

Facility Name & ID Number Flora Rehabilitation & Health Care Center

0046615 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>32</u>	Skilled (SNF)	<u>32</u>	<u>11,680</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>67</u>	Intermediate (ICF)	<u>67</u>	<u>24,455</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>99</u>	TOTALS	<u>99</u>	<u>36,135</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			<u>5,587</u>	<u>5,587</u>	8
9	SNF/PED					9
10	ICF	<u>22,528</u>	<u>4,629</u>		<u>27,157</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>22,528</u>	<u>4,629</u>	<u>5,587</u>	<u>32,744</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.62%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES

NO

Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES

NO

I. On what date did you start providing long term care at this location?

Date started 12/17/2004

J. Was the facility purchased or leased after January 1, 1978?

YES

Date 12/17/2004

NO

K. Was the facility certified for Medicare during the reporting year?

YES

NO

If YES, enter number of beds certified 32 and days of care provided 5,587

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL

MODIFIED

CASH*

CASH*

Is your fiscal year identical to your tax year?

YES NO

Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number Flora Rehabilitation & Health Care Center # 0046615 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	157,605	15,704	9,824	183,133		183,133	2,740	185,873		1
2	Food Purchase		171,732		171,732		171,732	(3,665)	168,067		2
3	Housekeeping	72,226	28,228		100,454		100,454	31	100,485		3
4	Laundry	55,557	15,115		70,672		70,672	2	70,674		4
5	Heat and Other Utilities			100,155	100,155		100,155	468	100,623		5
6	Maintenance	41,325	14,932	19,961	76,218		76,218	4,583	80,801		6
7	Other (specify):* Home Off. Ben. All.							1,250	1,250		7
8	TOTAL General Services	326,713	245,711	129,940	702,364		702,364	5,409	707,773		8
	B. Health Care and Programs										
9	Medical Director			28,800	28,800		28,800		28,800		9
10	Nursing and Medical Records	1,313,027	158,280	1,510	1,472,817		1,472,817	7,245	1,480,062		10
10a	Therapy	372,573	1,296		373,869		373,869		373,869		10a
11	Activities	49,921	797	632	51,350		51,350		51,350		11
12	Social Services	39,962			39,962		39,962		39,962		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.							1,611	1,611		15
16	TOTAL Health Care and Programs	1,775,483	160,373	30,942	1,966,798		1,966,798	8,856	1,975,654		16
	C. General Administration										
17	Administrative	39,481		165,000	204,481		204,481	(144,603)	59,878		17
18	Directors Fees										18
19	Professional Services			12,225	12,225		12,225	9,272	21,497		19
20	Dues, Fees, Subscriptions & Promotions			9,114	9,114		9,114	2,068	11,182		20
21	Clerical & General Office Expenses	25,338	12,742	13,471	51,551		51,551	55,361	106,912		21
22	Employee Benefits & Payroll Taxes			279,663	279,663		279,663	10,725	290,388		22
23	Inservice Training & Education			345	345		345	563	908		23
24	Travel and Seminar							893	893		24
25	Other Admin. Staff Transportation			10,757	10,757		10,757	5,129	15,886		25
26	Insurance-Prop.Liab.Malpractice			18,023	18,023		18,023	3,223	21,246		26
27	Other (specify):* Home Off. Ben. All.							13,280	13,280		27
28	TOTAL General Administration	64,819	12,742	508,598	586,159		586,159	(44,089)	542,070		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,167,015	418,826	669,480	3,255,321		3,255,321	(29,824)	3,225,497		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 Flora Rehabilitation & Health Care Center

#0046615

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			183,621	183,621		183,621	(29,011)	154,610			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			191,988	191,988		191,988	22,505	214,493			32
33	Real Estate Taxes			62,747	62,747		62,747	1,072	63,819			33
34	Rent-Facility & Grounds							66	66			34
35	Rent-Equipment & Vehicles			12,133	12,133		12,133	890	13,023			35
36	Other (specify):*											36
37	TOTAL Ownership			450,489	450,489		450,489	(4,478)	446,011			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		105,251		105,251		105,251		105,251			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,203	54,203		54,203		54,203			42
43	Other (specify):* Non-allowable Cost		170	189,521	189,691		189,691	(189,691)				43
44	TOTAL Special Cost Centers		105,421	243,724	349,145		349,145	(189,691)	159,454			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,167,015	524,247	1,363,693	4,054,955		4,054,955	(223,993)	3,830,962			45

