

Facility Name & ID Number Flora Rehabilitation & Health Care Center

0046615 Report Period Beginning: 1/1/2008 Ending: 12/31/2008

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	32	Skilled (SNF)	32	11,712	1
2		Skilled Pediatric (SNF/PED)			2
3	67	Intermediate (ICF)	67	24,522	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,234	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			5,537	5,537	8
9	SNF/PED					9
10	ICF	21,255	4,195		25,450	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,255	4,195	5,537	30,987	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.52%

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 5,537

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: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number Flora Rehabilitation & Health Care Center # 0046615 Report Period Beginning: 1/1/2008 Ending: 12/31/2008

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	150,922	20,522	867	172,311		172,311	5,508	177,819		1
2	Food Purchase		170,362		170,362		170,362	(5,012)	165,350		2
3	Housekeeping	71,376	20,756		92,132		92,132	41	92,173		3
4	Laundry	51,141	12,244		63,385		63,385	2	63,387		4
5	Heat and Other Utilities			110,663	110,663		110,663	571	111,234		5
6	Maintenance	38,427	14,285	20,400	73,112		73,112	4,784	77,896		6
7	Other (specify):* <u>Home Off. Ben. All.</u>							1,354	1,354		7
8	TOTAL General Services	311,866	238,169	131,930	681,965		681,965	7,248	689,213		8
	B. Health Care and Programs										
9	Medical Director			24,000	24,000		24,000		24,000		9
10	Nursing and Medical Records	1,288,440	159,524	26,382	1,474,346		1,474,346	8,748	1,483,094		10
10a	Therapy	326,474	4,929		331,403		331,403		331,403		10a
11	Activities	41,682	240	2,120	44,042		44,042		44,042		11
12	Social Services	21,375			21,375		21,375		21,375		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Off. Ben. All.</u>							1,669	1,669		15
16	TOTAL Health Care and Programs	1,677,971	164,693	52,502	1,895,166		1,895,166	10,417	1,905,583		16
	C. General Administration										
17	Administrative	62,870		126,000	188,870		188,870	(83,123)	105,747		17
18	Directors Fees										18
19	Professional Services			7,279	7,279		7,279	11,285	18,564		19
20	Dues, Fees, Subscriptions & Promotions			8,912	8,912		8,912	3,782	12,694		20
21	Clerical & General Office Expenses	26,649	11,090	11,274	49,013		49,013	61,717	110,730		21
22	Employee Benefits & Payroll Taxes			304,537	304,537		304,537	1,078	305,615		22
23	Inservice Training & Education			198	198		198	327	525		23
24	Travel and Seminar			50	50		50	449	499		24
25	Other Admin. Staff Transportation			20,116	20,116		20,116	7,006	27,122		25
26	Insurance-Prop.Liab.Malpractice			19,469	19,469		19,469	1,941	21,410		26
27	Other (specify):* <u>Home Off. Ben. All.</u>							15,318	15,318		27
28	TOTAL General Administration	89,519	11,090	497,835	598,444		598,444	19,780	618,224		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,079,356	413,952	682,267	3,175,575		3,175,575	37,445	3,213,020		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:

1/1/2008

Ending:

12/31/2008

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			183,751	183,751		183,751	(21,554)	162,197			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			185,899	185,899		185,899	35,295	221,194			32
33	Real Estate Taxes			58,918	58,918		58,918	786	59,704			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			15,021	15,021		15,021	834	15,855			35
36	Other (specify):*											36
37	TOTAL Ownership			443,589	443,589		443,589	15,361	458,950			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		149,812		149,812		149,812		149,812			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,354	54,354		54,354		54,354			42
43	Other (specify):* Non-allowable Cost		433	227,985	228,418		228,418	(228,418)				43
44	TOTAL Special Cost Centers		150,245	282,339	432,584		432,584	(228,418)	204,166			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,079,356	564,197	1,408,195	4,051,748		4,051,748	(175,612)	3,876,136			45

