



Facility Name & ID Number Flora Manor

# 0023176 Report Period Beginning: 10/01/04 Ending: 09/30/05

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 \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	59	Intermediate (ICF)	59	21,535	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	59	TOTALS	59	21,535	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Medicaid Recipient	4 Private Pay	Other		
8	SNF					8
9	SNF/PED					9
10	ICF	21,177			21,177	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,177			21,177	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.34%

D. How many bed-hold days during this year were paid by the Department? 209 (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)  
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES  NO

I. On what date did you start providing long term care at this location?  
Date started 12/01/76

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 11/17/88 NO

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 09/30/05 Fiscal Year: 09/30/05

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

STATE OF ILLINOIS

Facility Name & ID Number Flora Manor # 0023176 Report Period Beginning: 10/01/04 Ending: 09/30/05

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	166,518	16,657	4,485	187,660	(50)	187,610		187,610		1
2	Food Purchase		164,252		164,252	(6,159)	158,093		158,093		2
3	Housekeeping	76,246	16,679		92,925		92,925		92,925		3
4	Laundry	68,679	21,795		90,474		90,474		90,474		4
5	Heat and Other Utilities			56,165	56,165		56,165		56,165		5
6	Maintenance	20,703	8,701	4,411	33,815		33,815	12,510	46,325		6
7	Other (specify):* <b>Garbage Pickup</b>			2,966	2,966		2,966		2,966		7
8	<b>TOTAL General Services</b>	332,146	228,084	68,027	628,257	(6,209)	622,048	12,510	634,558		8
	<b>B. Health Care and Programs</b>										
9	Medical Director										9
10	Nursing and Medical Records	782,933	20,092	13,358	816,383	(180)	816,203		816,203		10
10a	Therapy			11,053	11,053	(60)	10,993		10,993		10a
11	Activities	60,150	9,908		70,058		70,058		70,058		11
12	Social Services	9,039			9,039		9,039		9,039		12
13	CNA Training	10,148	297		10,445		10,445		10,445		13
14	Program Transportation			3,023	3,023	(2,324)	699		699		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	862,270	30,297	27,434	920,001	(2,564)	917,437		917,437		16
	<b>C. General Administration</b>										
17	Administrative	96,394			96,394		96,394		96,394		17
18	Directors Fees			5,200	5,200		5,200		5,200		18
19	Professional Services			328,826	328,826		328,826		328,826		19
20	Dues, Fees, Subscriptions & Promotions			3,092	3,092		3,092		3,092		20
21	Clerical & General Office Expenses	84,562	12,134	8,382	105,078		105,078		105,078		21
22	Employee Benefits & Payroll Taxes			378,556	378,556	6,159	384,715		384,715		22
23	Inservice Training & Education			731	731	290	1,021		1,021		23
24	Travel and Seminar			748	748		748		748		24
25	Other Admin. Staff Transportation			7,178	7,178		7,178		7,178		25
26	Insurance-Prop.Liab.Malpractice			23,041	23,041		23,041		23,041		26
27	Other (specify):* <b>Donations</b>			23,760	23,760		23,760	(23,760)			27
28	<b>TOTAL General Administration</b>	180,956	12,134	779,514	972,604	6,449	979,053	(23,760)	955,293		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,375,372	270,515	874,975	2,520,862	(2,324)	2,518,538	(11,250)	2,507,288		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 &amp; ID Number

Flora Manor

#0023176

Report Period Beginning:

10/01/04

Ending:

09/30/05

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			65,979	65,979		65,979	(3,499)	62,480			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			1,636	1,636		1,636	(1,636)				33
34	Rent-Facility & Grounds			10,800	10,800		10,800		10,800			34
35	Rent-Equipment & Vehicles			7,155	7,155		7,155		7,155			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			85,570	85,570		85,570	(5,135)	80,435			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation					2,324	2,324		2,324			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			153,515	153,515		153,515		153,515			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			153,515	153,515	2,324	155,839		155,839			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,375,372	270,515	1,114,060	2,759,947		2,759,947	(16,385)	2,743,562			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 **Flora Manor**