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

**See schedule of adjustments attached at end of cost report.

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,760)	2		4
5	Telephone, TV & Radio in Resident Rooms	(1,561)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(51,240)	30		9
10	Interest and Other Investment Income	(2,254)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(732)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(164,508)	43		24
25	Fund Raising, Advertising and Promotional	(5,012)	43		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 Pg. 5A	(18,821)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (247,888)		\$	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	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)	23,895	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 23,895		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (223,993)		37

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

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

		1	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.		x	\$	38
39					39
40	Gift and Coffee Shops		x		40
41	Barber and Beauty Shops		x		41
42	Laboratory and Radiology		x		42
43	Prescription Drugs		x		43
44	Exceptional Care Program		x		44
45	Other-Attach Schedule		x		45
46	Other-Attach Schedule		x		46
47	TOTAL (C): (sum of lines 38-46)			\$	47

Flora Rehabilitation & Health Care Center

ID# 0046615

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (13,050)	43	1
2	X-Rays-Part A	(2,346)	43	2
3	Resident Flower	(629)	43	3
4	Offset Miscellaneous Office Supplies Revenue	(943)	21	4
5	Disallowed Special Events	(1,853)	43	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
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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	(18,821)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Flora Rehabilitation & Health Care Center# 0046615

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	2,740	0	0	0	0	0	0	0	0	0	2,740	1
2	Food Purchase	(3,760)	95	0	0	0	0	0	0	0	0	0	(3,665)	2
3	Housekeeping	0	31	0	0	0	0	0	0	0	0	0	31	3
4	Laundry	0	2	0	0	0	0	0	0	0	0	0	2	4
5	Heat and Other Utilities	0	468	0	0	0	0	0	0	0	0	0	468	5
6	Maintenance	0	3,817	0	766	0	0	0	0	0	0	0	4,583	6
7	Other (specify):*	0	1,250	0	0	0	0	0	0	0	0	0	1,250	7
8	TOTAL General Services	(3,760)	8,403	0	766	0	5,409	8						
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	7,245	0	0	0	0	0	0	0	0	0	7,245	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	1,611	0	0	0	0	0	0	0	0	0	1,611	15
16	TOTAL Health Care and Programs	0	8,856	0	0	0	0	0	0	0	0	0	8,856	16
	C. General Administration													
17	Administrative	0	(144,603)	0	0	0	0	0	0	0	0	0	(144,603)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	5,537	0	3,735	0	0	0	0	0	0	0	9,272	19
20	Fees, Subscriptions & Promotions	0	0	1,200	868	0	0	0	0	0	0	0	2,068	20
21	Clerical & General Office Expenses	(943)	0	46,445	9,859	0	0	0	0	0	0	0	55,361	21
22	Employee Benefits & Payroll Taxes	0	0	0	10,725	0	0	0	0	0	0	0	10,725	22
23	Inservice Training & Education	0	0	534	29	0	0	0	0	0	0	0	563	23
24	Travel and Seminar	0	0	850	43	0	0	0	0	0	0	0	893	24
25	Other Admin. Staff Transportation	0	0	3,080	2,049	0	0	0	0	0	0	0	5,129	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,254	1,969	0	0	0	0	0	0	0	3,223	26
27	Other (specify):*	0	0	13,280	0	0	0	0	0	0	0	0	13,280	27
28	TOTAL General Administration	(943)	(139,066)	66,643	29,277	0	(44,089)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(4,703)	(121,807)	66,643	30,043	0	(29,824)	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Flora Rehabilitation & Health Care Center# 0046615

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(51,240)	0	3,252	18,977	0	0	0	0	0	0	0	(29,011)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,254)	0	5,653	19,106	0	0	0	0	0	0	0	22,505	32
33	Real Estate Taxes	0	0	1,072	0	0	0	0	0	0	0	0	1,072	33
34	Rent-Facility & Grounds	0	0	66	0	0	0	0	0	0	0	0	66	34
35	Rent-Equipment & Vehicles	0	0	863	27	0	0	0	0	0	0	0	890	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(53,494)	0	10,906	38,110	0	(4,478)	37						
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(189,691)	0	0	0	0	0	0	0	0	0	0	(189,691)	43
44	TOTAL Special Cost Centers	(189,691)	0	0	0	0	0	0	0	0	0	0	(189,691)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(247,888)	(121,807)	77,549	68,153	0	(223,993)	45						