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

Flora Rehabilitation & Health Care Center

ID# 0046615

Report Period Beginning: 1/1/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (48,440)	43	1
2	X-Rays-Part A	(7,887)	43	2
3	Resident Flower	2,794	43	3
4	Offset Miscellaneous Office Supplies Revenue	(409)	21	4
5	Disallowed Special Events	(385)	43	5
6	Offset Miscellaneous Nursing Supplies Revenue	(811)	10	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
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32				32
33				33
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40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(55,138)		49

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%	\$ 5,508	\$ 5,508	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	90	90	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	41	41	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	2	2	4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	571	571	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	3,366	3,366	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,354	1,354	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	9,559	9,559	8
9	V	11 Activities		Petersen Health Care, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,669	1,669	10
11	V	17 Administrative	126,000	Petersen Health Care, Inc.	100.00%	42,877	(83,123)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	4,839	4,839	12
13	V							13
14	Total		\$ 126,000			\$ 69,876	\$ * (56,124)	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 Prmotions	\$	Petersen Health Care, Inc.	100.00%	\$ 1,493	\$	1,493	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	53,806		53,806	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	327		327	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	327		327	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	4,236		4,236	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	258		258	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	15,318		15,318	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	5,862		5,862	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	4,123		4,123	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	786		786	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0			25
26	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	670		670	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		\$			\$ 87,206	\$ *	87,206	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	\$
16	V	2 Food		Petersen Health Care II, Inc.	100.00%	0	
17	V	3 Housekeeping		Petersen Health Care II, Inc.	100.00%	0	
18	V	4 Laundry		Petersen Health Care II, Inc.	100.00%	0	
19	V	5 Utilities		Petersen Health Care II, Inc.	100.00%	0	
20	V	6 Maintenance		Petersen Health Care II, Inc.	100.00%	1,418	1,418
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0	
22	V	10 Nursing and Medical Records		Petersen Health Care II, Inc.	100.00%	0	
23	V	15 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0	
24	V	17 Administrative		Petersen Health Care II, Inc.	100.00%	0	
25	V	19 Professional Services		Petersen Health Care II, Inc.	100.00%	6,446	6,446
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Care II, Inc.	100.00%	2,289	2,289
27	V	21 Clerical and General Office		Petersen Health Care II, Inc.	100.00%	8,320	8,320
28	V	22 Employee Benefits & Payroll		Petersen Health Care II, Inc.	100.00%	1,078	1,078
29	V	23 Inservice Training & Education		Petersen Health Care II, Inc.	100.00%	0	
30	V	24 Travel and Seminar		Petersen Health Care II, Inc.	100.00%	122	122
31	V	25 Other Admin. Staff Transport.		Petersen Health Care II, Inc.	100.00%	2,770	2,770
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care II, Inc.	100.00%	1,683	1,683
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0	
34	V	30 Depreciation		Petersen Health Care II, Inc.	100.00%	22,130	22,130
35	V	32 Interest		Petersen Health Care II, Inc.	100.00%	31,172	31,172
36	V	33 Real Estate Taxes		Petersen Health Care II, Inc.	100.00%	0	
37	V	34 Rent-Facility and Grounds		Petersen Health Care II, Inc.	100.00%	0	
38	V	35 Rent-Equipment & Vehicles		Petersen Health Care II, Inc.	100.00%	164	164
39	Total		\$			77,592	\$ * 77,592

* 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: 1/1/2008 Ending: 12/31/2008

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	1,785,797	1.28	2.14	Salary	\$ 42,877	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	\$ 42,877		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:

