FOR BHF USE

LL1

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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 Lving & 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 01/01/2015 to 12/31/2015 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) (Date)
(Print Name and Title)
(Firm Name & Address) RSM US 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 Lving & Rehab # 0051599 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	745	754	3,714	5,213	8
9	SNF/PED					9
10	ICF	12,594	14,076	1,116	27,786	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,339	14,830	4,830	32,999	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.72%

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 3,714

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: 12/31/15 Fiscal Year: 12/31/15

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

Facility Name & ID Number Franklin Grove Lving & Rehab # 0051599 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	269,217	25,221	8,298	302,736		302,736		302,736			1
2	Food Purchase		248,929		248,929		248,929	(12,527)	236,402			2
3	Housekeeping	231,701	62,063		293,764		293,764	73	293,837			3
4	Laundry	99,667	10,645		110,312		110,312		110,312			4
5	Heat and Other Utilities			143,414	143,414		143,414	827	144,241			5
6	Maintenance	141,246	63,101	8,715	213,062		213,062	875	213,937			6
7	Other (specify):*											7
8	**TOTAL General Services**	741,831	409,959	160,427	1,312,217		1,312,217	(10,752)	1,301,465			8
	B. Health Care and Programs											
9	Medical Director			9,300	9,300		9,300		9,300			9
10	Nursing and Medical Records	1,835,459	73,664	8,925	1,918,048		1,918,048	4,279	1,922,327			10
10a	Therapy											10a
11	Activities	93,633	2,072		95,705		95,705		95,705			11
12	Social Services	80,541			80,541		80,541		80,541			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,009,633	75,736	18,225	2,103,594		2,103,594	4,279	2,107,873			16
	C. General Administration											
17	Administrative	189,809		213,054	402,863		402,863	(117,943)	284,920			17
18	Directors Fees											18
19	Professional Services			46,134	46,134		46,134	610	46,744			19
20	Dues, Fees, Subscriptions & Promotions			28,337	28,337		28,337	(4,421)	23,916			20
21	Clerical & General Office Expenses	281,709		53,105	334,814		334,814	48,197	383,011			21
22	Employee Benefits & Payroll Taxes			469,963	469,963		469,963	6,565	476,528			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,551	5,551		5,551	(1,593)	3,958			24
25	Other Admin. Staff Transportation			32,510	32,510		32,510	1,263	33,773			25
26	Insurance-Prop.Liab.Malpractice			3,342	3,342		3,342	55,887	59,229			26
27	Other (specify):* Mgmt Alloc of Benefi							10,697	10,697			27
28	**TOTAL General Administration**	471,518		851,996	1,323,514		1,323,514	(738)	1,322,776			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,222,982	485,695	1,030,648	4,739,325		4,739,325	(7,211)	4,732,114			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 Lving & Rehab #0051599 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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			48,177	48,177		48,177	82,072	130,249			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			184,051	184,051		184,051	201,596	385,647			32
33	Real Estate Taxes							46,878	46,878			33
34	Rent-Facility & Grounds			588,000	588,000		588,000	(588,000)				34
35	Rent-Equipment & Vehicles			385	385		385	770	1,155			35
36	Other (specify):* Insurance - MIP							31,481	31,481			36
37	TOTAL Ownership			820,613	820,613		820,613	(225,203)	595,410			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		92,103	528,211	620,314		620,314		620,314			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			253,841	253,841		253,841		253,841			42
43	Other (specify):* Non-Allowable Cos			150,952	150,952		150,952	(150,952)				43
44	TOTAL Special Cost Centers		92,103	933,004	1,025,107		1,025,107	(150,952)	874,155			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,222,982	577,798	2,784,265	6,585,045		6,585,045	(383,366)	6,201,679			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 Lving & Rehab # 0051599 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	(211,995)	30		9
10	Interest and Other Investment Income	(16,461)	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	(187)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(925)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(7,881)	43		24
25	Fund Raising, Advertising and Promotional	(2,755)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(4,108)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,042)	43		28
29	Other-Attach Schedule See Page 5A	(190,529)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (437,366)		$	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)	54,000		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 54,000		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (383,366)		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 Lving & Rehab

