



Facility Name & ID Number Flora Rehabilitation & Health Care Center

# 0046615 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	32	Skilled (SNF)	32	11,680	1
2		Skilled Pediatric (SNF/PED)			2
3	67	Intermediate (ICF)	67	24,455	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	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	4 Private Pay	Other	Total	
8	SNF			5,325	5,325	8
9	SNF/PED					9
10	ICF	19,402	4,089	528	24,019	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,402	4,089	5,853	29,344	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.21%

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 5,325

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 Rehabilitation & Health Care Center # 0046615 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
	<b>A. General Services</b>										
1	Dietary	158,104	16,804		174,908		174,908	5,132	180,040		1
2	Food Purchase		164,180		164,180		164,180	(4,413)	159,767		2
3	Housekeeping	79,097	20,488		99,585		99,585	48	99,633		3
4	Laundry	47,344	11,739		59,083		59,083		59,083		4
5	Heat and Other Utilities			111,775	111,775		111,775	507	112,282		5
6	Maintenance	40,583	12,652	20,513	73,748		73,748	2,540	76,288		6
7	Other (specify):* <u>Home Off. Ben. All.</u>							927	927		7
8	<b>TOTAL General Services</b>	325,128	225,863	132,288	683,279		683,279	4,741	688,020		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			24,000	24,000		24,000		24,000		9
10	Nursing and Medical Records	1,354,067	148,696	5,041	1,507,804		1,507,804	2,900	1,510,704		10
10a	Therapy	425,952	981	385	427,318		427,318		427,318		10a
11	Activities	48,759	798	1,449	51,006		51,006		51,006		11
12	Social Services	25,603	3		25,606		25,606		25,606		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Off. Ben. All.</u>							383	383		15
16	<b>TOTAL Health Care and Programs</b>	1,854,381	150,478	30,875	2,035,734		2,035,734	3,283	2,039,017		16
	<b>C. General Administration</b>										
17	Administrative	16,250		199,000	215,250		215,250	(146,318)	68,932		17
18	Directors Fees										18
19	Professional Services			6,193	6,193		6,193	19,328	25,521		19
20	Dues, Fees, Subscriptions & Promotions			5,290	5,290		5,290	3,486	8,776		20
21	Clerical & General Office Expenses	29,418	8,603	8,310	46,331		46,331	61,442	107,773		21
22	Employee Benefits & Payroll Taxes			322,335	322,335		322,335	7,532	329,867		22
23	Inservice Training & Education							749	749		23
24	Travel and Seminar			35	35		35	165	200		24
25	Other Admin. Staff Transportation			11,728	11,728		11,728	6,356	18,084		25
26	Insurance-Prop.Liab.Malpractice			32,693	32,693		32,693	1,070	33,763		26
27	Other (specify):* <u>Home Off. Ben. All.</u>							14,046	14,046		27
28	<b>TOTAL General Administration</b>	45,668	8,603	585,584	639,855		639,855	(32,144)	607,711		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,225,177	384,944	748,747	3,358,868		3,358,868	(24,120)	3,334,748		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: 1/1/2009 Ending: 12/31/2009

## 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			184,732	184,732		184,732	(20,517)	164,215			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			182,496	182,496		182,496	30,990	213,486			32
33	Real Estate Taxes			66,760	66,760		66,760	650	67,410			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			14,914	14,914		14,914	624	15,538			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			448,902	448,902		448,902	11,747	460,649			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		208,447		208,447		208,447		208,447			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,203	54,203		54,203		54,203			42
43	Other (specify):* <b>Non-allowable Cost</b>		387	167,004	167,391		167,391	(167,391)				43
44	<b>TOTAL Special Cost Centers</b>		208,834	221,207	430,041		430,041	(167,391)	262,650			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,225,177	593,778	1,418,856	4,237,811		4,237,811	(179,764)	4,058,047			45