1/1/2008Ending: 2/31/2008

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	1,413,604	69	\$ 251,260	\$ 250,687	30,987	\$ 5,508	1
2	2	Food	Resident Days	1,413,604	69	4,125	0	30,987	90	2
3	3	Housekeeping	Resident Days	1,413,604	69	1,859	0	30,987	41	3
4	4	Laundry	Resident Days	1,413,604	69	110	0	30,987	2	4
5	5	Utilities	Resident Days	1,413,604	69	26,036	0	30,987	571	5
6	6	Maintenance	Resident Days	1,413,604	69	153,551	100,245	30,987	3,366	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	61,774	0	30,987	1,354	7
8	10	Nursing and Medical Records	Resident Days	1,413,604	69	436,084	432,530	30,987	9,559	8
9	10A	Therapy	Resident Days	1,413,604	69	0	0	30,987	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	76,136	0	30,987	1,669	10
11	17	Administrative	Resident Days	1,413,604	69	1,955,999	1,956,000	30,987	42,877	11
12	19	Professional Services	Resident Days	1,413,604	69	220,762	0	30,987	4,839	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,413,604	69	68,094	0	30,987	1,493	13
14	21	Clerical and General Office	Resident Days	1,413,604	69	2,454,596	2,013,896	30,987	53,806	14
15	23	Inservice Training & Education	Resident Days	1,413,604	69	14,912	0	30,987	327	15
16	24	Travel and Seminar	Resident Days	1,413,604	69	14,938	0	30,987	327	16
17	25	Other Admin. Staff Transport.	Resident Days	1,413,604	69	193,264	0	30,987	4,236	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,413,604	69	11,767	0	30,987	258	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	698,810	0	30,987	15,318	19
20	30	Depreciation	Resident Days	1,413,604	69	267,426	0	30,987	5,862	20
21	32	Interest	Resident Days	1,413,604	69	188,107	0	30,987	4,123	21
22	33	Real Estate Taxes	Resident Days	1,413,604	69	35,872	0	30,987	786	22
23	34	Rent-Facility and Grounds	Resident Days	1,413,604	69	0	0	30,987	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,413,604	69	30,580	0	30,987	670	24
25	TOTALS					\$ 7,166,062	\$ 4,753,358		\$ 157,082	25

Facility Name & ID Number Flora Rehabilitation & Health Care Center

0046615

Report Period Beginning:

1/1/2008

Ending: 2/31/2008

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	331,413	13	\$	30,987	\$	1
2	2	Food	Resident Days	331,413	13		30,987		2
3	3	Housekeeping	Resident Days	331,413	13		30,987		3
4	4	Laundry	Resident Days	331,413	13		30,987		4
5	5	Utilities	Resident Days	331,413	13		30,987		5
6	6	Maintenance	Resident Days	331,413	13	15,163	30,987	1,418	6
7	7	Mgmt. Allocation of Benefits	Resident Days	331,413	13		30,987		7
8	10	Nursing and Medical Records	Resident Days	331,413	13		30,987		8
9	15	Mgmt. Allocation of Benefits	Resident Days	331,413	13		30,987		9
10	17	Administrative	Resident Days	331,413	13		30,987		10
11	19	Professional Services	Resident Days	331,413	13	68,939	30,987	6,446	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	331,413	13	24,482	30,987	2,289	12
13	21	Clerical and General Office	Resident Days	331,413	13	88,982	30,987	8,320	13
14	22	Employee Benefits & Payroll	Resident Days	331,413	13	11,527	30,987	1,078	14
15	23	Inservice Training & Education	Resident Days	331,413	13		30,987		15
16	24	Travel and Seminar	Resident Days	331,413	13	1,299	30,987	122	16
17	25	Other Admin. Staff Transport.	Resident Days	331,413	13	29,621	30,987	2,770	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	331,413	13	18,001	30,987	1,683	18
19	27	Mgmt. Allocation of Benefits	Resident Days	331,413	13		30,987		19
20	30	Depreciation	Resident Days	331,413	13	236,686	30,987	22,130	20
21	32	Interest	Resident Days	331,413	13	333,393	30,987	31,172	21
22	33	Real Estate Taxes	Resident Days	331,413	13		30,987		22
23	34	Rent-Facility and Grounds	Resident Days	331,413	13		30,987		23
24	35	Rent-Equipment & Vehicles	Resident Days	331,413	13	1,756	30,987	164	24
25	TOTALS					\$ 829,849	\$	\$ 77,592	25

