,407	$ 73,407	$ 1,490,202	1
2	South Porch Remodel	2008	4,175		20	209	209	1,357	2
3	Wallpaper & Installation	2008	8,467		20	423	423	2,751	3
4	Steel studs & drywall on outside walls, retrim windows, and	2008	101,179		20	5,059	5,059	32,883	4
5	extend electrical boxes in 36 rooms								5
6	Gas Water heater	2008	4,399		20	220	220	1,430	6
7	Painting	2008	9,395		20	470	470	3,053	7
8	Replace Boiler Sections	2008	12,164		20	608	608	3,954	8
9	Vinyl Flooring	2008	83,058		20	4,153	4,153	26,994	9
10	Landscaping	2008	14,896		15	993	993	6,455	10
11	New Sprinkler System	2009	155,270		20	7,764	7,764	42,702	11
12	New Water Line for Sprinkler System	2009	14,936		20	747	747	4,108	12
13	Fire Alarm Interface-Sprinkler System	2009	3,000		20	150	150	825	13
14	Laminate Flooring	2009	2,946		20	147	147	809	14
15	Repave parking lots	2010	36,093		20	1,805	1,805	8,121	15
16	Replace concrete for front sidewalk	2010	4,653		20	233	233	1,047	16
17	Water heater	2010	8,047		20	402	402	1,809	17
18	Remodel Kitchen: Install Wall Cabinets, Flooring,	2011	25,348		20	1,267	1,267	4,435	18
19	- Countertops, Backsplash & Drywalls								19
20	Remodel Laundry Room: Install Wall Panels, Plumbing,	2011	11,100		20	555	555	1,943	20
21	- Tiles/Flooring, Shelving and Cabinets								21
22	Dining Room Floor	2011	9,658		20	483	483	1,690	22
23	Carpet & Installation	2011	3,705		20	185	185	648	23
24	Front Entrance Soffit	2011	2,100		20	105	105	368	24
25	Parking lot Seal coating	2011	8,400		20	560	560	1,773	25
26									26
27	Drywall Rooms & Ceilings (Rooms: 409, 501, 502, 504, 505 & 515)	2012	6,865	250	20	343	93	972	27
28	Drywall Rooms & Ceilings (Rooms: 409, 501, 502, 504, 505 & 515)	2012	3,433	125	20	172	47	373	28
29	Hot Water Tank: Boiler Room off the 100 Hall	2012	7,914	288	20	396	108	1,155	29
30	FGA: Repave Driveway	2012	10,000		15	667	667	1,666	30
31									31
32	Grab Bars in Bathrooms	2013	2,589	94	10	259	165	388	32
33	2 PTAC Units	2013	2,508		10	251	251	376	33
34	TOTAL (lines 1 thru 33)		$ 2,648,805	$ 757		$ 102,031	$ 101,274	$ 1,644,287	34

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

Facility Name & ID Number Franklin Grove Lvg & Rehab # 0051599 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,648,805	$ 757		$ 102,031	$ 101,274	$ 1,644,287	1
2	Water Heater - services 400 & 500 Hall	2014	3,250		15	217	217	217	2
3	Telephone System Upgrade - Throughout Entire Facility	2014	15,316		10	766	766	766	3
4									4
5									5
6	Allocated from SW Financial Services Co. - Leasehold Improveme	1995	3,027			7	7	3,027	6
7	Allocated from SW Financial Services Co. - Leasehold Improveme	1996	504			25	25	468	7
8	Allocated from SW Financial Services Co. - Leasehold Improveme	1997	584			29	29	583	8
9	Allocated from SW Financial Services Co. - Leasehold Improveme	1998	500			25	25	418	9
10	Allocated from SW Financial Services Co. - Leasehold Improveme	1999	1,387			69	69	1,046	10
11	Allocated from SW Financial Services Co. - Leasehold Improveme	2005	2,870			144	144	1,363	11
12	Allocated from SW Financial Services Co. - Leasehold Improveme	2007	1,625			81	81	609	12
13	Allocated from SW Financial Services Co. - Leasehold Improveme	2009	3,392			170	170	933	13
14	Allocated from SW Financial Services Co. - Leasehold Improveme	2013	1,811			91	91	136	14
15	Allocated from SW Financial Services Co. - Leasehold Improveme	2014	1,826			46	46	46	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,684,897	$ 757		$ 103,701	$ 102,944	$ 1,653,899	34