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
Mark Petersen	100	See Attached Schedule 6E		See Attached Sch 6E		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 2,740	\$ 2,740	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	95	95	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	31	31	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	2	2	4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	468	468	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	3,817	3,817	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,250	1,250	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	7,245	7,245	8
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,611	1,611	10
11	V	17 Administrative	165,000	Petersen Health Care, Inc.	100.00%	20,397	(144,603)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	5,537	5,537	12
13	V							13
14	Total		\$ 165,000			\$ 43,193	\$ * (121,807)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	20 Dues, Fees, Subs and Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 1,200	\$	1,200	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	46,445		46,445	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	534		534	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	850		850	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	3,080		3,080	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	1,254		1,254	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	13,280		13,280	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	3,252		3,252	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	5,653		5,653	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	1,072		1,072	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	66		66	25
26	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	863		863	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		\$			\$ 77,549	\$ *	77,549	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 Dietary	\$	Petersen Health Care II, Inc.	100.00%	\$ 0	\$ 0
16	V	2 Food		Petersen Health Care II, Inc.	100.00%	0	0
17	V	3 Housekeeping		Petersen Health Care II, Inc.	100.00%	0	0
18	V	4 Laundry		Petersen Health Care II, Inc.	100.00%	0	0
19	V	5 Utilities		Petersen Health Care II, Inc.	100.00%	0	0
20	V	6 Maintenance		Petersen Health Care II, Inc.	100.00%	766	766
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0	0
22	V	10 Nursing and Medical Records		Petersen Health Care II, Inc.	100.00%	0	0
23	V	15 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0	0
24	V	17 Administrative		Petersen Health Care II, Inc.	100.00%	0	0
25	V	19 Professional Services		Petersen Health Care II, Inc.	100.00%	3,735	3,735
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Care II, Inc.	100.00%	868	868
27	V	21 Clerical and General Office		Petersen Health Care II, Inc.	100.00%	9,859	9,859
28	V	22 Employee Benefits & Payroll		Petersen Health Care II, Inc.	100.00%	10,725	10,725
29	V	23 Inservice Training & Education		Petersen Health Care II, Inc.	100.00%	29	29
30	V	24 Travel and Seminar		Petersen Health Care II, Inc.	100.00%	43	43
31	V	25 Other Admin. Staff Transport.		Petersen Health Care II, Inc.	100.00%	2,049	2,049
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care II, Inc.	100.00%	1,969	1,969
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0	0
34	V	30 Depreciation		Petersen Health Care II, Inc.	100.00%	18,977	18,977
35	V	32 Interest		Petersen Health Care II, Inc.	100.00%	19,106	19,106
36	V	33 Real Estate Taxes		Petersen Health Care II, Inc.	100.00%	0	0
37	V	34 Rent-Facility and Grounds		Petersen Health Care II, Inc.	100.00%	0	0
38	V	35 Rent-Equipment & Vehicles		Petersen Health Care II, Inc.	100.00%	27	27
39	Total		\$			\$ 68,153	\$ * 68,153

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

Facility Name & ID Number Flora Rehabilitation & Health Care Center # 0046615 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	Mark Petersen	President	Administrative	100.00	See Schedule 7A	1.34	2.44	Salary	\$ 20,397	L17, C7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 20,397		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 Rehabilitation & Health Care Center# 0046615

Report Period Beginning:

01/01/2007Ending: 2/31/2007

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

Petersen Health Care, Inc.