Facility Name & ID Number

Flora Rehabilitation & Health Care Center

0046615

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

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	Reporting Period Interest Expense										
											Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)
												YES	NO				Original	Balance		
A. Directly Facility Related																				
Long-Term																				
1	US Bank		X	Mortgage Loan	Varies	1/4/05	\$ 2,912,000	\$ 2,610,726	12/18/2011	0.0699	\$ 184,916	1								
2	Ford		X	Purchase Vehicle	\$609.00	10/27/04	33,137	5,993	10/27/2009	0.0390	393	2								
3												3								
4							Home Office Allocation-PHC				4,123	4								
5							Home Office Allocation-PHC II				31,172	5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related				\$609.00		\$ 2,945,137	\$ 2,616,719			\$ 220,604	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	\$ 2,616,719			\$ 221,194	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.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2007 report.		\$	62,500	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.)	2007	\$	59,918	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(2,582)	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	61,500	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
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. Home Office Allocation			786	
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	59,704	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003		8
	2004	56,661	9
	2005	59,602	10
	2006	60,247	11
	2007	59,918	12

Accrual based on prior year tax bill.

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2007	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 2007 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 2007.

(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>59,917.90</u>	\$ <u>59,917.90</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>59,917.90</u>	\$ <u>59,917.90</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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.

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 Use	2 Square Feet	3 Year Acquired	4 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

Facility Name & ID Number **Flora Rehabilitation & Health Care Center**

0046615

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

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	\$ 258,324	4
5										5
6										6
7	Home Office Allocation									7
8										8
	Improvement Type**									
9	Sidewalks		2006	3,605		15	240	240	600	9
10	Front Door Repair		2008	5,090		25	102	102	102	10
11	Rooftop A/C Repair		2008	2,619		15	87	87	87	11
12	B-Unit Shower Units		2008	14,000		25	280	280	280	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	Building Booked				88,622			(88,622)		28
29	Building Improvement Booked				665			(665)		29
30										30
31										31
32	2008-Home Office Allocation-Land Improvements			1,077			69	69		32
33	2008-Home Office Allocation-Building Improvements			16,089			386	386		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)	\$ 2,256,680	\$ 89,287		\$ 64,427	\$ (24,860)	\$ 259,393	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	\$ 624,407	\$ 87,136	\$ 62,440	\$ (24,696)	10	\$ 251,766	71
72	Current Year Purchases	13,903	685	695	10	10	695	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			27,992	27,992			74
75	TOTALS	\$ 638,310	\$ 87,821	\$ 91,127	\$ 3,306		\$ 252,461	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	\$ 27,680	76
77										77
78										78
79										79
80	TOTALS			\$ 33,216	\$ 6,643	\$ 6,643	\$		\$ 27,680	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)	\$ 3,057,206	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 183,751	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 162,197	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (21,554)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 539,534	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	N/A				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								6
7	TOTAL				\$			7

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 15,855 Description: See Attached 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			N/A		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. _____ /2009 \$ _____

13. _____ /2010 \$ _____

14. _____ /2011 \$ _____

* 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 1/1/2008

Period End 12/31/2008

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$ 11,792
Dishwasher	205
Maintenance Equipment	24
Copier	3,000
Home Office Allocation	834
	<u>15,855</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(2)	1424 hrs	\$ 44,393		\$	\$ 1,856	1,424	\$ 46,249	1
2	Licensed Speech and Language Development Therapist	10A(1)	2107 hrs	65,676				2,107	65,676	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(1), 10A(2)	6509 hrs	202,882			\$ 3,073	6,509	205,955	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 prescripts				\$ 149,812		149,812	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Other Therapists</u>	10A(3)	434	13,523				434	13,523	12
13	Other (specify):									13
14	TOTAL			\$ 326,474		\$	\$ 154,741	10,474	\$ 481,215	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: 1/1/2008