ID# 0051599

Report Period Beginning: 01/01/2015

Ending: 12/31/2015

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Lab Expense Med A	$ (2,702)	43	1
2	X Ray Expense Med A	(2,789)	43	2
3	Miscellaneous Income Offset	25	21	3
4	Non Allowable Lobbying	(4,029)	20	4
5	Non Allowable Chamber of Commerce	(763)	20	5
6	Managed Care Costs	(124,390)	43	6
7	Non Allowable Management Fees	(50,466)	17	7
8	Non Allowable Travel and Seminar	(1,800)	24	8
9	Non Allowable Public Relations	(3,615)	43	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**	(190,529)		49

Facility Name & ID Number Franklin Grove Lving & Rehab # 0051599 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	20	Licenses	$	FOM Property LLC	100.00%	$ 250	$ 250	1
2	V	26	Insurance		FOM Property LLC	100.00%	55,092	55,092	2
3	V	30	Depreciation		FOM Property LLC	100.00%	292,027	292,027	3
4	V	32	Interest	994	FOM Property LLC	100.00%	214,884	213,890	4
5	V	32	Amortization		FOM Property LLC	100.00%	4,167	4,167	5
6	V	33	Real Estate Taxes		FOM Property LLC	100.00%	44,523	44,523	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%	31,481	31,481	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 588,994			$ 642,424	$ * 53,430	14

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

Facility Name & ID Number Franklin Grove Lving & Rehab # 0051599 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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%	$ 99	$ 99	15
16	V	3	Housekeeping		SW Financial Services Company	100.00%	73	73	16
17	V	5	Utilities		SW Financial Services Company	100.00%	827	827	17
18	V	6	Maintenance		SW Financial Services Company	100.00%	875	875	18
19	V	17	Administrative	75,054	SW Financial Services Company	100.00%	7,577	(67,477)	19
20	V	19	Professional Services		SW Financial Services Company	100.00%	1,535	1,535	20
21	V	20	Dues, Fees, Subs. & Promotions		SW Financial Services Company	100.00%	121	121	21
22	V	21	Clerical & General Office Expenses		SW Financial Services Company	100.00%	48,172	48,172	22
23	V	24	Travel & Seminar		SW Financial Services Company	100.00%	207	207	23
24	V	25	Other Admin. Staff Transportation		SW Financial Services Company	100.00%	1,263	1,263	24
25	V	26	Insurance-Prop, Liab & Malpractice		SW Financial Services Company	100.00%	795	795	25
26	V	27	Other		SW Financial Services Company	100.00%	10,697	10,697	26
27	V	30	Depreciation		SW Financial Services Company	100.00%	2,040	2,040	27
28	V	33	Real Estate Taxes		SW Financial Services Company	100.00%	2,355	2,355	28
29	V	35	Rent - Equipment & Vehicles		SW Financial Services Company	100.00%	770	770	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			$ 77,406	$ * 2,352	39

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

Facility Name & ID Number Franklin Grove Lving & Rehab # 0051599 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	$ 17,647	S & E Medical Supply Co.	100.00%	$ 11,586	$ (6,061)	15
16	V	10	Medical Supplies	1,069	S & E Medical Supply Co.	100.00%	5,348	4,279	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			$ 18,716			$ 16,934	$ * (1,782)	39

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

Facility Name & ID Number Franklin Grove Lving & Rehab # 0051599 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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%	Cahokia Nursing and Rehab	Cahokia	Prairie Crossing	Shabbona	Supportive Living	1
2	Stuart Milstein	7.33%	Caseyville Nursing and Rehab	Caseyville	Assisted Living		Facility	2
3	Ari Milstein	7.33%			SW Financial	Skokie	Bookkeeping/	3
4	Elana Minkove	7.34%			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	Groves Community	Independence, MO	Hospice	7
8	Neil Wolfe	4.40%	Tower Hill Rehabilitation, LLC	South Elgin, IL	Hospice			8
9	Richard Wolfe	4.40%			Forest View Senior	Independence, MO	Independent	9
10	Robin Krystal	4.00%	Beauvais Manor Healthcare and Rehab	St. Louis, MO	Residences		Living	10
11	David Zuckerman	2.00%	Hillside Manor Healthcare and Rehab	St. Louis, MO	White Oak Living	Independence, MO	Residential	11
12			Rancho Manor Healthcare and Rehab	Florissant, MO	Center		Care	12
13			Rosewood Health & Rehab	Independence, MO				13
14			Seasons Care Center	Kansas City, MO	Seasons Day Services	Kansas City, MO	Adult Day Care	14
15			Carriage Square	St. Joseph, MO	Program LLC			15
16			Linn Living & Rehabilitation Center	Linn, MO				16
17					Cahokia Building LLC	Cahokia	Real Estae	17
18					Caseyville Property LI	Caseyville	Real Estate	18
19					Green Acres	Amboy	Real Estate	19
20								20
21					FOM Property LLC	Franklin Grove	Real Estate	21
22								22
23					Oregon Property LLC	Oregon	Real Estate	23
24					Shabbona Building	Shabbona	Real Estate	24
25					Associates LLC			25
26								26
27					Tower Hill Property L	South Elgin	Real Estate	27
28								28
29								29
30								30