# **0023176**

Report Period Beginning: **10/01/04**

Ending: **09/30/05**

**VI. ADJUSTMENT DETAIL**

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF 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	(3,499)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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	(23,760)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Attached	10,874			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (16,385)</b>		<b>\$</b>	<b>30</b>

OHF 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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (16,385)</b>		<b>37</b>

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.	X		\$ 2,324		38
39			X			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	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$ 2,324</b>		<b>47</b>

Flora Manor

ID# 0023176

Report Period Beginning: 10/01/04

Ending: 09/30/05

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Deferred Maintenance	\$ 12,510	6	1
2	Noncare related real estate taxes	(1,636)	33	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				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	<b>Total</b>	10,874		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Flora Manor

# 0023176 Report Period Beginning:

10/01/04

Ending:

09/30/05

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	12,510	0	0	0	0	0	0	0	0	0	0	12,510	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>12,510</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>12,510</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(23,760)	0	0	0	0	0	0	0	0	0	0	(23,760)	27
28	<b>TOTAL General Administration</b>	<b>(23,760)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(23,760)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(11,250)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(11,250)</b>	<b>29</b>



**VII. RELATED PARTIES**

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached 6a						

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.**  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$					1
2	V	None		Clay County Horizon Center	0.00%			2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

Facility Name & ID Number      Flora Manor      #      0023176      Report Period Beginning:      10/01/04      Ending:      09/30/05

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	John Kolmer	Director	Board Member	0.00	0	3	7.00	Director Fee	\$ 2,450	L18,C3	1
2	Marsha Taylor	Director	Board Member	0.00	0	1	3.00	Director Fee	1,500	L18,C3	2
3	Raymond Halbrook	Director	Board Member	0.00	0	1	3.00	Director Fee	1,250	L18,C3	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 5,200		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 Flora Manor # 0023176 Report Period Beginning: 10/01/04 Ending: 09/30/05

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Clay County Horizon Center  
 Street Address East 12th Street  
 City / State / Zip Code Flora, IL 62839  
 Phone Number ( 618) 662-8494  
 Fax Number ( 618) 662-9519

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

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

Facility Name & ID Number Flora Manor

# 0023176

Report Period Beginning:

10/01/04

Ending:

09/30/05

**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
	<b>A. Directly Facility Related</b>																			
	<b>Long-Term</b>																			
1			No loans at 9-30-05			\$	\$			\$	1									
2											2									
3											3									
4											4									
5											5									
	<b>Working Capital</b>																			
6											6									
7											7									
8											8									
9	<b>TOTAL Facility Related</b>					\$	\$			\$	9									
	<b>B. Non-Facility Related*</b>																			
10											10									
11											11									
12											12									
13											13									
14	<b>TOTAL Non-Facility Related</b>					\$	\$			\$	14									
15	<b>TOTALS (line 9+line14)</b>					\$	\$			\$	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line # \_\_\_\_\_

\* 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 & ID Number **Flora Manor**# **0023176** Report Period Beginning: **10/01/04** Ending: **09/30/05****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																							
1.	Real Estate Tax accrual used on 2004 report.			\$	1,137	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.)			\$	1,585	2																			
3.	Under or (over) accrual (line 2 minus line 1).			\$	448	3																			
4.	Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	1,188	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$		5																			
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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$		6																			
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	1,636	7																			
Real Estate Tax History:																									
Real Estate Tax Bill for Calendar Year:		2000	1,544	8	<table border="1"> <tr> <td colspan="3"><b>FOR OHF USE ONLY</b></td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2004</td> <td>\$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td>\$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6</td> <td>\$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td>\$</td> <td>16</td> </tr> </table>		<b>FOR OHF USE ONLY</b>			13	FROM R. E. TAX STATEMENT FOR 2004	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
<b>FOR OHF USE ONLY</b>																									
13	FROM R. E. TAX STATEMENT FOR 2004	\$	13																						
14	PLUS APPEAL COST FROM LINE 5	\$	14																						
15	LESS REFUND FROM LINE 6	\$	15																						
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																						
		2001	1,549	9																					
		2002	1,552	10																					
		2003	1,515	11																					
		2004	1,585	12																					
<b>Non-care related real estate tax paid of \$1585. Accrual \$1585 X (9/12) = \$1189.</b>																									
<b>Real estate tax exemption received for the care-related portion of Flora Manor's real estate.</b>																									
<b>Total non-care expense of \$1636 was adjusted off the cost report on line 33, column 8 of Schedule V. (Page 4 of cost report)</b>																									

