

Facility Name & ID Number Flora Gardens Care Center

0048538 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

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>56</u>	Skilled (SNF)	<u>56</u>	<u>20,440</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>54</u>	Intermediate (ICF)	<u>54</u>	<u>19,710</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>110</u>	TOTALS	<u>110</u>	<u>40,150</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	Private Pay	4 Other	Total	
8	SNF			<u>2,024</u>	<u>2,024</u>	8
9	SNF/PED					9
10	ICF	<u>12,958</u>	<u>2,460</u>		<u>15,418</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>12,958</u>	<u>2,460</u>	<u>2,024</u>	<u>17,442</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 43.44%

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 1/31/2007

J. Was the facility purchased or leased after January 1, 1978?
YES Date 1/31/2007 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 56 and days of care provided 1,867

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: 12/31/2009 Fiscal Year: 12/31/2009

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

Facility Name & ID Number Flora Gardens Care Center # 0048538 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

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	111,811	8,249		120,060		120,060	3,050	123,110		1
2	Food Purchase		92,685		92,685		92,685	(425)	92,260		2
3	Housekeeping	73,938	14,980		88,918		88,918	29	88,947		3
4	Laundry	17,205	9,263		26,468		26,468		26,468		4
5	Heat and Other Utilities			80,731	80,731		80,731	301	81,032		5
6	Maintenance	46,746	11,929	18,451	77,126		77,126	1,477	78,603		6
7	Other (specify):* <u>Home Off. Ben. All.</u>							551	551		7
8	TOTAL General Services	249,700	137,106	99,182	485,988		485,988	4,983	490,971		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	811,630	90,757	9,698	912,085		912,085	1,655	913,740		10
10a	Therapy	133,047	31	1,834	134,912		134,912		134,912		10a
11	Activities	34,841	107	314	35,262		35,262	(652)	34,610		11
12	Social Services	40,203	45		40,248		40,248		40,248		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Off. Ben. All.</u>							227	227		15
16	TOTAL Health Care and Programs	1,019,721	90,940	17,846	1,128,507		1,128,507	1,230	1,129,737		16
	C. General Administration										
17	Administrative	12,500		94,500	107,000		107,000	(80,017)	26,983		17
18	Directors Fees										18
19	Professional Services			10,350	10,350		10,350	5,882	16,232		19
20	Dues, Fees, Subscriptions & Promotions			7,206	7,206		7,206	1,565	8,771		20
21	Clerical & General Office Expenses	30,203	8,410	9,774	48,387		48,387	34,848	83,235		21
22	Employee Benefits & Payroll Taxes			207,599	207,599		207,599	5,596	213,195		22
23	Inservice Training & Education							317	317		23
24	Travel and Seminar							98	98		24
25	Other Admin. Staff Transportation			9,338	9,338		9,338	1,533	10,871		25
26	Insurance-Prop.Liab.Malpractice			37,190	37,190		37,190	636	37,826		26
27	Other (specify):* <u>Home Off. Ben. All.</u>							8,349	8,349		27
28	TOTAL General Administration	42,703	8,410	375,957	427,070		427,070	(21,193)	405,877		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,312,124	236,456	492,985	2,041,565		2,041,565	(14,980)	2,026,585		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 Gardens Care Center

#0048538

Report Period Beginning:

1/1/2009

Ending:

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			105,807	105,807		105,807	(17,724)	88,083			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			118,057	118,057		118,057	15,213	133,270			32
33	Real Estate Taxes			43,356	43,356		43,356	386	43,742			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			4,152	4,152		4,152	370	4,522			35
36	Other (specify):*											36
37	TOTAL Ownership			271,372	271,372		271,372	(1,755)	269,617			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		71,908		71,908		71,908		71,908			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			60,225	60,225		60,225		60,225			42
43	Other (specify):* Non-allowable Cost		394	136,373	136,767		136,767	(136,767)				43
44	TOTAL Special Cost Centers		72,302	196,598	268,900		268,900	(136,767)	132,133			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,312,124	308,758	960,955	2,581,837		2,581,837	(153,502)	2,428,335			45