Facility Name & ID Number Franklin Grove Lving & Rehab # 0051599 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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					Linn Property LLC	Linn, MO	Real Estate	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 Lving & Rehab # 0051599 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	Salary & Fees	$ 87,534	17,3 & 17,7	1
2	David Zuckerman	Owner	Administrative	2.00	See Sch 7B	1	2.22	Salary	3,288	17(7)	2
3	Sheldon Wolfe	Administrative	Administrative	22.00	See Sch 7C	1	2.22	Salary	4,289	17(7)	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 95,111		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 Lving & Rehab # 0051599 Report Period Beginning: 01/01/2015 Ending: 2/31/2015

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	692,990	13	$ 1,561	$	44,165	$ 99	1
2	3	Housekeeping	Bed Days Available	692,990	13	1,145		44,165	73	2
3	5	Utilities	Bed Days Available	692,990	13	12,970		44,165	827	3
4	6	Maintenance	Bed Days Available	692,990	13	13,724		44,165	875	4
5	19	Professional Services-Legal	Bed Days Available	692,990	13	10,483		44,165	668	5
6	19	Professional Services-Other	Bed Days Available	692,990	13	13,601		44,165	867	6
7	20	Dues, Fees, Subscriptions & Prom	Bed Days Available	692,990	13	1,892		44,165	121	7
8	21	Clerical & General Office Expens	Bed Days Available	692,990	13	605,197	605,197	44,165	38,570	8
9	21	Clerical & General Office Expens	Bed Days Available	692,990	13	150,663		44,165	9,602	9
10	24	Travel & Seminar	Bed Days Available	692,990	13	3,246		44,165	207	10
11	25	Other Admin. Staff Transportion	Bed Days Available	692,990	13	19,825		44,165	1,263	11
12	26	Insurance-Prop, Liab & Malpract	Bed Days Available	692,990	13	12,479		44,165	795	12
13	27	Other - Mgmt Allocation of Benef	Bed Days Available	692,990	13	167,853		44,165	10,697	13
14	33	Real Estate Taxes	Bed Days Available	692,990	13	36,950		44,165	2,355	14
15	35	Rent - Equipment & Vehicles	Bed Days Available	692,990	13	12,077		44,165	770	15
16										16
17	17	Administrative	Avg. Hours Worked	45	13	193,000	193,000	1	4,289	17
18	17	Administrative	Avg. Hours Worked	45	13	147,950	147,950	1	3,288	18
19	30	Depreciation	Direct Cost	32,013					2,040	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,404,615	$ 946,147		$ 77,406	25

Facility Name & ID Number Franklin Grove Lving & Rehab # 0051599 Report Period Beginning: 01/01/2015 Ending: 2/31/2015

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			$	$		$ 11,586	1
2	10	Medical Supplies	Direct Cost						5,348	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					$	$		$ 16,934	25