**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.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2004 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Flora Manor COUNTY Clay

FACILITY IDPH LICENSE NUMBER 0023176

CONTACT PERSON REGARDING THIS REPORT Angela Simmons

TELEPHONE (618) 548-0309 FAX #: (618) 548-3720

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 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 2004.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>11-00-008-840</u>	<u>King Add Lot 6 Blk 4</u>	\$ <u>297.02</u>	\$ _____
2. <u>11-00-008-815</u>	<u>Kings Add E1/2 Lot 2</u>	\$ <u>222.76</u>	\$ _____
3. <u>11-00-008-820</u>	<u>Kings Add S1/2 Lot 3</u>	\$ <u>148.52</u>	\$ _____
4. <u>11-00-008-825</u>	<u>King Add S1/2 Lot 4</u>	\$ <u>148.52</u>	\$ _____
5. <u>11-00-008-845</u>	<u>King Add Lots 7 &amp; 8</u>	\$ <u>595.88</u>	\$ _____
6. <u>08-24-200-004</u>	<u>S1/2 NE &amp; SE NW</u>	\$ <u>171.96</u>	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>1,584.66</u>	\$ _____

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Flora Manor# 0023176 Report Period Beginning:10/01/04 Ending:09/30/05**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 14,240 B. General Construction Type: Exterior Masonry/Brick Front Frame 1 hr fire rate plaster Number of Stories OneC. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Farm land 120 acres of which all related costs have been adjusted out of this cost report, including real estate taxes.F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
If so, please complete the following:1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs:

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>90,000</u>	<u>1989</u>	<u>\$ 23,080</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>90,000</b>		<b>\$ 23,080</b>	<b>3</b>

Facility Name &amp; ID Number Flora Manor

# 0023176

Report Period Beginning:

10/01/04

Ending:

09/30/05

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4		1988	1968	\$ 692,310	\$ 21,978	31.5	\$ 21,978	\$	\$ 370,880	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Remodeling		1983	3,343		15			3,343	9
10	Covering, blinds, painting		1984	8,970		15			8,970	10
11	Remodeling, painting		1985	6,940		15			6,940	11
12	Remodeling		1986	1,287		10			1,287	12
13	Remodeling, floor, tile		1987	45,273		15			45,242	13
14	Fixtures, door		1988	2,921	146	20	146		2,556	14
15	Door, frame		1989	788	25	31.5	25		312	15
16	Parking lot		1991	22,176	1,478	15	1,478		21,189	16
17	Doors, vinyl, patio		1993	15,750	601	15	601		14,060	17
18	Windows, shower		1993	10,441	696	15	696		8,237	18
19	Roof, boiler, contracting		1994	9,396	564	15	564		6,416	19
20	Rock driveway		1994	4,540		5			4,540	20
21	Garage		1994	9,154	610	15	610		6,712	21
22	Tile, windows, lockset		1995	6,261	417	15	417		4,277	22
23	Alarm system upgrade		1995	8,225	411	20	411		4,112	23
24	Furnace ductwork		1995	5,063	338	15	338		3,320	24
25	Water heater, installation		1996	1,915	192	10	192		1,821	25
26	Floor covering		1996	1,007	67	15	67		626	26
27	Bathroom vents, shower, ventilation		1996	3,812	254	15	254		2,329	27
28	Remodel two bathrooms into showers		1996	13,803	920	15	920		8,435	28
29	Plumbing throughout facility		1996	46,034	1,841	25	1,841		17,031	29
30	Bathroom remodeling men's wing		1996	7,283	486	15	486		4,452	30
31	Condenser / installation 5 ton		1996	1,317	88	15	88		849	31
32	Trees, tree planting		1996	1,955	196	10	196		1,875	32
33	Remodeling		1997	7,492		7			7,492	33
34										34
35										35
36										36