Ending: 12/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008

(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	\$ 1,798,821	\$ 1,798,821	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>N/A</u>)	1,150,991	1,150,991	3
4	Supply Inventory (priced at <u> </u>)			4
5	Short-Term Investments			5
6	Prepaid Insurance	24,585	24,585	6
7	Other Prepaid Expenses	17,073	17,073	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)	\$ 2,991,470	\$ 2,991,470	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	2,230,289	14
15	Leasehold Improvements, at Historical Cost	21,709	26,391	15
16	Equipment, at Historical Cost	668,026	671,526	16
17	Accumulated Depreciation (book methods)	(748,906)	(539,534)	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>)	20,480	20,480	22
23	Other(specify): <u> </u>			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,308,114	\$ 2,538,152	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,299,584	\$ 5,529,622	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 715,152	\$ 715,152	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	129,957	129,957	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,661	3,661	31
32	Accrued Real Estate Taxes(Sch.IX-B)	61,500	61,500	32
33	Accrued Interest Payable	14,563	14,563	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Payroll Withholdings</u>	33,729	33,729	36
37	<u> </u>			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 958,562	\$ 958,562	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	5,993	5,993	39
40	Mortgage Payable	2,610,726	2,610,726	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u> </u>			43
44	<u> </u>			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,616,719	\$ 2,616,719	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,575,281	\$ 3,575,281	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,724,303	\$ 1,954,341	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,299,584	\$ 5,529,622	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,218,653	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)	\$ 1,218,652	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	505,651	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)	\$ 505,651	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)	\$ 1,724,303	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Flora Rehabilitation & Health Care Center

0046615

Report Period Beginning: 1/1/2008

Ending: 12/31/2008

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	\$ 3,416,157	1
2	Discounts and Allowances for all Levels	321,321	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,737,478	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	462,756	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 462,756	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	5,102	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	312,026	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	32,167	20
21	Other Medical Services	6,650	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 355,945	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	1,220	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,220	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,557,399	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	681,965	31
32	Health Care	1,895,166	32
33	General Administration	598,444	33
	B. Capital Expense		
34	Ownership	443,589	34
	C. Ancillary Expense		
35	Special Cost Centers	378,230	35
36	Provider Participation Fee	54,354	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,051,748	40
41	Income before Income Taxes (line 30 minus line 40)**	505,651	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 505,651	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 part of 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: 1/1/2008