Facility Name & ID Number Franklin Grove Lving & Rehab # 0051599 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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** 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	Lancaster Pollard Mortgage Co		X	Mortgage	$37,669.35	12/1/13	$ 4,971,254	$ 4,803,762	12/1/43	0.0438	$ 212,133	1
2												2
3	Amortization of Loan Costs										101,407	3
4												4
5												5
	Working Capital											
6	Sheldon Wolfe	X		Working Capital	$250,000.00	9/1/11	250,000	100,000	8/31/16	0.0128	668	6
7	Albert Milstein	X		Working Capital	$250,000.00	9/1/11	250,000	100,000	8/31/16	0.0128	668	7
8	See Schedule 9A			Working Capital			2,208,598	1,387,248			88,226	8
9	TOTAL Facility Related				$537,669.35		$ 7,679,852	$ 6,391,010			$ 403,102	9
	B. Non-Facility Related*											
10												10
11												11
12								Interest Income			(17,455)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (17,455)	14
15	TOTALS (line 9+line14)						$ 7,679,852	$ 6,391,010			$ 385,647	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 31,481 **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 Lving & Rehab
IDPH License ID Number: 0051599
Fiscal Year End: 12/31/2015

Schedule 9A

IX. Interest Expense and Real Estate Tax Expense

	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							$	$			$	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	1,237,248	12/1/43	0.0650	86,668	6
7	MB Financial Bank		X	Working Capital	Interest Only	2/10/15	750,000	150,000	2/10/16	0.0425	1,558	7
8												8
9	TOTAL Facility Related				$0.00		$ 2,208,598	$ 1,387,248			$ 88,226	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 Lving & Rehab **#** 0051599 **Report Period Beginning:** 01/01/2015 **Ending:** 12/31/2015

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$ 42,800	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.)	2014	$ 43,023	2
3. Under or (over) accrual (line 2 minus line 1).		$ 223	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 44,300	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.	2,355	
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.		$ 46,878	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	16,711	8
	2011	40,660	9
	2012	41,070	10
	2013	41,558	11
	2014	43,023	12

2015 Tax accrual= 43,023 * 1.03 = 44,313

Will use 44,300

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 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 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 2014 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 2014.

	(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	$ 43,022.76	$ 43,022.76
2.	10-28-412-049-0000	SW Financial Services Co. Allocation	$ 39,174.83	$ 2,355.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 82,197.59	$ 45,377.76

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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 Lving & Rehab # 0051599 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 48,667 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 Lving & Rehab # 0051599 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	$ 1,037,631	4
5											5
6	Mgmt. Alloc		1995		26,018		39	743	743	15,354	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			17,652	12
13	Various			1995	10,809		20	215	215	10,809	13
14	Various			1997	55,791		20	2,790	2,790	53,337	14
15	Various			1998	87,964		20	4,398	4,398	74,125	15
16	Various			1999	24,113		20	1,206	1,206	19,818	16
17	Retroaire Chassis			2000	2,321		20	116	116	1,740	17
18	Water Main Line			2001	3,294		20	165	165	2,431	18
19	Walk In Freezer			2001	8,947		20	447	447	6,447	19
20	Wiring To Kitchen			2001	12,250		20	613	613	9,038	20
21	Kitchen Labor			2001	3,163		20	158	158	2,239	21
22	Kitchen Labor			2001	1,532		20	77	77	1,087	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	662	27
28	Code Alert			2003	3,887		20	194	194	2,589	28
29	Magnetic Door Holders			2003	1,652		20	83	83	1,158	29
30	Air Conditioners			2003	4,244		20	212	212	2,969	30
31	Tub & Lift			2003	8,738		20	437	437	6,262	31
32	3 Air Conditioners			2003	478		20	24	24	335	32
33	Boiler Repair			2003	1,683		20	84	84	1,086	33
34	Shower - Glass, Bars			2003	550		20	28	28	358	34
35	Carpet			2003	599		20	30	30	367	35
36	Gutters & Down Spouts			2003	10,759		20	538		6,815	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 Lving & Rehab # 0051599 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	$ 1,165	37
38	Painting (24 Rooms)	2004	5,520		20	276	276	3,174	38
39	Nurses station	2004	18,750		20	938	938	10,784	39
40	Dining Area	2004	2,400		20	120	120	1,380	40
41	New Windows	2004	6,335		20	317	317	3,644	41
42	Bathroom Plumbing and Electrical	2004	12,600		20	630	630	7,245	42
43	Kitchen and Dining Room	2004	16,369		20	818	818	9,409	43
44	Remodel Shower and Flooring	2004	10,595		20	530	530	6,094	44
45	Display Case - Nurses Station	2004	3,800		20	190	190	2,185	45
46	Dining Room Windows	2004	9,614		20	481	481	5,530	46
47	Glass Block Shower Windows	2004	1,427		20	71	71	819	47
48	Remodel Glass and Shower	2004	3,100		20	155	155	1,783	48
49	Carpet	2004	2,660		20	133	133	1,530	49
50	Windows	2005	34,060		20	1,703	1,703	17,882	50
51	Remodel Wall	2005	6,518		20	326	326	3,423	51
52	Outside Soffit	2005	6,268		20	313	313	3,289	52
53	Install Valves	2005	4,500		20	225	225	2,363	53
54	Tiles and Flooring	2006	15,604		20	780	780	7,411	54
55	Exterior and Resident Doors	2006	21,725		20	1,086	1,086	10,318	55
56	Kick Plates	2006	5,533		20	277	277	2,630	56
57	Windows	2006	58,240		20	2,912	2,912	27,664	57
58	Siding	2006	2,080		20	104	104	988	58
59	Paving	2006	7,517		20	376	376	3,571	59
60	Wallpaper	2006	3,078		20	154	154	1,463	60
61	Air Conditioners	2006	20,183		20	1,009	1,009	9,586	61
62	Water Heater	2006	9,984		20	499	499	4,741	62
63									63
64	Glue Down Carpet	2007	3,036		20	152	152	1,292	64
65									65
66	New Doors	2008	41,645		20	2,082	2,082	15,617	66
67	Wiring-Kitchen Ansul System to Fire Alarm	2008	5,571		20	279	279	2,089	67
68	Lighting Insulation	2008	12,804		20	640	640	4,802	68
69	New Ceiling-Laundry	2008	3,755		20	188	188	1,408	69
70	TOTAL (lines 4 thru 69)		$ 2,091,478	$		$ 72,813	$ 72,275	$ 1,562,437	70