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

See Page 12A, Line 70 for total

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

Facility Name &amp; ID Number Flora Manor

# 0023176

Report Period Beginning:

10/01/04

Ending:

09/30/05

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Bathroom remodeling / women's wing	1996	\$ 2,809	\$ 187	15	\$ 187	\$	\$ 1,638	37
38	Bathroom floor / Women's	1997	659	44	15	44		355	38
39	Sprinkler line for women's bathroom	1997	1,786	119	15	119		1,032	39
40	Bathroom remodeling / plumbing women's wing	1997	22,740	910	25	910		7,809	40
41	Floor, walls, women's wing remodeling	1997	8,284	552	15	552		4,785	41
42	Ceiling / women's bathroom	1997	1,344	90	15	90		785	42
43	Fence	1998	1,700	170	10	170		1,204	43
44	Remodel outside of building	1998	3,200	128	25	128		992	44
45	Central air conditioner / condenser	1998	4,025	268	15	268		1,900	45
46	Storage building remodeling	1998	22,341	894	25	894		6,331	46
47	Remodel front entrance	1999	4,107	274	15	274		1,894	47
48	Siding, gutting, roof repair	1999	13,659	911	15	911		6,300	48
49	Security system addition	1999	2,089	139	15	139		963	49
50	Driveway concrete	1999	1,730	115	15	115		787	50
51	Outside furnace / air conditioner	1999	5,146	515	10	515		3,475	51
52	Outside painting / fence repair	1999	2,827	283	10	283		1,815	52
53	Kitchen cabinets & installation	1999	4,368	291	15	291		1,771	53
54	Bathroom remodeling	2000	5,336	356	15	356		1,957	54
55	Patient middle room remodeling	2001	2,800	187	15	187		947	55
56	Concrete-parking area	2002	3,301	220	15	220		770	56
57	Dining room remodeling	2003	3,934	262	15	262		677	57
58	New Boiler, Radiator, Water heater / installation	2004	9,897	660	15	660		1,210	58
59	Enlarge dining room, install drywall & fire rated doors	2004	4,569	305	15	305		533	59
60	Install new handrails in main hallway	2004	1,464	98	15	98		139	60
61	Bathroom & Kitchen Boiler	2005	5,979	332	15	332		332	61
62	Boiler door unit installation	2005	2,811	47	15	47		47	62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,080,361	\$ 39,665		\$ 39,665	\$	\$ 607,751	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 240,782	\$ 12,726	\$ 12,726	\$	10	\$ 201,745	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 240,782	\$ 12,726	\$ 12,726	\$		\$ 201,745	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Transportation	2000 Dodge Liftwagon Van	2000	\$ 37,694	\$ 7,539	\$ 7,539	\$	4	\$ 33,925	76
77	Facility Transportation	1998 Dodge Van	2000	12,750	2,550	2,550		4	11,475	77
78										78
79										79
80	TOTALS			\$ 50,444	\$ 10,089	\$ 10,089	\$		\$ 45,400	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 12L, if applicable)	\$ 1,394,667	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12L, if applicable)	\$ 62,480	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12L, if applicable)	\$ 62,480	83**
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12L, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12L, if applicable)	\$ 854,896	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		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: Jack Woods

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

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Office	1987		03/09/92	3,600	5	Not	5
6	Storage Bld	1998		08/01/98	7,200	5	Determinable	6
7	TOTAL				\$ 10,800			7

10. Effective dates of current rental agreement:

Beginning 03/09/92  
Ending 03/09/08

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	<u>09/30/06</u>	\$ <u>10,800</u>
13.	<u>09/30/07</u>	\$ <u>10,800</u>
14.	<u>09/30/08</u>	\$ <u>10,800</u>

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized \_\_\_\_\_  
by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 2,355 Description: Dishwasher \$2355

(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	Activities/Patient Care	1992 Dodge Van	\$ 400.00	\$ 4,800	17
18					18
19					19
20					20
21	TOTAL		\$ 400.00	\$ 4,800	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.