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

Facility Name & ID Number Franklin Grove Lvg & Rehab # 0051599 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 284,367	$ 5,570	$ 27,308	$ 21,738	10	$ 156,825	71
72	Current Year Purchases	33,351		6,006	6,006	10	6,006	72
73	Fully Depreciated Assets	519,222					519,222	73
74	Allocation from Management Co.	8,725		178	178		7,305	74
75	TOTALS	$ 845,665	$ 5,570	$ 33,492	$ 27,922		$ 689,358	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	Facility	2002 Ford E450 Passenger Bus	2012	$ 20,328	$ 3,903	$ 4,066	$ 163	5	$ 8,809	76
77	Facility	2002 Ford E450 Passenger Bus &	2013	6,688	1,070	669	(401)	10	1,059	77
78	Facility	2011 Chevy Van	2013	16,904	6,762		(6,762)	5		78
79	Allocation from Management	2010 Infiniti	2010	4,805		961	961	5	4,325	79
80	TOTALS			$ 48,725	$ 11,735	$ 5,695	$ (6,040)		$ 14,193	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)	$ 3,615,492	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 18,062	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 142,889	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 124,827	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,357,450	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	Allocated from RE Entity	$ 11,040	92
93			93
94			94
95		$ 11,040	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.

Facility Name & ID Number Franklin Grove Lvg & Rehab # 0051599 Report Period Beginning: 01/01/14 Ending: 12/31/14

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: *

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.	/2015	$
13.	/2016	$
14.	/2017	$

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: $ 850 Description: Medical Supplies - $850
    (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.		$	$ 800	17
18					18
19					19
20					20
21	TOTAL		$	$ 800	21

* 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.

Facility Name & ID Number Franklin Grove Lvg & Rehab # 0051599 Report Period Beginning: 01/01/14 Ending: 12/31/14

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
   [X] 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.

Facility Name & ID Number Franklin Grove Lvg & Rehab # 0051599 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L39, C3	hrs	$	3,054	$ 219,883	$	3,054	$ 219,883	1
2	Licensed Speech and Language Development Therapist	L39, C3	hrs		2,057	98,739		2,057	98,739	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L39, C3	hrs		3,740	239,365		3,740	239,365	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				105,327		105,327	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Oxygen	L39,C2					255		255	12
13	Other (specify):									13
14	TOTAL			$	8,851	$ 557,987	$ 105,582	8,851	$ 663,569	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.

STATE OF ILLINOIS

Facility Name & ID Number Franklin Grove Lvg & Rehab # 0051599 Report Period Beginning: 01/01/14 Ending: 12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14 (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	$ 263,032	$ 305,837	1
2	Cash-Patient Deposits	850	850	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 10,096)	1,368,131	1,368,131	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	36,000	36,000	5
6	Prepaid Insurance	744	39,789	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Schedule 17A	497,530	1,853,070	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,166,287	$ 3,603,677	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		1,361,148	14
15	Leasehold Improvements, at Historical Cost	29,201	1,323,749	15
16	Equipment, at Historical Cost	129,280	894,390	16
17	Accumulated Depreciation (book methods)	(105,003)	(2,357,450)	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 Schedule 17A	1,264,118	1,404,895	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,317,596	$ 2,662,937	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,483,883	$ 6,266,614	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 217,278	$ 217,278	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	778	778	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	100,616	100,616	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,899	11,899	31
32	Accrued Real Estate Taxes(Sch.IX-B)		42,800	32
33	Accrued Interest Payable	22,586	40,432	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	288,500	603,224	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 641,657	$ 1,017,027	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,551,509	6,440,847	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Prior Owner Balance	61,766	61,766	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,613,275	$ 6,502,613	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,254,932	$ 7,519,640	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,228,951	$ (1,253,026)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,483,883	$ 6,266,614	48