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309) 691-8113

Fax Number

(309) 691-8622

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,316,550	66	\$ 110,171	\$ 109,587	32,744	\$ 2,740	1
2	2	Food	Resident Days	1,316,550	66	3,806	0	32,744	95	2
3	3	Housekeeping	Resident Days	1,316,550	66	1,250	0	32,744	31	3
4	4	Laundry	Resident Days	1,316,550	66	73	0	32,744	2	4
5	5	Utilities	Resident Days	1,316,550	66	18,812	0	32,744	468	5
6	6	Maintenance	Resident Days	1,316,550	66	153,468	113,063	32,744	3,817	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	50,271	0	32,744	1,250	7
8	10	Nursing and Medical Records	Resident Days	1,316,550	66	291,305	286,855	32,744	7,245	8
9	10A	Therapy	Resident Days	1,316,550	66	0	0	32,744	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	64,765	0	32,744	1,611	10
11	17	Administrative	Resident Days	1,316,550	66	820,116	820,116	32,744	20,397	11
12	19	Professional Services	Resident Days	1,316,550	66	222,628	0	32,744	5,537	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,316,550	66	48,243	0	32,744	1,200	13
14	21	Clerical and General Office	Resident Days	1,316,550	66	1,867,440	1,544,801	32,744	46,445	14
15	23	Inservice Training & Education	Resident Days	1,316,550	66	21,481	0	32,744	534	15
16	24	Travel and Seminar	Resident Days	1,316,550	66	34,177	0	32,744	850	16
17	25	Other Admin. Staff Transport.	Resident Days	1,316,550	66	123,847	0	32,744	3,080	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,316,550	66	50,427	0	32,744	1,254	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	533,953	0	32,744	13,280	19
20	30	Depreciation	Resident Days	1,316,550	66	130,767	0	32,744	3,252	20
21	32	Interest	Resident Days	1,316,550	66	227,295	0	32,744	5,653	21
22	33	Real Estate Taxes	Resident Days	1,316,550	66	43,090	0	32,744	1,072	22
23	34	Rent-Facility and Grounds	Resident Days	1,316,550	66	2,648	0	32,744	66	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,316,550	66	34,690	0	32,744	863	24
25	TOTALS					\$ 4,854,723	\$ 2,874,422		\$ 120,742	25

Facility Name & ID Number Flora Rehabilitation & Health Care Center

0046615

Report Period Beginning:

01/01/2007

Ending: 2/31/2007

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 Petersen Health Care II, Inc.
 Street Address 830 W. Trailcreek Drive
 City / State / Zip Code Peoria, IL 61614
 Phone Number (309) 691-8113
 Fax Number (309) 691-8622

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	340,686	11	\$	32,744	\$	1
2	2	Food	Resident Days	340,686	11		32,744		2
3	3	Housekeeping	Resident Days	340,686	11		32,744		3
4	4	Laundry	Resident Days	340,686	11		32,744		4
5	5	Utilities	Resident Days	340,686	11		32,744		5
6	6	Maintenance	Resident Days	340,686	11	7,966	32,744	766	6
7	7	Mgmt. Allocation of Benefits	Resident Days	340,686	11		32,744		7
8	10	Nursing and Medical Records	Resident Days	340,686	11		32,744		8
9	15	Mgmt. Allocation of Benefits	Resident Days	340,686	11		32,744		9
10	17	Administrative	Resident Days	340,686	11		32,744		10
11	19	Professional Services	Resident Days	340,686	11	38,857	32,744	3,735	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	340,686	11	9,036	32,744	868	12
13	21	Clerical and General Office	Resident Days	340,686	11	102,581	32,744	9,859	13
14	22	Employee Benefits & Payroll	Resident Days	340,686	11	111,591	32,744	10,725	14
15	23	Inservice Training & Education	Resident Days	340,686	11	300	32,744	29	15
16	24	Travel and Seminar	Resident Days	340,686	11	451	32,744	43	16
17	25	Other Admin. Staff Transport.	Resident Days	340,686	11	21,324	32,744	2,049	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	340,686	11	20,484	32,744	1,969	18
19	27	Mgmt. Allocation of Benefits	Resident Days	340,686	11		32,744		19
20	30	Depreciation	Resident Days	340,686	11	197,442	32,744	18,977	20
21	32	Interest	Resident Days	340,686	11	198,787	32,744	19,106	21
22	33	Real Estate Taxes	Resident Days	340,686	11		32,744		22
23	34	Rent-Facility and Grounds	Resident Days	340,686	11		32,744		23
24	35	Rent-Equipment & Vehicles	Resident Days	340,686	11	280	32,744	27	24
25	TOTALS					\$ 709,099	\$	\$ 68,153	25