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

**VI. ADJUSTMENT DETAIL**

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

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

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(1,767)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(50,290)	30		9
10	Interest and Other Investment Income	(1,396)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(283)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,431)	43		18
19	Entertainment				19
20	Contributions	(70)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(106,935)	43		24
25	Fund Raising, Advertising and Promotional	(2,576)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg. 5A	(59,306)	Various		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (224,054)		\$	30

**B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)**

		1	2	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	44,290	Various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 44,290		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (179,764)		37

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

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

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

**BHF USE ONLY**

48		49		50		51		52	
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Flora Rehabilitation & Health Care Center

ID# 0046615

Report Period Beginning: 1/1/2009

Ending: 12/31/2009

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Labs-Part A	\$ (42,139)	43	1
2	X-Rays-Part A	(10,256)	43	2
3	Offset Miscellaneous Nursing Supplies Revenue	(206)	10	3
4	Offset Miscellaneous Food Revenue	(4,528)	2	4
5	Offset Miscellaneous Office Supplies Revenue	(243)	21	5
6	Resident Flowers	(129)	43	6
7	Disallowed Special Events	(1,805)	43	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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43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(59,306)		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%	\$ 5,132	\$ 5,132	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	115	115	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	48	48	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	507	507	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	2,485	2,485	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	927	927	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	3,106	3,106	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%	383	383	10
11	V	17 Administrative	199,000	Petersen Health Care, Inc.	100.00%	52,682	(146,318)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	7,195	7,195	12
13	V							13
14	Total		\$ 199,000			\$ 72,580	\$ * (126,420)	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%	\$ 2,005	\$	2,005	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	52,326		52,326	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	534		534	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	165		165	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	2,579		2,579	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	1,070		1,070	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	14,046		14,046	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	4,229		4,229	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	6,505		6,505	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	650		650	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%	622		622	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	<b>Total</b>		\$			\$ 84,731	\$ *	84,731	39

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

Facility Name & ID Number Flora Rehabilitation & Health Care Center# 0046615Report Period Beginning: 1/1/2009Ending: 12/31/2009

## 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	\$	15	
16	V	2 Food		Petersen Health Care II, Inc.	100.00%	0		16	
17	V	3 Housekeeping		Petersen Health Care II, Inc.	100.00%	0		17	
18	V	4 Laundry		Petersen Health Care II, Inc.	100.00%	0		18	
19	V	5 Utilities		Petersen Health Care II, Inc.	100.00%	0		19	
20	V	6 Maintenance		Petersen Health Care II, Inc.	100.00%	55	55	20	
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0		21	
22	V	10 Nursing and Medical Records		Petersen Health Care II, Inc.	100.00%	0		22	
23	V	15 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0		23	
24	V	17 Administrative		Petersen Health Care II, Inc.	100.00%	0		24	
25	V	19 Professional Services		Petersen Health Care II, Inc.	100.00%	12,133	12,133	25	
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Care II, Inc.	100.00%	1,481	1,481	26	
27	V	21 Clerical and General Office		Petersen Health Care II, Inc.	100.00%	9,359	9,359	27	
28	V	22 Employee Benefits & Payroll		Petersen Health Care II, Inc.	100.00%	7,532	7,532	28	
29	V	23 Inservice Training & Education		Petersen Health Care II, Inc.	100.00%	215	215	29	
30	V	24 Travel and Seminar		Petersen Health Care II, Inc.	100.00%	0		30	
31	V	25 Other Admin. Staff Transport.		Petersen Health Care II, Inc.	100.00%	3,777	3,777	31	
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care II, Inc.	100.00%	0		32	
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0		33	
34	V	30 Depreciation		Petersen Health Care II, Inc.	100.00%	25,544	25,544	34	
35	V	32 Interest		Petersen Health Care II, Inc.	100.00%	25,881	25,881	35	
36	V	33 Real Estate Taxes		Petersen Health Care II, Inc.	100.00%	0		36	
37	V	34 Rent-Facility and Grounds		Petersen Health Care II, Inc.	100.00%	0		37	
38	V	35 Rent-Equipment & Vehicles		Petersen Health Care II, Inc.	100.00%	2	2	38	
39	Total		\$			\$ 85,979	\$ *	85,979	39