***(See instructions.)**

Facility Name: **Franklin Grove Lvg & Rehab**
IDPH License ID Number: **0051599**
Fiscal Year End: **12/31/14**

Schedule 17A

XV. Balance Sheet
Line 9 Current Assets Other (specify):

Description	Operating	After Consolidation
Due From State - Interest	94,303	94,303
Escrow - Replacement Reserve	-	214,441
Escrow - Repairs	-	1,034,987
Escrow - Insurance	-	26,227
Escrow - Re Taxes	-	30,028
Excrow - MIP	-	857
Employee Payroll Advance	432	432
Rent Receivable - F	-	49,000
Short Term Loan Exchange	133,095	133,095
Due To/from Property	268,698	268,698
Due To Public Aid	1,002	1,002
Total - Line 9	**497,530**	**1,853,070**

XV. Balance Sheet
Line 22 Long-Term Assets Other (specify):

Description	Operating	After Consolidation
CIP	-	11,040
Loan Costs	-	-
Intangible Asset - Goodwill	1,458,598	1,468,000
Accum. Amort. - Goodwill	(194,480)	(194,480)
Goodwill	-	-
Accum Amort - Goodwill	-	-
Mortgage Costs	-	125,004
Accum Amort - Mortgage Costs	-	(4,669)

Total - Line 22	**1,264,118**	**1,404,895**

XV. Balance Sheet

Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
Reimbursement Due	774	774
Insurance Premiums Payable	3,286	3,286
Acc. Retirement (from P/R)	350	350
Accrued Expenses	229,857	229,857
Accrued Real Estate Taxes	49,000	49,000
Due From Franklin Grove Inc.	-	275,857
Due To/from Franklin Gr Assoc	5,233	44,100
Total - Line 36	**288,500**	**603,224**

Facility Name & ID Number Franklin Grove Lvg & Rehab # 0051599 Report Period Beginning: 01/01/14 Ending: 12/31/14

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,150,076	1
2	Restatements (describe):		2
3	**Prior Period Adjustment**	(371,655)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 778,421	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	360,976	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised	95,000	10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(5,446)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **ROUNDING**		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 450,530	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)**	$ 1,228,951	24 *

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

Facility Name & ID Number Franklin Grove Lvg & Rehab # 0051599 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,827,825	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,827,825	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	226,342	6
7	Oxygen	21,395	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 247,737	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	2,490	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,490	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	20,698	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 20,698	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	See Schedule 19A	14,136	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 14,136	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,112,886	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,375,329	31
32	Health Care	2,200,683	32
33	General Administration	1,355,813	33
	B. Capital Expense		
34	Ownership	803,055	34
	C. Ancillary Expense		
35	Special Cost Centers	753,607	35
36	Provider Participation Fee	263,423	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,751,910	40
41	**Income before Income Taxes (line 30 minus line 40)****	360,976	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 360,976	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,545,759	44
45	Private Pay - Net Inpatient Revenue	2,544,176	45
46	Medicare - Net Inpatient Revenue	1,737,887	46
47	Other-(specify) Hospice	3	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,827,825	49

* **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.**

*** **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.**

^ - This entity is a cash basis taxpayer

Facility Name: **Franklin Grove Lvg & Rehab**
IDPH License ID Number: **0051599**
Fiscal Year End: **12/31/14**

Schedule 19A

XVII. Income Statement
Line 28 Other Revenue (specify):

Description	Amount
Misc. Income	4218
Medicaid Income Adjustments	9918
Total - Line 28	**14,136**