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

Facility Name & ID Number Franklin Grove Lving & Rehab # 0051599 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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		$ 2,091,478	$		$ 72,813	$ 72,813	$ 1,562,437	1
2	South Porch Remodel	2008	4,175		20	209	209	1,566	2
3	Wallpaper & Installation	2008	8,467		20	423	423	3,174	3
4	Steel studs & drywall on outside walls, retrim windows, and	2008	101,179		20	5,059	5,059	37,942	4
5	extend electrical boxes in 36 rooms								5
6	Gas Water heater	2008	4,399		20	220	220	1,650	6
7	Painting	2008	9,395		20	470	470	3,523	7
8	Replace Boiler Sections	2008	12,164		20	608	608	4,562	8
9	Vinyl Flooring	2008	83,058		20	4,153	4,153	31,147	9
10	Landscaping	2008	14,896		15	993	993	7,448	10
11	New Sprinkler System	2009	155,270		20	7,764	7,764	50,466	11
12	New Water Line for Sprinkler System	2009	14,936		20	747	747	4,855	12
13	Fire Alarm Interface-Sprinkler System	2009	3,000		20	150	150	975	13
14	Laminate Flooring	2009	2,946		20	147	147	956	14
15	Repave parking lots	2010	36,093		20	1,805	1,805	9,926	15
16	Replace concrete for front sidewalk	2010	4,653		20	233	233	1,280	16
17	Water heater	2010	8,047		20	402	402	2,211	17
18	Remodel Kitchen: Install Wall Cabinets, Flooring,	2011	25,348		20	1,267	1,267	5,702	18
19	- Countertops, Backsplash & Drywalls								19
20	Remodel Laundry Room: Install Wall Panels, Plumbing,	2011	11,100		20	555	555	2,498	20
21	- Tiles/Flooring, Shelving and Cabinets								21
22	Dining Room Floor	2011	9,658		20	483	483	2,173	22
23	Carpet & Installation	2011	3,705		20	185	185	833	23
24	Front Entrance Soffit	2011	2,100		20	105	105	473	24
25	Parking lot Seal coating	2011	8,400		20	560	560	2,333	25
26									26
27	Drywall Rooms & Ceilings (Rooms: 409, 501, 502, 504, 505 & 515)	2012	6,865	250	20	343	93	1,315	27
28	Drywall Rooms & Ceilings (Rooms: 409, 501, 502, 504, 505 & 515)	2012	3,433	125	20	172	47	545	28
29	Hot Water Tank: Boiler Room off the 100 Hall	2012	7,914	288	20	396	108	1,551	29
30	FGA: Repave Driveway	2012	10,000		15	667	667	2,333	30
31									31
32	Grab Bars in Bathrooms	2013	2,589	94	10	259	165	647	32
33	2 PTAC Units	2013	2,508		10	251	251	627	33
34	TOTAL (lines 1 thru 33)		$ 2,647,776	$ 757		$ 101,438	$ 100,681	$ 1,745,146	34