**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS** (See instructions.)

**A. TYPE OF TRAINING PROGRAM** (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input checked="" type="checkbox"/> YES      <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM      <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY      <input type="checkbox"/></p> <p>COMMUNITY COLLEGE      <input type="checkbox"/></p> <p>HOURS PER CNA      <u>50</u></p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM      <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY      <input type="checkbox"/></p> <p>HOURS PER CNA      <u>80</u></p>
---	--	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		297		297
3	Classroom Wages (a)		3,263		3,263
4	Clinical Wages (b)		5,220		5,220
5	In-House Trainer Wages (c)		1,665		1,665
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$ 10,445	\$	\$ 10,445
10	SUM OF line 9, col. 1 and 2 (e)	\$	10,445		

**C. CONTRACTUAL INCOME**

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

\$ None

**D. NUMBER OF CNAs TRAINED**

COMPLETED	
1. From this facility	9
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>9</b>

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
1	Licensed Occupational Therapist		hrs	\$ N/A		\$	\$		\$	#VALUE!	1
2	Licensed Speech and Language Development Therapist		hrs								2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs								4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescripts								9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	<b>TOTAL</b>			\$		\$	\$		\$	#VALUE!	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 Flora Manor # 0023176 Report Period Beginning: 10/01/04 Ending: 09/30/05  
 XV. BALANCE SHEET - Unrestricted Operating Fund. As of 09/30/05 (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 292,859	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	607,042		3
4	Supply Inventory (priced at cost )	14,450		4
5	Short-Term Investments	348,672		5
6	Prepaid Insurance	39,439		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Accrued Interest</u>	2,618		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,305,080	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	198,420		13
14	Buildings, at Historical Cost	702,252		14
15	Leasehold Improvements, at Historical Cost	378,109		15
16	Equipment, at Historical Cost	344,188		16
17	Accumulated Depreciation (book methods)	(898,025)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Note receivable MCHC</u>	50,000		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 774,944	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,080,024	\$	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 29,704	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	74,717		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,423		31
32	Accrued Real Estate Taxes(Sch.IX-B)	1,188		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 110,032	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 110,032	\$	46
47	<b>TOTAL EQUITY (page 18, line 24)</b>	\$ 1,969,992	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,080,024	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>2,105,729</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>2,105,729</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(135,737)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(135,737)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,969,992</b>	<b>24</b> *

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

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,584,446	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,584,446	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	16,459	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		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 16,459	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	18,676	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 18,676	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Transportation revenue	2,324	28
28a	See attached page 19a	2,305	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 4,629	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,624,210	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	628,257	31
32	Health Care	920,001	32
33	General Administration	972,604	33
<b>B. Capital Expense</b>			
34	Ownership	85,570	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	153,515	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,759,947	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(135,737)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (135,737)	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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.

Facility Name & ID Number **Flora Manor**# **0023176**Report Period Beginning: **10/01/04**Ending: **09/30/05**

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,008	2,080	\$ 47,594	\$ 22.88	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,216	7,552	128,667	17.04	3
4	Licensed Practical Nurses	2,331	2,403	29,401	12.24	4
5	CNAs & Orderlies	58,814	60,342	464,650	7.70	5
6	CNA Trainees	1,170	1,170	8,483	7.25	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,463	1,551	16,311	10.52	9
10	Activity Assistants	5,391	5,463	43,839	8.02	10
11	Social Service Workers	760	760	9,039	11.89	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	3,678	3,758	39,255	10.45	14
15	Cook Helpers/Assistants	13,138	13,898	127,263	9.16	15
16	Dishwashers					16
17	Maintenance Workers	1,838	1,910	20,703	10.84	17
18	Housekeepers	8,021	8,229	76,246	9.27	18
19	Laundry	7,048	7,224	68,679	9.51	19
20	Administrator	2,520	2,600	78,329	30.13	20
21	Assistant Administrator	1,000	1,040	18,065	17.37	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,398	4,550	84,562	18.59	24
25	Vocational Instruction					25
26	Academic Instruction	130	130	1,665	12.81	26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	7,281	7,529	112,621	14.96	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	128,205	132,189	\$ 1,375,372 *	\$ 10.40	34

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

\*\* See instructions.