Facility Name & ID Number Franklin Grove Lvg & Rehab # 0051599 Report Period Beginning: 01/01/14 Ending: 12/31/14

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,080	$ 80,821	$ 38.86	1
2	Assistant Director of Nursing	2,080	2,240	65,800	29.38	2
3	Registered Nurses	4,434	4,855	119,967	24.71	3
4	Licensed Practical Nurses	24,888	26,483	631,648	23.85	4
5	CNAs & Orderlies	88,054	89,936	988,437	10.99	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,125	4,178	45,613	10.92	8
9	Activity Director					9
10	Activity Assistants	7,451	7,831	92,041	11.75	10
11	Social Service Workers	3,573	3,640	78,638	21.60	11
12	Dietician					12
13	Food Service Supervisor	2,040	2,080	37,643	18.10	13
14	Head Cook					14
15	Cook Helpers/Assistants	26,828	28,018	253,308	9.04	15
16	Dishwashers					16
17	Maintenance Workers	7,104	7,297	125,015	17.13	17
18	Housekeepers	25,008	26,267	247,752	9.43	18
19	Laundry	9,457	9,595	81,044	8.45	19
20	Administrator	2,080	2,080	141,437	68.00	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,038	16,698	344,930	20.66	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Ca					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	225,240	233,278	$ 3,334,094 *	$ 14.29	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 7,612	L1, C3	35
36	Medical Director	Monthly	9,300	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	9,809	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				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)		$ 26,721		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

Facility Name & ID Number Franklin Grove Lvg & Rehab # 0051599 Report Period Beginning: 01/01/14 Ending: 12/31/14

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jill Gee	Administrator	0	$ 141,437
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 141,437

B. Administrative - Other

Description	Amount
SW Financial Services Co. Fees (Eliminated on Sch. V, Col. 7)	$ 75,054
Moshe Herman / Momentum Healthcare, LLC	126,000
(Eliminated on Sch. V. Col 7.)	
TOTAL (agree to Schedule V, line 17, col. 3)	$ 201,054
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See SCH 21C	See SCH 21C	$ 39,560
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 39,560

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 149,956
Unemployment Compensation Insurance	32,409
FICA Taxes	253,544
Employee Health Insurance	56,563
Employee Meals	7,557
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	8,585
Holiday Expense	883
Life Insurance	335
TOTAL (agree to Schedule V, line 22, col.8)	$ 509,832

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 181)	2,168
Patient Background Checks	
Illinois Council on Long Term Care	12,418
Miscellaneous Dues & Permits	1,301
Miscellaneous Inspections & Licenses	3,298
Allocated from Management Co.	169
Less: Lobbying & Chamber Fees	(4,796)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,548

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,297
Allocated from Management Co.	112
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,409

* Attach copy of IMRF notifications

**See instructions.

Facility Name: **Franklin Grove Lvg & Rehab**
IDPH License ID Number: **0051599**
Fiscal Year End: **12/31/14**

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
Field and Goldbery, LLC	Legal	414
Alan H. Cooper	Legal	3,236
Stephen N. Sher	Legal	4,326
Lancaster Pollard	Legal	5,000
McGladrey LLP	Accounting	21,826
HK Payroll Services	Accounting	4,759
	Total (agree to Schedule V, line 19, column 3)	39,560
Reclass Weblinx Computer Services		924
Allocated from Management Company	Legal Fees	122
Allocated from Management Company	Professional Services	1,057
Less: Non-Allowable Legal Fees		(8,236)
	Total (agree to Schedule V, line 19, column 8)	33,427

Facility Name & ID Number Franklin Grove Lvg & Rehab # 0051599 Report Period Beginning: 01/01/14 Ending: 12/31/14

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		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Franklin Grove Lvg & Rehab # 0051599 Report Period Beginning: 01/01/14 Ending: 12/31/14

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-$8,320**

(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. $ **10,671** 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. $ **263,423**
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. $ **7,557** 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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.