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

Facility Name & ID Number Franklin Grove Lving & Rehab # 0051599 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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		$ 2,647,776	$ 757		$ 101,438	$ 100,681	$ 1,745,146	1
2	Water Heater - services 400 & 500 Hall	2014	3,250		15	217	217	325	2
3	Telephone System Upgrade - Throughout Entire Facility	2014	15,316		10	1,532	1,532	2,298	3
4									4
5	Storm Drain and Drainage	2015	13,209	6,935	20	330	(6,605)	330	5
6	Installing new cabling for 6 rooms	2015	4,054	6	20	101	95	101	6
7	Installing surveillance camera system throughout the building	2015	27,195	27,195	5	2,719	(24,476)	2,719	7
8	Seal Coating parking lot for the entire parking	2015	4,420		20	111	111	111	8
9	Installing soft water system throughout the building	2015	3,482		5	348	348	348	9
10									10
11									11
12									12
13	Allocated from SW Financial Services Co. - Leasehold Improveme	1995	2,912					2,912	13
14	Allocated from SW Financial Services Co. - Leasehold Improveme	1996	485			24	24	474	14
15	Allocated from SW Financial Services Co. - Leasehold Improveme	1997	562			1	1	562	15
16	Allocated from SW Financial Services Co. - Leasehold Improveme	1998	481			24	24	427	16
17	Allocated from SW Financial Services Co. - Leasehold Improveme	1999	1,334			67	67	1,073	17
18	Allocated from SW Financial Services Co. - Leasehold Improveme	2005	2,761			138	138	1,449	18
19	Allocated from SW Financial Services Co. - Leasehold Improveme	2007	1,563			78	78	664	19
20	Allocated from SW Financial Services Co. - Leasehold Improveme	2009	3,263			163	163	1,060	20
21	Allocated from SW Financial Services Co. - Leasehold Improveme	2013	1,742			87	87	218	21
22	Allocated from SW Financial Services Co. - Leasehold Improveme	2014	1,757			88	88	132	22
23	Allocated from SW Financial Services Co. - Leasehold Improveme	2015	361			12	12	12	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)		$ 2,735,923	$ 34,893		$ 107,478	$ 72,585	$ 1,760,361	34

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

Facility Name & ID Number Franklin Grove Lving & Rehab # 0051599 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	$ 317,718	$ 2,915	$ 14,529	$ 11,614		$ 177,360	71
72	Current Year Purchases	13,197	3,328	1,203	(2,125)		1,203	72
73	Fully Depreciated Assets	519,222					519,222	73
74	Allocation from Management Co.	8,393		152	152		7,179	74
75	TOTALS	$ 858,530	$ 6,243	$ 15,884	$ 9,641		$ 704,964	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	$ 2,342	$ 4,066	$ 1,724	5	$ 12,875	76
77	Facility	2002 Ford E450 Passenger Bus &	2013	6,688	642	669	27	10	1,728	77
78	Facility	2011 Chevy Van	2013	16,904	4,057	1,690	(2,367)	5	1,690	78
79	Allocation from Management	2010 Infiniti	2010	4,622		462	462	5	4,622	79
80	TOTALS			$ 48,542	$ 7,041	$ 6,887	$ (154)		$ 20,915	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)	$ 3,679,200	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 48,177	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 130,249	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 82,072	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,486,240	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	$ 1,462,063	92
93			93
94			94
95		$ 1,462,063	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 Lving & Rehab # 0051599 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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.	/2016	$
13.	/2017	$
14.	/2018	$