## B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	125	\$ 4,485	L1,C3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	11	550	L10,C3	39
40	Physical Therapy Consultant	87	2,729	L10a,C3	40
41	Occupational Therapy Consultant	112	5,510	L10a,C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	56	2,814	L10a,C3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	Physician Consultant	72	9,000	L10,C3	47
48	Psychology Consultant	61	3,808	L10,C3	48
49	TOTAL (lines 35 - 48)	524	\$ 28,896		49

## C. CONTRACT NURSES

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

Facility Name & ID Number Flora Manor

# 0023176

Report Period Beginning: 10/01/04

Ending: 09/30/05

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Dayo Adenekan	Administrator	0	\$ 78,329	Workers' Compensation Insurance	\$ 138,016	IDPH License Fee	\$ 200	
Patricia Strong	Assist Admin	0	18,065	Unemployment Compensation Insurance	12,354	Advertising: Employee Recruitment	1,308	
				FICA Taxes	105,216	Health Care Worker Background Check		
				Employee Health Insurance	70,592	(Indicate # of checks performed <u>53</u> )	848	
				Employee Meals	6,159	Dues, Books, Subscriptions	736	
				Illinois Municipal Retirement Fund (IMRF)*				
				Pension Contribution for employees	51,940			
				Employee morale, miscellaneous benefits	438			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)					\$ 96,394			
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Description			Amount		\$ 384,715	Less: Public Relations Expense	( )	
			\$			Non-allowable advertising	( )	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount					
Krehbiel & Associates	Accounting		\$ 9,450				Out-of-State Travel	\$
Health Care Management	Admin.Consulting Fees		318,600					
Miscellaneous	Acctg/Data Processing		776				In-State Travel	546
							Seminar Expense	202
							Entertainment Expense	( )
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)				TOTAL			TOTAL	
			\$ 328,826				\$ 748	

\* Attach copy of IMRF notifications

\*\*See instructions.

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										
1	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year									
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	
1	Interior Painting	Mar 04	\$ 3,723	36 mo	\$	\$	\$ 517	\$ 1,241	\$ 1,241	\$ 724	\$	\$	\$	
2	Interior Painting	Oct 04	2,072	36 mo				633	691	691	57			
3	Interior Painting	July 04	4,030	36 mo			336	1,343	1,343	1,008				
4	Interior Painting	Sept 04	2,072	36 mo			58	679	679	656				
5	Interior Painting	Feb 02	1,794	36 mo	399	598	598	199						
6	Interior Painting	Oct 02	9,816	36 mo		3,272	3,272	3,272						
7	Interior Painting	July 03	15,109	36 mo		1,259	5,036	5,036	3,778					
8	Interior Painting	Dec 03	6,538	36 mo			1,816	2,179	2,179	364				
9														
10														
11														
12														
13														
14														
15														
16														
17														
18														
19														
20	TOTALS		\$ 45,154		\$ 399	\$ 5,129	\$ 11,633	\$ 14,582	\$ 9,911	\$ 3,443	\$ 57	\$	\$	

Facility Name & ID Number Flora Manor# 0023176Report Period Beginning: 10/01/04Ending: 09/30/05**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? No  
If YES, give association name and amount. \_\_\_\_\_
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (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? \_\_\_\_\_
- (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. \$ 0 Line N/A
- (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. \_\_\_\_\_
- (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.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 153,515  
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? Yes 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. \$ 6,159 Has any meal income been offset against related costs? N/A 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? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 2,324  
c. What percent of all travel expense relates to transportation of nurses and patients? 29.6%  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
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? Yes**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0**
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Krehbiel & Associates The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.