Facility Name & ID Number Flora Rehabilitation & Health Care Center# 0046615

Report Period Beginning:

01/01/2007

Ending:

12/31/2007**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE****A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	US Bank		X	Mortgage Loan	Varies	1/4/05	\$ 2,912,000	\$ 2,695,641	12/18/2011	0.0699	\$ 190,753	1								
2	Ford		X	Purchase Vehicle	\$609.00	10/27/04	33,137	12,905	10/27/2009	0.0390	645	2								
3							Offset Interest Income				(2,254)	3								
4							Home Office Allocation-PHC				5,653	4								
5							Home Office Allocation-PHC II				19,106	5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related				\$609.00		\$ 2,945,137	\$ 2,708,546			\$ 213,903	9								
B. Non-Facility Related*																				
10							Amortization of Loan Costs				590	10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ 590	14								
15	TOTALS (line 9+line14)						\$ 2,945,137	\$ 2,708,546			\$ 214,493	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2007 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.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Flora Rehabilitation & Health Care Center COUNTY Clay

FACILITY IDPH LICENSE NUMBER 0046615

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE (309) 691-8113 FAX #: (309) 691-8622

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2006 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 2006.

	(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>10-23-400-014</u>	<u>Long-Term Care Facility</u>	\$ <u>60,247.00</u>	\$ <u>60,247.00</u>
2.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		TOTALS	\$ <u>60,247.00</u>	\$ <u>60,247.00</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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 Flora Rehabilitation & Health Care Center

0046615

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24,488 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

N/A

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>278,784</u>	<u>2004</u>	<u>\$ 129,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	278,784		\$ 129,000	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	99		2004	1973	\$ 2,214,200	\$	35	\$ 63,263	\$ 63,263	\$ 195,061	4
5											5
6											6
7	Home Office Allocation				18,255			446	446		7
8											8
	Improvement Type**										
9	Sidewalks		2006		3,605		15	240	240	360	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18	Building Booked					88,621			(88,621)		18
19	Building Improvement Booked					240			(240)		19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31	2007-Home Office Allocation-Building Improvements				1,221			73	73		31
32											32
33											33
34											34
35											35
36											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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 2,237,281	\$ 88,861		\$ 64,022	\$ (24,839)	\$ 195,421	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	\$ 620,309	\$ 87,845	\$ 62,030	\$ (25,815)	10	\$ 189,121	71
72	Current Year Purchases	4,098	272	205	(67)	10	205	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			21,710	21,710			74
75	TOTALS	\$ 624,407	\$ 88,117	\$ 83,945	\$ (4,172)		\$ 189,326	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	Administrative	2005 Ford	2004	\$ 33,216	\$ 6,643	\$ 6,643	\$	5	\$ 21,037	76
77										77
78										78
79										79
80	TOTALS			\$ 33,216	\$ 6,643	\$ 6,643	\$		\$ 21,037	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)	\$ 3,023,904	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 183,621	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 154,610	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (29,011)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 405,784	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	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6		<u>Home Office Allocation</u>			<u>66</u>			6
7	TOTAL				\$ <u>66</u>			7

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

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

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 13,023 Description: See Schedule 14A

(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			\$	\$	17
18			<u>N/A</u>		18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2008 \$ _____

13. _____ /2009 \$ _____

14. _____ /2010 \$ _____

* 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.

Flora Rehabilitation & Health Care Center

0046615

Period Beginning 01/01/2007

Period End 12/31/2007

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$ 8,779
Dishwasher	522
Copier	2,832
Home Office Allocation	890
	<u>13,023</u>

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

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

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

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	10A(1)&10A(3)	2273 hrs	\$ 58,598		\$		2,273	\$ 58,598	1
2	Licensed Speech and Language Development Therapist	10A(1)&10A(3)	2125 hrs	68,177				2,125	68,177	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(1),10A(2)&10A(3)	8859 hrs	245,798			1,296	8,859	247,094	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				105,251		105,251	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	TOTAL			\$ 372,573		\$	\$ 106,547	13,257	\$ 479,120	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.