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: $ 385 Description: Medical Supplies - $385
    (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.		$	$ 770	17
18					18
19					19
20					20
21	TOTAL		$	$ 770	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 Lving & Rehab # 0051599 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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 Lving & Rehab # 0051599 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	$	3,159	$ 227,442	$	3,159	$ 227,442	1
2	Licensed Speech and Language Development Therapist	L39, C3	hrs		1,566	75,171		1,566	75,171	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L39, C3	hrs		3,525	225,598		3,525	225,598	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				91,988		91,988	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Oxygen	L39,C2					115		115	12
13	Other (specify):									13
14	TOTAL			$	8,250	$ 528,211	$ 92,103	8,250	$ 620,314	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 Lving & Rehab # 0051599 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2015 (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	$ 400	$ 400	1
2	Cash-Patient Deposits	850	850	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 3,000)	1,213,986	1,213,986	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	72,000	72,000	5
6	Prepaid Insurance	61,336	103,404	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Schedule 17A	860,491	1,364,083	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,209,063	$ 2,754,723	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		1,360,119	14
15	Leasehold Improvements, at Historical Cost	46,464	1,375,804	15
16	Equipment, at Historical Cost	159,803	907,072	16
17	Accumulated Depreciation (book methods)	(153,180)	(2,486,240)	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 (sp See Schedule 17A	1,166,878	2,754,666	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,219,965	$ 3,947,626	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,429,028	$ 6,702,349	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 339,545	$ 182,077	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,391	1,391	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	96,724	96,724	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,857	10,857	31
32	Accrued Real Estate Taxes(Sch.IX-B)		44,300	32
33	Accrued Interest Payable	23,302	40,836	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	251,125	862,638	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 722,944	$ 1,238,823	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,587,248	6,391,010	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,587,248	$ 6,391,010	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,310,192	$ 7,629,833	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,118,836	$ (927,484)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,429,028	$ 6,702,349	48

***(See instructions.)**

Facility Name: **Franklin Grove Lving & Rehab**
IDPH License ID Number: **0051599**
Fiscal Year End: **12/31/2015**

Schedule 17A

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

	Description	Operating	After Consolidation
2073	DUE FROM STATE - INTEREST	106,083	106,083
2900	Escrow - Replacement Reserve	-	189,127
2902	Escrow - Repairs	-	284,376
2903	Escrow - Insurance	-	10,664
2904	Escrow - RE Taxes	-	18,568
2905	Excrow - MIP	-	857
3030	SHORT TERM LOAN EXCHANGE	183,631	183,631
7680	DUE TO PUBLIC AID	1,658	1,658
8811	DUE TO/FROM PROPERTY	569,105	569,105
3029	REIMBURSEMENT DUE	14	14
	Total - Line 9	**860,491**	**1,364,083**

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

	Description	Operating	After Consolidation
5050	CIP	-	1,462,063
6040	INTANGIBLE ASSET - GOODWILL	1,458,598	1,468,000
6041	ACCUM. AMORT. - GOODWILL	(291,720)	(291,720)
6044	Mortgage Costs	-	125,004
6045	Accum Amort - Mortgage Costs	-	(8,681)
	Total - Line 23	**1,166,878**	**2,754,666**

XV. Balance Sheet
Line 36 Other Current Liabilities (specify):

	Description	Operating	After Consolidation
7055	INSURANCE PREMIUMS PAYABLE	45,075	45,075
7145	ACC. RETIREMENT (FROM P/R)	500	500
7310	ACCRUED EXPENSES	200,317	200,317
8810	DUE FROM FRANKLIN GROVE INC.	-	573,137
8812	DUE TO/FROM FRANKLIN GR ASS	5,233	43,609
	Total - Line 36	**251,125**	**862,638**

Facility Name & ID Number Franklin Grove Lving & Rehab # 0051599 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,228,951	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,228,951	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	192,276	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	(302,392)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe) **ROUNDING**	1	15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (110,115)	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)**	$ 1,118,836	24	*