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

Flora Gardens Care Center

ID# 0048538

Report Period Beginning: 1/1/2009

Ending: 12/31/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (21,254)	43	1
2	X-Rays-Part A	(4,246)	43	2
3	Resident Flowers	(631)	43	3
4	Offset Miscellaneous Office Supplies Revenue	(54)	21	4
5	Disallow Special Events	(178)	43	5
6	Offset Transportation Revenue	(652)	11	6
7	Offset Nursing Supply Revenue	(191)	10	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
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21				21
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39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(27,206)		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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 3,050	\$ 3,050	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	69	69	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	29	29	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	301	301	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,477	1,477	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	551	551	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	1,846	1,846	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%	227	227	10
11	V	17 Administrative	94,500	Petersen Health Care, Inc.	100.00%	14,483	(80,017)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	4,277	4,277	12
13	V							13
14	Total		\$ 94,500			\$ 26,310	\$ * (68,190)	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%	\$ 1,192	\$	1,192	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	31,103		31,103	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	317		317	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	98		98	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	1,533		1,533	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	636		636	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	8,349		8,349	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	2,514		2,514	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	3,867		3,867	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	386		386	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%	370		370	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		\$			\$ 50,365	\$ *	50,365	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 Companies, LLC	100.00%	\$ 0	\$	15	
16	V	2 Food		Petersen Companies, LLC	100.00%	0		16	
17	V	3 Housekeeping		Petersen Companies, LLC	100.00%	0		17	
18	V	4 Laundry		Petersen Companies, LLC	100.00%	0		18	
19	V	5 Utilities		Petersen Companies, LLC	100.00%	0		19	
20	V	6 Maintenance		Petersen Companies, LLC	100.00%	0		20	
21	V	7 Mgmt. Allocation of Benefits		Petersen Companies, LLC	100.00%	0		21	
22	V	10 Nursing and Medical Records		Petersen Companies, LLC	100.00%	0		22	
23	V	10A Therapy		Petersen Companies, LLC	100.00%	0		23	
24	V	15 Mgmt. Allocation of Benefits		Petersen Companies, LLC	100.00%	0		24	
25	V	17 Administrative		Petersen Companies, LLC	100.00%	0		25	
26	V	19 Professional Services		Petersen Companies, LLC	100.00%	1,605	1,605	26	
27	V	20 Dues, Fees, Subs & Promotions		Petersen Companies, LLC	100.00%	373	373	27	
28	V	21 Clerical and General Office		Petersen Companies, LLC	100.00%	3,799	3,799	28	
29	V	22 Employee Benefits & Payroll		Petersen Companies, LLC	100.00%	5,596	5,596	29	
30	V	24 Travel and Seminar		Petersen Companies, LLC	100.00%	0		30	
31	V	25 Other Admin. Staff Transport.		Petersen Companies, LLC	100.00%	0		31	
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Companies, LLC	100.00%	0		32	
33	V	27 Mgmt. Allocation of Benefits		Petersen Companies, LLC	100.00%	0		33	
34	V	30 Depreciation		Petersen Companies, LLC	100.00%	414	414	34	
35	V	32 Interest		Petersen Companies, LLC	100.00%	7,586	7,586	35	
36	V	33 Real Estate Taxes		Petersen Companies, LLC	100.00%	0		36	
37	V	34 Rent-Facility and Grounds		Petersen Companies, LLC	100.00%	0		37	
38	V	35 Rent-Equipment & Vehicles		Petersen Companies, LLC	100.00%	0		38	
39	Total		\$			\$ 19,373	\$ *	19,373	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 Network, LLC	100.00%	\$	\$	15
16	V	2 Food		Petersen Health Network, LLC	100.00%			16
17	V	3 Housekeeping		Petersen Health Network, LLC	100.00%			17
18	V	4 Laundry		Petersen Health Network, LLC	100.00%			18
19	V	5 Utilities		Petersen Health Network, LLC	100.00%			19
20	V	6 Maintenance		Petersen Health Network, LLC	100.00%			20
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%			21
22	V	10 Nursing and Medical Records		Petersen Health Network, LLC	100.00%			22
23	V	10A Therapy		Petersen Health Network, LLC	100.00%			23
24	V	15 Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%			24
25	V	17 Administrative		Petersen Health Network, LLC	100.00%			25
26	V	19 Professional Services		Petersen Health Network, LLC	100.00%			26
27	V	20 Dues, Fees, Subs & Promotions		Petersen Health Network, LLC	100.00%			27
28	V	21 Clerical and General Office		Petersen Health Network, LLC	100.00%			28
29	V	23 Inservice Training & Education		Petersen Health Network, LLC	100.00%			29
30	V	24 Travel and Seminar		Petersen Health Network, LLC	100.00%			30
31	V	25 Other Admin. Staff Transport.		Petersen Health Network, LLC	100.00%			31
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Network, LLC	100.00%			32
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%			33
34	V	30 Depreciation		Petersen Health Network, LLC	100.00%			34
35	V	32 Interest		Petersen Health Network, LLC	100.00%	4,533	4,533	35
36	V	33 Real Estate Taxes		Petersen Health Network, LLC	100.00%			36
37	V	34 Rent-Facility and Grounds		Petersen Health Network, LLC	100.00%			37
38	V	35 Rent-Equipment & Vehicles		Petersen Health Network, LLC	100.00%			38
39	Total		\$			\$ 4,533	\$ * 4,533	39