Facility Name & ID Number Flora Rehabilitation & Health Care Center

0046615

Report Period Beginning: 01/01/2007

Ending:

12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,302,255	\$ 1,302,255	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>N/A</u>)	811,141	811,141	3
4	Supply Inventory (priced at <u> </u>)			4
5	Short-Term Investments			5
6	Prepaid Insurance	16,723	16,723	6
7	Other Prepaid Expenses	7,338	7,338	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u> </u>			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,137,457	\$ 2,137,457	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	132,605	129,000	13
14	Buildings, at Historical Cost	2,214,200	2,232,455	14
15	Leasehold Improvements, at Historical Cost		4,826	15
16	Equipment, at Historical Cost	654,123	657,623	16
17	Accumulated Depreciation (book methods)	(565,155)	(405,784)	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 (spec <u>Loan Cost/Goodwill</u>)	21,070	21,070	22
23	Other(specify): <u> </u>			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,456,843	\$ 2,639,190	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,594,300	\$ 4,776,647	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 400,859	\$ 400,859	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	123,871	123,871	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,121	8,121	31
32	Accrued Real Estate Taxes(Sch.IX-B)	62,500	62,500	32
33	Accrued Interest Payable	15,702	15,702	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	36,115	36,115	36
37	<u>Due to Related Parties</u>	10,062	10,062	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 657,230	\$ 657,230	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	12,905	12,905	39
40	Mortgage Payable	2,695,641	2,695,641	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>A/P-Prior Owner</u>	9,871	9,871	43
44	<u> </u>			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,718,417	\$ 2,718,417	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,375,647	\$ 3,375,647	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,218,653	\$ 1,401,000	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,594,300	\$ 4,776,647	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 917,757	1
2	Restatements (describe):		2
3	Rounding	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 917,756	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	300,897	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	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 300,897	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)	\$ 1,218,653	24 *

* 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	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,264,236	1
2	Discounts and Allowances for all Levels	415,813	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,680,049	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	426,748	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 426,748	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	3,760	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	207,386	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	27,977	20
21	Other Medical Services	6,735	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 245,858	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,254	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,254	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Revenue</u>	943	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 943	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,355,852	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	702,364	31
32	Health Care	1,966,798	32
33	General Administration	586,159	33
	B. Capital Expense		
34	Ownership	450,489	34
	C. Ancillary Expense		
35	Special Cost Centers	294,942	35
36	Provider Participation Fee	54,203	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,054,955	40
41	Income before Income Taxes (line 30 minus line 40)**	300,897	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 300,897	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. Facility is a division of a larger entity.