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

Facility Name & ID Number Franklin Grove Lving & Rehab # 0051599 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	$ 6,553,716	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,553,716	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	194,007	6
7	Oxygen	9,723	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 203,730	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	1,920	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,920	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	16,461	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 16,461	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	(25)	28
28a	Medicaid Income Adjustments	1,519	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,494	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,777,321	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,312,217	31
32	Health Care	2,103,594	32
33	General Administration	1,323,514	33
	B. Capital Expense		
34	Ownership	820,613	34
	C. Ancillary Expense		
35	Special Cost Centers	771,266	35
36	Provider Participation Fee	253,841	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,585,045	40
41	**Income before Income Taxes (line 30 minus line 40)****	192,276	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 192,276	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,965,147	44
45	Private Pay - Net Inpatient Revenue	2,875,497	45
46	Medicare - Net Inpatient Revenue	1,712,797	46
47	Other-(specify) Hospice	275	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,553,716	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 & ID Number Franklin Grove Lving & Rehab # 0051599 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	1,800	1,976	$ 64,449	$ 32.62	1
2	Assistant Director of Nursing	2,000	2,080	61,197	29.42	2
3	Registered Nurses	3,694	3,849	98,830	25.68	3
4	Licensed Practical Nurses	25,642	27,323	665,340	24.35	4
5	CNAs & Orderlies	84,096	85,871	945,643	11.01	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	7,333	7,778	93,633	12.04	10
11	Social Service Workers	3,564	3,694	80,541	21.80	11
12	Dietician					12
13	Food Service Supervisor	1,992	2,112	32,908	15.58	13
14	Head Cook					14
15	Cook Helpers/Assistants	25,658	26,452	236,309	8.93	15
16	Dishwashers					16
17	Maintenance Workers	7,753	7,961	141,246	17.74	17
18	Housekeepers	23,766	24,931	231,701	9.29	18
19	Laundry	10,679	11,073	99,667	9.00	19
20	Administrator	2,816	3,056	189,809	62.11	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,744	14,577	281,709	19.33	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)	214,537	222,733	$ 3,222,982 *	$ 14.47	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	$ 8,298	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	8,925	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)		$ 26,523		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 Lving & Rehab # 0051599 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jill Gee	Administrator	0	$ 133,994
Dana Payton	Administrator	0	38,255
Jessica Rogers	Administrator	0	17,560
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 189,809

B. Administrative - Other

Description	Amount
SW Financial Services Co. Fees (Eliminated on Sch. V, Col. 7)	$ 75,054
Moshe Herman / Momentum Healthcare, LLC	138,000
(Eliminated on Sch. V. Col 7.)	
TOTAL (agree to Schedule V, line 17, col. 3)	$ 213,054
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Field & Goldberg	Legal	$ 2,719
Grotefeld Hoffmann	Legal	2,500
Stephen N. Sher	Legal	5,694
Vorys, Sater, Seymour and Pease LL	Legal	2,325
RSM US LLP	Accounting	22,948
HK Payroll Services	Accounting	2,548
FLS Group, LLC	Accounting	7,400
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 46,134

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 107,236
Unemployment Compensation Insurance	27,975
FICA Taxes	245,991
Employee Health Insurance	69,832
Employee Meals	6,565
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	8,976
Holiday Expense	513
Life Insurance	9,440
TOTAL (agree to Schedule V, line 22, col.8)	$ 476,528

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	$ 3,980
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	8,149
Patient Background Checks	
Illinois Council on Long Term Care	12,208
Miscellaneous Dues & Permits	1,545
Miscellaneous Inspections & Licenses	2,455
Allocated from Management Co. & RE	371
Less: Lobbying & Chamber Fees	(4,792)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 23,916

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	5,551
Less: Out of Period Expenses	(1,800)
Allocated from Management Co.	207
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,958

* Attach copy of IMRF notifications

**See instructions.

Facility Name: **Franklin Grove Lving & Rehab**
IDPH License ID Number: **0051599**
Fiscal Year End: **12/31/2015**

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
From Page 21 Section C		46,134
	Total (agree to Schedule V, line 19, column 3)	46,134
Allocated from Management Company Legal Fees		668
Allocated from Management Company Professional Services		867
Less: Non-Allowable Legal Fees		(925)
	Total (agree to Schedule V, line 19, column 8)	46,744

Facility Name & ID Number Franklin Grove Lving & Rehab # 0051599 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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 Lving & Rehab # 0051599 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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-$12,208**

(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**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **10,760** 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. $ **253,841**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **6,565** 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.