Ending: 12/31/2008

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,977	2,025	\$ 48,111	\$ 23.76	1
2	Assistant Director of Nursing	1,993	1,993	40,241	20.19	2
3	Registered Nurses	12,310	12,758	256,830	20.13	3
4	Licensed Practical Nurses	16,482	17,106	277,012	16.19	4
5	CNAs & Orderlies	55,473	57,967	584,851	10.09	5
6	CNA Trainees					6
7	Licensed Therapist	10,425	10,474	326,474	31.17	7
8	Rehab/Therapy Aides	25	25	322	12.88	8
9	Activity Director	1,961	1,961	18,529	9.45	9
10	Activity Assistants	749	785	5,835	7.43	10
11	Social Service Workers	2,080	2,080	21,375	10.28	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	37,006	17.79	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,410	14,711	113,916	7.74	15
16	Dishwashers					16
17	Maintenance Workers	1,985	2,225	38,427	17.27	17
18	Housekeepers	8,161	8,310	71,376	8.59	18
19	Laundry	5,735	6,055	51,141	8.45	19
20	Administrator	2,080	2,080	62,870	30.23	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,325	2,525	26,649	10.55	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: CPC	3,860	3,860	81,073	21.00	32
33	Other(specify) <u>Transportation</u>	2,023	2,056	17,318	8.42	33
34	TOTAL (lines 1 - 33)	146,134	151,076	\$ 2,079,356 *	\$ 13.76	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	57 hrs.	\$ 867	1(3)	35
36	Medical Director	Monthly	24,000	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,200	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)		\$ 26,067		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>62,870</u>	<u>Workers' Compensation Insurance</u>	\$ <u>33,529</u>	<u>IDPH License Fee</u>	\$ <u>1,990</u>	
				<u>Unemployment Compensation Insurance</u>	<u>33,735</u>	<u>Advertising: Employee Recruitment</u>	<u>1,656</u>	
				<u>FICA Taxes</u>	<u>154,781</u>	<u>Health Care Worker Background Check</u>		
				<u>Employee Health Insurance</u>	<u>78,911</u>	(Indicate # of checks performed)		
				<u>Employee Meals</u>		<u>Patient Background Checks</u>	<u>206</u> <u>2,066</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Miscellaneous Licenses & Permits</u>	<u>300</u>	
				<u>Employee Relations</u>	<u>1,558</u>	<u>Home Office Allocation</u>	<u>3,782</u>	
				<u>Employee Retirement</u>	<u>3,101</u>	<u>IHCA Dues</u>	<u>2,900</u>	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ <u>62,870</u>					
(List each licensed administrator separately.)								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
<u>Management Fees-See Page 6, Eliminated on P 3, C 7</u>			\$ <u>126,000</u>				<u>Out-of-State Travel</u>	\$
							<u>In-State Travel</u>	
							<u>Seminar Expense</u>	<u>50</u>
							<u>Home Office Allocation</u>	<u>449</u>
							<u>Entertainment Expense</u>	()
TOTAL (agree to Schedule V, line 17, col. 3)			\$ <u>126,000</u>				(agree to Sch. V, line 24, col. 8)	
(Attach a copy of any management service agreement)							TOTAL	\$ <u>499</u>
C. Professional Services								
Vendor/Payee	Type			Amount				
<u>Verizon North</u>	<u>Computer Services</u>			\$ <u>492</u>				
<u>LTC Solutions</u>	<u>Computer Services</u>			<u>1,600</u>				
<u>Wabash Independent Networks</u>	<u>Computer Services</u>			<u>961</u>				
<u>E-Health Data Solutions</u>	<u>Computer Services</u>			<u>2,700</u>				
<u>SKS Engineers</u>	<u>Architectural Services</u>			<u>1,526</u>				
TOTAL (agree to Schedule V, line 19, column 3)			\$ <u>7,279</u>	TOTAL		\$		
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications

**See instructions.

Flora Rehabilitation & Health Care Center

0046615

Period Beginning 1/1/2008

Period End 12/31/2008

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		7,279

Home Office Allocation

Heyl, Royster, Voelker & Allen	Legal	176
GoffWilson, P.A.	Legal	587
U.S. Bank	Legal	1,025
Ginoli & Company	Accountants	5,163
U.S. Bank	Accountants	629
RSM McGladrey	Accountants	13
Emdeon Business Services	Computer Services	69
Advanced Answers on Demand	Computer Services	95
Access 2 Go	Computer Services	1,112
Ivans	Computer Services	1,071
Kemper Technology	Computer Services	170
VisionShare	Computer Services	602
Logmein	Computer Services	64
Comm Net Communiations	Computer Services	46
Charter Communications	Computer Services	17
Advanced System Designs	Computer Services	14
Consolidated Communications	Computer Services	21
Miscellaneous Vendors	Computer Services	15
CDW	Computer Services	313
Miscellaneous Vendors	Miscellaneous	83

Total (agree to Schedule V, line 19, column 8)	<u><u>18,564</u></u>
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Flora Rehabilitation & Health Care Center

0046615

Period Beginning 1/1/2008

Period End 12/31/2008

XIX. SUPPORT SCHEDULES

Schedule 21B

A. Administrative Salaries

<u>Name</u>	<u>Function</u>	<u>Ownership %</u>	<u>Amount</u>
Nancy Geisinger	Administrator	0	62,870
	Total		<u>62,870</u>

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

Report Period Beginning:

1/1/2008

Ending:

12/31/2008**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. 2,900 -IHCA
- (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? No
- (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. \$ 24,389 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? N/A
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. \$ 54,354
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. \$ 5,102
- (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. \$ No
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? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. \$ No
- (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 currently 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