\* 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: 1/1/2009 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	155,777	1.15	1.91	Salary	\$ 3,336	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	\$ 3,336		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: 1/1/2009 Ending: 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	29,344	\$ 5,132	1
2	2	Food	Resident Days	1,493,044	75	5,864	0	29,344	115	2
3	3	Housekeeping	Resident Days	1,493,044	75	2,458	0	29,344	48	3
4	4	Laundry	Resident Days	1,493,044	75	0	0	29,344	0	4
5	5	Utilities	Resident Days	1,493,044	75	25,776	0	29,344	507	5
6	6	Maintenance	Resident Days	1,493,044	75	126,463	107,810	29,344	2,485	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	47,148	0	29,344	927	7
8	10	Nursing and Medical Records	Resident Days	1,493,044	75	158,020	151,697	29,344	3,106	8
9	10A	Therapy	Resident Days	1,493,044	75	0	0	29,344	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	19,462	0	29,344	383	10
11	17	Administrative	Resident Days	1,493,044	75	3,315,953	3,315,953	29,344	52,682	11
12	19	Professional Services	Resident Days	1,493,044	75	366,089	0	29,344	7,195	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,493,044	75	102,022	0	29,344	2,005	13
14	21	Clerical and General Office	Resident Days	1,493,044	75	2,662,394	2,253,243	29,344	52,326	14
15	23	Inservice Training & Education	Resident Days	1,493,044	75	27,176	0	29,344	534	15
16	24	Travel and Seminar	Resident Days	1,493,044	75	8,381	0	29,344	165	16
17	25	Other Admin. Staff Transport.	Resident Days	1,493,044	75	131,200	0	29,344	2,579	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,493,044	75	54,425	0	29,344	1,070	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	714,650	0	29,344	14,046	19
20	30	Depreciation	Resident Days	1,493,044	75	215,197	0	29,344	4,229	20
21	32	Interest	Resident Days	1,493,044	75	330,981	0	29,344	6,505	21
22	33	Real Estate Taxes	Resident Days	1,493,044	75	33,065	0	29,344	650	22
23	34	Rent-Facility and Grounds	Resident Days	1,493,044	75	0	0	29,344	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,493,044	75	31,635	0	29,344	622	24
25	TOTALS					\$ 8,639,461	\$ 6,088,287		\$ 157,311	25

Facility Name & ID Number Flora Rehabilitation & Health Care Center

# 0046615

Report Period Beginning:

1/1/2009

Ending: 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

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

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

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	336,837	13	\$	\$ 29,344	\$	1
2	2	Food	Resident Days	336,837	13		29,344		2
3	3	Housekeeping	Resident Days	336,837	13		29,344		3
4	4	Laundry	Resident Days	336,837	13		29,344		4
5	5	Utilities	Resident Days	336,837	13		29,344		5
6	6	Maintenance	Resident Days	336,837	13	628	29,344	55	6
7	7	Mgmt. Allocation of Benefits	Resident Days	336,837	13		29,344		7
8	10	Nursing and Medical Records	Resident Days	336,837	13		29,344		8
9	15	Mgmt. Allocation of Benefits	Resident Days	336,837	13		29,344		9
10	17	Administrative	Resident Days	336,837	13		29,344		10
11	19	Professional Services	Resident Days	336,837	13	139,269	29,344	12,133	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	336,837	13	17,001	29,344	1,481	12
13	21	Clerical and General Office	Resident Days	336,837	13	107,426	29,344	9,359	13
14	22	Employee Benefits & Payroll	Resident Days	336,837	13	86,458	29,344	7,532	14
15	23	Inservice Training & Education	Resident Days	336,837	13	2,464	29,344	215	15
16	24	Travel and Seminar	Resident Days	336,837	13		29,344		16
17	25	Other Admin. Staff Transport.	Resident Days	336,837	13	43,354	29,344	3,777	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	336,837	13		29,344		18
19	27	Mgmt. Allocation of Benefits	Resident Days	336,837	13		29,344		19
20	30	Depreciation	Resident Days	336,837	13	293,215	29,344	25,544	20
21	32	Interest	Resident Days	336,837	13	297,084	29,344	25,881	21
22	33	Real Estate Taxes	Resident Days	336,837	13		29,344		22
23	34	Rent-Facility and Grounds	Resident Days	336,837	13		29,344		23
24	35	Rent-Equipment & Vehicles	Resident Days	336,837	13	26	29,344	2	24
25	TOTALS					\$ 986,925	\$	\$ 85,979	25