*** 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 Rehabilitation & Health Care Center

0046615

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

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	2,080	2,080	\$ 50,636	\$ 24.34	1
2	Assistant Director of Nursing	2,080	2,080	40,109	19.28	2
3	Registered Nurses	13,767	14,112	271,635	19.25	3
4	Licensed Practical Nurses	16,833	17,412	273,300	15.70	4
5	CNAs & Orderlies	57,916	60,041	591,242	9.85	5
6	CNA Trainees					6
7	Licensed Therapist	13,257	13,295	372,573	28.02	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,335	1,335	14,031	10.51	9
10	Activity Assistants	2,866	2,883	20,554	7.13	10
11	Social Service Workers	3,120	3,120	39,962	12.81	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	36,212	17.41	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,037	15,366	121,393	7.90	15
16	Dishwashers					16
17	Maintenance Workers	2,374	2,518	41,325	16.41	17
18	Housekeepers	9,202	9,525	72,226	7.58	18
19	Laundry	6,609	6,885	55,557	8.07	19
20	Administrator	1,915	1,915	39,481	20.62	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,994	2,138	25,338	11.85	23
24	Clerical					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 C: Care Plan Coord.	4,114	4,114	86,105	20.93	32
33	Other(specify) <u>Transportation</u>	1,930	1,971	15,336	7.78	33
34	TOTAL (lines 1 - 33)	158,509	162,870	\$ 2,167,015 *	\$ 13.31	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	187	\$ 9,824	1(3)	35
36	Medical Director	Monthly	28,800	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,100	10(3)	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)	187	\$ 39,724		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
<u>Nancy Geisinger</u>	<u>Administrator</u>	<u>0</u>	\$ <u>21,981</u>	<u>Workers' Compensation Insurance</u>	\$ <u>27,968</u>	<u>IDPH License Fee</u>	\$ _____	
<u>Jami Gibbons</u>	<u>Administrator</u>	<u>0</u>	<u>17,500</u>	<u>Unemployment Compensation Insurance</u>	<u>52,035</u>	<u>Advertising: Employee Recruitment</u>	<u>694</u>	
				<u>FICA Taxes</u>	<u>167,589</u>	<u>Health Care Worker Background Check</u>		
				<u>Employee Health Insurance</u>	<u>36,011</u>	(Indicate # of checks performed)		
				<u>Employee Meals</u>		<u>Patient Background Checks</u>	<u>277</u> <u>2,770</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Miscellaneous Dues & Subscriptions</u>	<u>75</u>	
				<u>Employee Relations</u>	<u>700</u>	<u>Home Office Allocation</u>	<u>2,068</u>	
				<u>Employee Retirement</u>	<u>3,161</u>	<u>Misc. Licenses & Permits</u>	<u>225</u>	
				<u>Smoking Cessation</u>	<u>2,924</u>	<u>LTC Solutions License</u>	<u>1,600</u>	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ <u>39,481</u>			<u>IHCA Dues</u>	<u>3,750</u>	
(List each licensed administrator separately.)						<u>Less: Public Relations Expense</u>	(_____)	
B. Administrative - Other						<u>Non-allowable advertising</u>	(_____)	
Description			Amount			<u>Yellow page advertising</u>	(_____)	
<u>Management Fees-See Page 6, Eliminated on P 3, C 7</u>			\$ <u>165,000</u>					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ <u>165,000</u>	TOTAL (agree to Schedule V,	\$ <u>290,388</u>	TOTAL (agree to Sch. V,	\$ <u>11,182</u>	
(Attach a copy of any management service agreement)				line 22, col.8)		line 20, col. 8)		
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type	Amount	Amount	Description	Line #	Amount	Description	Amount
<u>McGladrey & Pullen, LLC</u>	<u>Accounting Services</u>	\$ <u>8,680</u>					<u>Out-of-State Travel</u>	\$ _____
<u>Verizon North</u>	<u>Computer Services</u>	<u>482</u>						
<u>Miscellaneous Vendors</u>	<u>Computer Services</u>	<u>100</u>		<u>N/A</u>				
<u>Wabash Independent Networks</u>	<u>Computer Services</u>	<u>938</u>					<u>In-State Travel</u>	
<u>E-Health Data Solutions</u>	<u>Computer Services</u>	<u>2,025</u>						
							<u>Seminar Expense</u>	
							<u>Home Office Allocation</u>	<u>893</u>
							<u>Entertainment Expense</u>	(_____)
TOTAL (agree to Schedule V, line 19, column 3)			\$ <u>12,225</u>	TOTAL		\$ _____	(agree to Sch. V,	
(If total legal fees exceed \$5,000, attach copy of invoices.)							line 24, col. 8)	
							TOTAL	\$ <u>893</u>

* Attach copy of IMRF notifications

**See instructions.

Flora Rehabilitation & Health Care Center

0046615

Period Beginning 01/01/2007

Period End 12/31/2007

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		12,225

Home Office Allocation

Pearl & Associates	Legal	36
Addy Bush & Assoc	Legal	18
Registered Agent Solutions	Legal	3
Heyl, Royster, Voelker & Allen	Legal	80
Duane Morris	Legal	124
Ginoli & Co.	Accountants	4,146
RSM McGladrey	Accountants	219
McGladrey & Pullen	Accountants	334
Emdeon Business Services	Computer Services	87
Advanced Answers on Demand	Computer Services	2,348
Access 2 Go	Computer Services	177
Ivans	Computer Services	767
Kemper Technology	Computer Services	368
Administar Federal	Computer Services	46
Logmein	Computer Services	29
E-Health Data Solutions	Computer Services	230
Miscellaneous Vendors	Computer Services	17
CDW	Computer Services	185
Miscellaneous Vendors	Professional Services	58

Total (agree to Schedule V, line 19, column 8)	<u>21,497</u>
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Facility Name & ID Number Flora Rehabilitation & Health Care Center# 0046615Report Period Beginning: 01/01/2007Ending: 12/31/2007**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. IHCA-\$3,750
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 21,075 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. \$ 54,203
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 3,760
- (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? Yes
Firm Name: Ginoli & Company The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit still in progress
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees