

Facility Name & ID Number Flora Rehab & Hlth Care Ctr

0052266 Report Period Beginning: 1/1/14 Ending: 12/31/14

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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			3,829	3,829	8
9	SNF/PED					9
10	ICF	15,923	4,281	94	20,298	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,923	4,281	3,923	24,127	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.77%

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

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 3,829

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/14 Fiscal Year: 12/31/14

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

Facility Name & ID Number

Flora Rehab & Hlth Care Ctr

0052266

Report Period Beginning:

1/1/14

Ending:

12/31/14

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	160,334	11,885		172,219		172,219	8,155	180,374		1
2	Food Purchase		150,439		150,439		150,439	(7,149)	143,290		2
3	Housekeeping	97,738	30,372		128,110		128,110	50	128,160		3
4	Laundry	55,647	6,644		62,291		62,291		62,291		4
5	Heat and Other Utilities			131,486	131,486		131,486	307	131,793		5
6	Maintenance	56,475	14,449	19,060	89,984		89,984	3,066	93,050		6
7	Other (specify):* Home Off. Ben. All.										7
8	TOTAL General Services	370,194	213,789	150,546	734,529		734,529	4,429	738,958		8
	B. Health Care and Programs										
9	Medical Director			10,000	10,000		10,000	29	10,029		9
10	Nursing and Medical Records	1,207,345	127,406	29,010	1,363,761		1,363,761	(2,640)	1,361,121		10
10a	Therapy			609,343	609,343		609,343		609,343		10a
11	Activities	51,317	81	2,924	54,322		54,322	(4,379)	49,943		11
12	Social Services	33,892			33,892		33,892		33,892		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.										15
16	TOTAL Health Care and Programs	1,292,554	127,487	651,277	2,071,318		2,071,318	(6,990)	2,064,328		16
	C. General Administration										
17	Administrative			301,600	301,600		301,600	(236,375)	65,225		17
18	Directors Fees										18
19	Professional Services			10,174	10,174		10,174	30,457	40,631		19
20	Dues, Fees, Subscriptions & Promotions			8,695	8,695		8,695	415	9,110		20
21	Clerical & General Office Expenses	32,439	4,738	17,952	55,129		55,129	91,085	146,214		21
22	Employee Benefits & Payroll Taxes			238,356	238,356		238,356	19,244	257,600		22
23	Inservice Training & Education							37	37		23
24	Travel and Seminar							31	31		24
25	Other Admin. Staff Transportation			9,693	9,693		9,693	4,951	14,644		25
26	Insurance-Prop.Liab.Malpractice			29,710	29,710		29,710	47,694	77,404		26
27	Other (specify):* Home Off. Ben. All.										27
28	TOTAL General Administration	32,439	4,738	616,180	653,357		653,357	(42,461)	610,896		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,695,187	346,014	1,418,003	3,459,204		3,459,204	(45,022)	3,414,182		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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			5,636	5,636		5,636	138,082	143,718			30
31	Amortization of Pre-Op. & Org.							6,036	6,036			31
32	Interest							154,168	154,168			32
33	Real Estate Taxes							78,901	78,901			33
34	Rent-Facility & Grounds			409,571	409,571		409,571	(409,571)				34
35	Rent-Equipment & Vehicles			29,998	29,998		29,998	1,207	31,205			35
36	Other (specify):*											36
37	TOTAL Ownership			445,205	445,205		445,205	(31,177)	414,028			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		115,601		115,601		115,601		115,601			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			187,534	187,534		187,534		187,534			42
43	Other (specify):*			53,260	53,260		53,260	(53,260)				43
44	TOTAL Special Cost Centers		115,601	240,794	356,395		356,395	(53,260)	303,135			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,695,187	461,615	2,104,002	4,260,804		4,260,804	(129,459)	4,131,345			45

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

Facility Name & ID Number Flora Rehab & Hlth Care Ctr

0052266

Report Period Beginning: 1/1/14

Ending: 12/31/14

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(7,244)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,804)	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	29,344	30		9
10	Interest and Other Investment Income	(2,590)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(446)	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	(29,613)	43		18
19	Entertainment				19
20	Contributions		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		1 43		24
25	Fund Raising, Advertising and Promotional	(1,216)	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 Page 5A	(24,463)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (41,031)		\$	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	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(88,428)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (88,428)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (129,459)		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