**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			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1	US Bank		X	Mortgage Loan	Varies	1/4/05	\$ 2,912,000	\$ 2,519,672	12/18/2011	0.0699	\$ 181,153	1							
2	Ford		X	Purchase Vehicle	\$609.00	10/27/04	33,137		Paid	0.0390	753	2							
3							Interest Income Offset				(1,396)	3							
4							Home Office Allocation-PHC				6,505	4							
5							Home Office Allocation-PHC II				25,881	5							
<b>Working Capital</b>																			
6												6							
7												7							
8												8							
9	<b>TOTAL Facility Related</b>				\$609.00		\$ 2,945,137	\$ 2,519,672			\$ 212,896	9							
<b>B. Non-Facility Related*</b>																			
10							Amortization of Loan Costs				590	10							
11												11							
12												12							
13												13							
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 590	14							
15	<b>TOTALS (line 9+line14)</b>						\$ 2,945,137	\$ 2,519,672			\$ 213,486	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 Rehabilitation & Health Care Center

# 0046615 Report Period Beginning:

1/1/2009 Ending:

12/31/2009

**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	<b>TOTALS</b>	<b>278,784</b>		<b>\$ 129,000</b>	<b>3</b>

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	\$ 321,587
5									
6									
7									
8									
<b>Improvement Type**</b>									
9	Sidewalks		2006	3,605		15	240	240	840
10	Front Door Repair		2008	5,090		25	204	204	306
11	Rooftop A/C Repair		2008	2,619		15	174	174	261
12	B-Unit Shower Units		2008	14,000		25	560	560	840
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27	Land Improvements Booked				240			(240)	
28	Building Booked				88,621			(88,621)	
29	Building Improvement Booked				735			(735)	
30									
31									
32	2009-Home Office Allocation-Land Improvements			965			61	61	
33	2009-Home Office Allocation-Building Improvements			14,426			346	346	
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)	\$ 2,254,905	\$ 89,596		\$ 64,848	\$ (24,748)	\$ 323,834	70

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

Facility Name & ID Number Flora Rehabilitation & Health Care Center

# 0046615

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	\$ 638,310	\$ 88,871	\$ 63,830	\$ (25,041)	10 yrs.	\$ 316,291	71
72	Current Year Purchases	4,568	452	228	(224)	10 yrs.	228	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			29,773	29,773			74
75	TOTALS	\$ 642,878	\$ 89,323	\$ 93,831	\$ 4,508		\$ 316,519	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	\$ 5,813	\$ 5,536	\$ (277)	5	\$ 33,216	76
77										77
78										78
79										79
80	TOTALS			\$ 33,216	\$ 5,813	\$ 5,536	\$ (277)		\$ 33,216	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)	\$ 3,059,999	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 184,732	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 164,215	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (20,517)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 673,569	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?  YES  NO

If NO, see instructions.

		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: \$ 15,538 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 Rehabilitation & Health Care Center**  
**0046615**  
**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	\$	11,890
Dishwasher		
Maintenance Equipment		24
Copier		3,000
Home Office Allocation		624
		<u>15,538</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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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**

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(1)	3435 hrs	\$ 140,447		\$		3,435	\$ 140,447	1
2	Licensed Speech and Language Development Therapist	10A(1), 10A(2)	35 hrs	1,670			516	35	2,186	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(1), 10A(2)	8294 hrs	283,835			465	8,294	284,300	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				208,447		208,447	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)			26	385		26	385	12
13	Other (specify):									13
14	<b>TOTAL</b>			\$ 425,952	26	\$ 385	\$ 209,428	11,790	\$ 635,765	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.

**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	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 2,561,336	\$ 2,561,336	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>50,000</u> )	841,534	841,534	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	49,351	49,351	6
7	Other Prepaid Expenses	15,982	15,982	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 3,468,203	\$ 3,468,203	10
<b>B. Long-Term Assets</b>				
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	2,228,626	14
15	Leasehold Improvements, at Historical Cost	16,619	26,279	15
16	Equipment, at Historical Cost	672,595	676,094	16
17	Accumulated Depreciation (book methods)	(933,511)	(673,569)	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> )	1,180	1,180	22
23	Other(specify): <u>Goodwill</u>	18,710	18,710	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 2,122,398	\$ 2,406,320	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 5,590,601	\$ 5,874,523	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 650,451	\$ 650,451	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	139,286	139,286	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,901	2,901	31
32	Accrued Real Estate Taxes(Sch.IX-B)	65,100	65,100	32
33	Accrued Interest Payable	15,868	15,868	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Payroll Withholdings</u>	103,006	103,006	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 976,612	\$ 976,612	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,519,672	2,519,672	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 2,519,672	\$ 2,519,672	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 3,496,284	\$ 3,496,284	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 2,094,317	\$ 2,378,239	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 5,590,601	\$ 5,874,523	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,724,303</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>2008 Bad Debt Allowance Entered After CR Completion</b>	<b>(50,000)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>1,674,303</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>420,014</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>420,014</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>2,094,317</b>	<b>24</b> *

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

Facility Name & ID Number **Flora Rehabilitation & Health Care Center**# **0046615**Report Period Beginning: **1/1/2009**Ending: **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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,637,035	1
2	Discounts and Allowances for all Levels	(50,574)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 3,586,461</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	601,069	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 601,069</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
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	4,528	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	364,637	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	87,308	20
21	Other Medical Services	7,539	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 464,012</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	1,396	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 1,396</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Miscellaneous Revenue	449	28
28a	Gain on Sale of Property/Equipment	4,438	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 4,887</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 4,657,825</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	683,279	31
32	Health Care	2,035,734	32
33	General Administration	639,855	33
<b>B. Capital Expense</b>			
34	Ownership	448,902	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	375,838	35
36	Provider Participation Fee	54,203	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 4,237,811</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>420,014</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 420,014</b>	<b>43</b>

\* 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:

1/1/2009

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	2,080	2,080	\$ 50,751	\$ 24.40	1
2	Assistant Director of Nursing	2,080	2,080	44,336	21.32	2
3	Registered Nurses	10,730	11,308	234,316	20.72	3
4	Licensed Practical Nurses	18,107	18,706	302,400	16.17	4
5	CNAs & Orderlies	60,751	63,420	635,332	10.02	5
6	CNA Trainees					6
7	Licensed Therapist	11,864	11,864	425,952	35.90	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,868	1,868	17,766	9.51	9
10	Activity Assistants	1,584	1,589	12,338	7.76	10
11	Social Service Workers	2,080	2,080	25,603	12.31	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	37,771	18.16	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,137	14,696	120,333	8.19	15
16	Dishwashers					16
17	Maintenance Workers	1,971	2,147	40,583	18.90	17
18	Housekeepers	8,786	9,013	79,097	8.78	18
19	Laundry	5,145	5,500	47,344	8.61	19
20	Administrator	2,080	2,080	65,596	31.54	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,145	2,396	29,418	12.28	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 Care(specify)					32
33	Other(specify) <u>See Sch. 20A</u>	6,277	6,406	105,587	16.48	33
34	TOTAL (lines 1 - 33)	153,765	159,313	\$ 2,274,523 *	\$ 14.28	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	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)		\$ 25,200		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 Rehabilitation & Health Care Center**