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

Facility Name & ID Number

Flora Gardens Care Center

0048538

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

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	157,130	0.68	1.13	Salary	\$ 1,983	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	\$ 1,983		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 Gardens Care Center# 0048538

Report Period Beginning:

1/1/2009Ending: 2/31/2009

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	1,493,044	75	\$ 261,102	\$ 259,584	17,442	\$ 3,050	1
2	2	Food	Resident Days	1,493,044	75	5,864	0	17,442	69	2
3	3	Housekeeping	Resident Days	1,493,044	75	2,458	0	17,442	29	3
4	4	Laundry	Resident Days	1,493,044	75	0	0	17,442	0	4
5	5	Utilities	Resident Days	1,493,044	75	25,776	0	17,442	301	5
6	6	Maintenance	Resident Days	1,493,044	75	126,463	107,810	17,442	1,477	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	47,148	0	17,442	551	7
8	10	Nursing and Medical Records	Resident Days	1,493,044	75	158,020	151,697	17,442	1,846	8
9	10A	Therapy	Resident Days	1,493,044	75	0	0	17,442	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	19,462	0	17,442	227	10
11	17	Administrative	Resident Days	1,493,044	75	3,315,953	3,315,953	17,442	14,483	11
12	19	Professional Services	Resident Days	1,493,044	75	366,089	0	17,442	4,277	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,493,044	75	102,022	0	17,442	1,192	13
14	21	Clerical and General Office	Resident Days	1,493,044	75	2,662,394	2,253,243	17,442	31,103	14
15	23	Inservice Training & Education	Resident Days	1,493,044	75	27,176	0	17,442	317	15
16	24	Travel and Seminar	Resident Days	1,493,044	75	8,381	0	17,442	98	16
17	25	Other Admin. Staff Transport.	Resident Days	1,493,044	75	131,200	0	17,442	1,533	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,493,044	75	54,425	0	17,442	636	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	714,650	0	17,442	8,349	19
20	30	Depreciation	Resident Days	1,493,044	75	215,197	0	17,442	2,514	20
21	32	Interest	Resident Days	1,493,044	75	330,981	0	17,442	3,867	21
22	33	Real Estate Taxes	Resident Days	1,493,044	75	33,065	0	17,442	386	22
23	34	Rent-Facility and Grounds	Resident Days	1,493,044	75	0	0	17,442	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,493,044	75	31,635	0	17,442	370	24
25	TOTALS					\$ 8,639,461	\$ 6,088,287		\$ 76,675	25

Facility Name & ID Number Flora Gardens Care Center# 0048538

Report Period Beginning:

1/1/2009Ending: 2/31/2009

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 Companies, LLC

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	198,749	13	\$	\$	14,835	\$	1
2	2	Food	Resident Days	198,749	13			14,835		2
3	3	Housekeeping	Resident Days	198,749	13			14,835		3
4	4	Laundry	Resident Days	198,749	13			14,835		4
5	5	Utilities	Resident Days	198,749	13			14,835		5
6	6	Maintenance	Resident Days	198,749	13			14,835		6
7	7	Mgmt. Allocation of Benefits	Resident Days	198,749	13			14,835		7
8	10	Nursing and Medical Records	Resident Days	198,749	13			14,835		8
9	10A	Therapy	Resident Days	198,749	13			14,835		9
10	15	Mgmt. Allocation of Benefits	Resident Days	198,749	13			14,835		10
11	17	Administrative	Resident Days	198,749	13			14,835		11
12	19	Professional Services	Resident Days	198,749	13	21,502		14,835	1,605	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	198,749	13	4,999		14,835	373	13
14	21	Clerical and General Office	Resident Days	198,749	13	50,893		14,835	3,799	14
15	22	Employee Benefits & Payroll	Resident Days	198,749	13	74,975		14,835	5,596	15
16	24	Travel and Seminar	Resident Days	198,749	13			14,835		16
17	25	Other Admin. Staff Transport.	Resident Days	198,749	13			14,835		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	198,749	13			14,835		18
19	27	Mgmt. Allocation of Benefits	Resident Days	198,749	13			14,835		19
20	30	Depreciation	Resident Days	198,749	13	5,550		14,835	414	20
21	32	Interest	Resident Days	198,749	13	101,632		14,835	7,586	21
22	33	Real Estate Taxes	Resident Days	198,749	13			14,835		22
23	34	Rent-Facility and Grounds	Resident Days	198,749	13			14,835		23
24	35	Rent-Equipment & Vehicles	Resident Days	198,749	13			14,835		24
25	TOTALS					\$ 259,551	\$		\$ 19,373	25

Facility Name & ID Number Flora Gardens Care Center# 0048538

Report Period Beginning:

1/1/2009Ending: 2/31/2009

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 Network, LLC

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	32,882	12	\$	\$	2,607	\$	1
2	2	Food	Resident Days	32,882	12			2,607		2
3	3	Housekeeping	Resident Days	32,882	12			2,607		3
4	4	Laundry	Resident Days	32,882	12			2,607		4
5	5	Utilities	Resident Days	32,882	12			2,607		5
6	6	Maintenance	Resident Days	32,882	12			2,607		6
7	7	Mgmt. Allocation of Benefits	Resident Days	32,882	12			2,607		7
8	10	Nursing and Medical Records	Resident Days	32,882	12			2,607		8
9	10A	Therapy	Resident Days	32,882	12			2,607		9
10	15	Mgmt. Allocation of Benefits	Resident Days	32,882	12			2,607		10
11	17	Administrative	Resident Days	32,882	12			2,607		11
12	19	Professional Services	Resident Days	32,882	12			2,607		12
13	20	Dues, Fees, Subs & Promotions	Resident Days	32,882	12			2,607		13
14	21	Clerical and General Office	Resident Days	32,882	12			2,607		14
15	23	Inservice Training & Education	Resident Days	32,882	12			2,607		15
16	24	Travel and Seminar	Resident Days	32,882	12			2,607		16
17	25	Other Admin. Staff Transport.	Resident Days	32,882	12			2,607		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	32,882	12			2,607		18
19	27	Mgmt. Allocation of Benefits	Resident Days	32,882	12			2,607		19
20	30	Depreciation	Resident Days	32,882	12			2,607		20
21	32	Interest	Resident Days	32,882	12	57,172		2,607	4,533	21
22	33	Real Estate Taxes	Resident Days	32,882	12			2,607		22
23	34	Rent-Facility and Grounds	Resident Days	32,882	12			2,607		23
24	35	Rent-Equipment & Vehicles	Resident Days	32,882	12			2,607		24
25	TOTALS					\$ 57,172	\$		\$ 4,533	25

Facility Name & ID Number

Flora Gardens Care Center

0048538

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

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										
										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	Associated Bank		X	Mortgage	\$14,365.73	9/28/2006	\$ 1,702,800	\$	Paid	0.0800	\$ 106,804	1							
2	The Private Bank		X	Mortgage	Varies	11/1/09	1,298,046	1,294,657	10/31/14	Varies	9,315	2							
3							Interest Income Offset				(773)	3							
4							Home Office Allocation-PHC				3,867	4							
5							Home Office Allocation-PC				7,586	5							
Working Capital																			
6							Home Office Allocation-PHN				4,533	6							
7							Amortization Expense				1,938	7							
8												8							
9	TOTAL Facility Related				\$14,365.73		\$ 3,000,846	\$ 1,294,657			\$ 133,270	9							
B. Non-Facility Related*																			
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$ 3,000,846	\$ 1,294,657			\$ 133,270	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.)

Facility Name & ID Number Flora Gardens Care Center

0048538

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,770 B. General Construction Type: Exterior Masonry Frame Concrete Block 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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>216,659</u>	<u>2006</u>	<u>\$ 50,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	216,659		\$ 50,000	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	110	2006	1970	\$ 1,615,000	\$	30	\$ 53,833	\$ 53,833	\$ 188,416
5									
6									
7									
8									
Improvement Type**									
9	Original Land Improvements	2006		15,000		15	1,000	1,000	3,500
10	Awning	2006		1,026		15	68	68	238
11	Install Drains, Venting and Sewer Lines in Utility Room	2007		3,250		15	217	217	542
12	Install Sidewalks	2007		10,270		15	685	685	1,712
13	Carpeting for 3 Offices	2007		2,099		10	210	210	525
14	Gutter Replacement	2007		661		15	44	44	110
15	Paint Dining Room	2007		3,875		10	388	388	970
16	Window Treatments	2007		755		10	76	76	190
17	Air Conditioner	2007		4,300		15	287	287	717
18	Interior work	2009		27,500		20	688	688	688
19	Exterior work	2009		37,430		20	936	936	936
20	Lock Installation	2009		9,265		7	662	662	662
21	Electrical Circuit	2009		2,700		7	193	193	193
22									
23									
24									
25									
26									
27	Land Improvements Booked				1,902			(1,902)	
28	Building Booked				64,600			(64,600)	
29	Building Improvement Booked				3,208			(3,208)	
30									
31									
32	2009-Home Office Allocation-Land Improvements			574			36	36	
33	2009-Home Office Allocation-Building Improvements			8,574			206	206	
34									
35									
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)	\$	\$		\$	\$	\$	70

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

Facility Name & ID Number Flora Gardens Care Center

0048538

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

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	\$ 234,258	\$ 33,830	\$ 23,426	\$ (10,404)	10 yrs.	\$ 79,829	71
72	Current Year Purchases	38,635	1,247	1,932	685	10 yrs.	1,932	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			2,686	2,686			74
75	TOTALS	\$ 272,893	\$ 35,077	\$ 28,044	\$ (7,033)		\$ 81,761	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	1997 Dodge Ram	2009	\$ 5,100	\$ 1,020	\$ 510	\$ (510)	5	\$ 510	76
77										77
78										78
79										79
80	TOTALS			\$ 5,100	\$ 1,020	\$ 510	\$ (510)		\$ 510	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)	\$ 2,070,272	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 105,807	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 88,083	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (17,724)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 281,670	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: \$ 4,522 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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* 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 Gardens Care Center
0048538**

**Period Beginning 1/1/2009
Period End 12/31/2009**

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$	258
Dishwasher		708
Laundry		(79)
Maintenance Equipment		168
Copier		3,097
Home Office allocation		370
		<u>4,522</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)	2180 hrs	\$ 65,475		\$		2,180	\$ 65,475	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(1), 10A(2)	155 hrs	9,061			31	155	9,092	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				71,908		71,908	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Respiratory Therapy</u>	10A(3)			122	1,834		122	1,834	12
13	Other (specify):									13
14	TOTAL			\$ 74,536	122	\$ 1,834	\$ 71,939	2,457	\$ 148,309	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 Gardens Care Center# 0048538Report Period Beginning: 1/1/2009Ending: 12/31/2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2009

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ (160,070)	\$ (160,070)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>80,000</u>)	304,018	304,018	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	55,781	55,781	6
7	Other Prepaid Expenses	10,064	10,064	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 209,793	\$ 209,793	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		50,000	13
14	Buildings, at Historical Cost	1,693,520	1,623,574	14
15	Leasehold Improvements, at Historical Cost	88,855	118,705	15
16	Equipment, at Historical Cost	278,749	277,993	16
17	Accumulated Depreciation (book methods)	(321,699)	(281,670)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe <u>Loan costs</u>)			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,739,425	\$ 1,788,602	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,949,218	\$ 1,998,395	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 296,988	\$ 296,988	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	71,124	71,124	30
31	Accrued Taxes Payable (excluding real estate taxes)	959	959	31
32	Accrued Real Estate Taxes(Sch.IX-B)	42,300	42,300	32
33	Accrued Interest Payable	4,739	4,739	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Payroll Withholdings</u>	55,426	55,426	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 471,536	\$ 471,536	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,294,657	1,294,657	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,294,657	\$ 1,294,657	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,766,193	\$ 1,766,193	46
47	TOTAL EQUITY(page 18, line 24)	\$ 183,025	\$ 232,202	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,949,218	\$ 1,998,395	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 20,178	1
2	Restatements (describe):		2
3	Prior period adjustments	(110,835)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (90,657)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(184,363)	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	(2,500)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Rounding	2	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (186,861)	17
	B. Transfers (Itemize):		
18	Transfer of net assets	460,543	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 460,543	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 183,025	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Flora Gardens Care Center# 0048538Report Period Beginning: 1/1/2009Ending: 12/31/2009

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	\$ 1,990,764	1
2	Discounts and Allowances for all Levels	(19,911)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,970,853	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	264,226	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 264,226	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	494	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	132,850	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	24,295	20
21	Other Medical Services	3,086	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 160,725	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	773	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 773	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous / Transportation Revenue</u>	897	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 897	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,397,474	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	485,988	31
32	Health Care	1,128,507	32
33	General Administration	427,070	33
B. Capital Expense			
34	Ownership	271,372	34
C. Ancillary Expense			
35	Special Cost Centers	208,675	35
36	Provider Participation Fee	60,225	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,581,837	40
41	Income before Income Taxes (line 30 minus line 40)**	(184,363)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (184,363)	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 Gardens Care Center**

0048538

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

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	1,994	2,050	49,107	\$ 23.95	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,064	10,470	207,482	19.82	3
4	Licensed Practical Nurses	8,022	8,337	139,050	16.68	4
5	CNAs & Orderlies	35,952	37,507	376,883	10.05	5
6	CNA Trainees					6
7	Licensed Therapist	2,332	2,335	74,536	31.92	7
8	Rehab/Therapy Aides	2,314	2,324	58,511	25.18	8
9	Activity Director	2,080	2,080	25,174	12.10	9
10	Activity Assistants					10
11	Social Service Workers	2080	2,080	40,203	19.33	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	21,632	10.40	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,604	10,097	90,179	8.93	15
16	Dishwashers					16
17	Maintenance Workers	4,059	4,152	46,746	11.26	17
18	Housekeepers	7,758	8,133	73,938	9.09	18
19	Laundry	1,887	2,047	17,205	8.40	19
20	Administrator	1,040	1,040	25,000	24.04	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,488	2,505	30,203	12.06	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: Transportation	1,082	1,083	9,667	8.93	32
33	Other(specify) Care Plan Coord.	1,987	2,053	39,108	19.05	33
34	TOTAL (lines 1 - 33)	96,823	100,373	\$ 1,324,624 *	\$ 13.20	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		\$		35
36	Medical Director	Monthly	6,000	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)		\$ 7,200		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

Flora Gardens Care Center

0048538

Period Beginning 1/1/2009

Period End 12/31/2009

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		10,350

Home Office Allocation

Heyl, Royster, Voelker & Allen	Legal	27
GoffWilson, P.A.	Legal	39
Jackson Lewis	Legal	306
Peter Gartelos	Legal	30
Misc.	Legal	26
Ginoli & Company	Accountants	2,285
Miscellaneous Vendors	Computer Services	28
Emdeon Business Services	Computer Services	13
Advanced Answers on Demand	Computer Services	1,643
Access 2 Go	Computer Services	158
Ivans	Computer Services	19
Kemper Technology	Computer Services	447
VisionShare	Computer Services	139
MediFax	Computer Services	57
LogmeIn	Computer Services	24
Charter Communications	Computer Services	1
Simple LTC	Computer Services	379
Miscellaneous Vendors	Miscellaneous	261
Total (agree to Schedule V, line 19, column 8)		<u>16,232</u>

Facility Name & ID Number Flora Gardens Care Center# 0048538Report Period Beginning: 1/1/2009Ending: 12/31/2009**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. 0
- (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. \$ 4,347 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. \$ 60,225
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. \$ 494
- (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? N/A
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
- (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.