**0046615**

**Period Beginning 1/1/2009**

**Period End 12/31/2009**

**Schedule 20A**

**XVIII. Staffing and Salary Costs**

	<b># of Hrs. Actually Worked</b>	<b># of Hrs. Paid and Accrued</b>	<b>Reporting Period Total Salaries, Wages</b>	<b>Average Hourly Wage</b>
<b>Restorative Aide</b>	11	11	562	51.09
<b>Care Plan Coordinator</b>	4,160	4,160	86,370	20.76
<b>Transportation</b>	2,106	2,235	18,655	8.35
<b>TOTAL (lines 1 - 35)</b>	<b>6,277</b>	<b>6,406</b>	<b>105,587</b>	

**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	
Nancy Geisinger	Administrator	0	\$ 65,596	Workers' Compensation Insurance	\$ 48,660	IDPH License Fee	\$	
				Unemployment Compensation Insurance	31,029	Advertising: Employee Recruitment	262	
				FICA Taxes	164,086	Health Care Worker Background Check		
				Employee Health Insurance	73,337	(Indicate # of checks performed )		
				Employee Meals		Patient Background Checks	327 3,270	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	258	
				Employee Relations	11,930	Miscellaneous Dues & Subscriptions	0	
				Employee Retirement	825	IHCA Dues	1,500	
						Home Office Allocation	3,486	
TOTAL (agree to Schedule V, line 17, col. 1)						Less: Public Relations Expense	( )	
(List each licensed administrator separately.)			\$ 65,596			Non-allowable advertising	( )	
						Yellow page advertising	( )	
B. Administrative - Other						TOTAL (agree to Sch. V, line 20, col. 8)		
Description			Amount				\$ 8,776	
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 199,000					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 199,000					
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type	Amount	Description	Line #	Amount	Description	Amount	
Verizon North	Computer Services	\$ 473				Out-of-State Travel	\$	
LTC Solutions	Computer Services	1,700						
Wabash Independent Networks	Computer Services	960						
E-Health Data Solutions	Computer Services	2,700	N/A			In-State Travel		
SimpleLTC., Inc.	Computer Services	81						
Web Café, Inc.	Computer Services	279						
						Seminar Expense	35	
						Home Office Allocation	165	
						Entertainment Expense	( )	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL	\$	(agree to Sch. V, line 24, col. 8)		
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 6,193			TOTAL	\$ 200	

\* Attach copy of IMRF notifications

\*\*See instructions.

**Flora Rehabilitation & Health Care Center**

**0046615**

**Period Beginning 1/1/2009**

**Period End 12/31/2009**

**Schedule 21A**

**XIX. SUPPORT SCHEDULE**

**C. Professional Services**

<b>Vendor/Payee</b>	<b>Type</b>	<b>Amount</b>
Total (agree to Schedule V, line 19, column 3)		6,193

**Home Office Allocation**

Heyl, Royster, Voelker & Allen	Legal	46
GoffWilson, P.A.	Legal	65
Jackson Lewis	Legal	516
Peter Gartelos	Legal	50
Misc.	Legal	44
Ginoli & Company	Accountants	3,405
Miscellaneous Vendors	Computer Services	48
Emdeon Business Services	Computer Services	22
Advanced Answers on Demand	Computer Services	2,764
Access 2 Go	Computer Services	266
Ivans	Computer Services	164
Kemper Technology	Computer Services	751
VisionShare	Computer Services	234
MediFax	Computer Services	95
LogmIn	Computer Services	41
Charter Communications	Computer Services	2
CDW	Computer Services	419
Simple LTC	Computer Services	638
Polaris Group	Other Professional Services	9,162
Donna Howard & Assoc.	Other Professional Services	157
Miscellaneous Vendors	Miscellaneous	439
Total (agree to Schedule V, line 19, column 8)		<u>25,521</u>



Facility Name & ID Number Flora Rehabilitation & Health Care Center# 0046615Report 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? Yes  
If YES, give association name and amount. 1,500 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. \$ 19,121 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. \$ 54,203  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 4,528
- (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. \$ 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.