Flora Rehab & Hlth Care Ctr

ID# 0052266

Report Period Beginning: 1/1/14

Ending: 12/31/14

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Labs-Part A	\$ (6,567)	43	1
2	X-Rays-Part A	(7,459)	43	2
3	Offset Miscellaneous Nursing Supplies Revenue	(2,663)	10	3
4	Offset Transportation Revenue	(4,379)	11	4
5	Offset Miscellaneous Office Supplies Revenue	(239)	21	5
6	Disallowed Special Events	(319)	43	6
7	Disallowed Marketing Expense	(924)	43	7
8				8
9	Resident Flowers	(463)	43	9
10	Pet Expense	(1,450)	43	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(24,463)	49

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark B. Petersen	100	See PG6 - Supp		See PG6 - Supp		

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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 3,552	\$ 3,552	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	85	85	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	18	18	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	240	240	4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	1,348	1,348	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	0		6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	29	29	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	1	1	8
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		10
11	V	17 Administrative	301,600	Petersen Health Care, Inc.	100.00%	65,225	(236,375)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	3,063	3,063	12
13	V							13
14	Total		\$ 301,600			\$ 73,561	\$ * (228,039)	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 & Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 171	\$	171	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	39,983		39,983	16
17	V	22 Employee Benefits & Payroll		Petersen Health Care, Inc.	100.00%	1,818		1,818	17
18	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	20		20	18
19	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	12		12	19
20	V	25 Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	3,233		3,233	20
21	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	570		570	21
22	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		0	22
23	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	3,265		3,265	23
24	V	32 Interest		Petersen Health Care, Inc.	100.00%	2,077		2,077	24
25	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	160		160	25
26	V	35 Rent-Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	822		822	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		\$			\$ 52,131	\$ *	52,131	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	\$		100.00%	\$ 0	\$	15	
16	V	2 Food			100.00%	0		16	
17	V	3 Housekeeping			100.00%	0		17	
18	V	4 Laundry			100.00%	0		18	
19	V	5 Utilities			100.00%	0		19	
20	V	6 Maintenance			100.00%	0		20	
21	V	7 Mgmt. Allocation of Benefits			100.00%	0		21	
22	V	10 Nursing and Medical Records			100.00%	0		22	
23	V	12 Social Services			100.00%	0		23	
24	V	17 Administrative			100.00%	0		24	
25	V	19 Professional Services			100.00%	16,121	16,121	25	
26	V	20 Dues, Fees, Subs & Promotions			100.00%	188	188	26	
27	V	21 Clerical and General Office			100.00%	826	826	27	
28	V	22 Employee Benefits & Payroll			100.00%	0		28	
29	V	23 Inservice Training & Education			100.00%	0		29	
30	V	24 Travel and Seminar			100.00%	0		30	
31	V	25 Other Admin. Staff Transport.			100.00%	0		31	
32	V	26 Insurance-Prop./Liab./Malprac.			100.00%	0		32	
33	V	27 Mgmt. Allocation of Benefits			100.00%	0		33	
34	V	30 Depreciation			100.00%	2,075	2,075	34	
35	V	32 Interest			100.00%	28,915	28,915	35	
36	V	33 Real Estate Taxes			100.00%	0		36	
37	V	34 Rent-Facility and Grounds			100.00%	0		37	
38	V	35 Rent-Equipment & Vehicles			100.00%	0		38	
39	Total		\$			\$ 48,125	\$ *	48,125	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:			
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)			
15	V	1 Dietary	\$	Petersen Health Care Management, Inc.	100.00%	\$	\$	4,603	15	
16	V	2 Food		Petersen Health Care Management, Inc.	100.00%			10	16	
17	V	3 Housekeeping		Petersen Health Care Management, Inc.	100.00%			32	17	
18	V	5 Utilities		Petersen Health Care Management, Inc.	100.00%			67	18	
19	V	6 Maintenance		Petersen Health Care Management, Inc.	100.00%			1,718	19	
20	V	7 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%			0	20	
21	V	9 Medical Director		Petersen Health Care Management, Inc.	100.00%			0	21	
22	V	10 Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%			22	22	
23	V	10A Therapy		Petersen Health Care Management, Inc.	100.00%			0	23	
24	V	15 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%			0	24	
25	V	17 Administrative		Petersen Health Care Management, Inc.	100.00%			0	25	
26	V	19 Professional Services		Petersen Health Care Management, Inc.	100.00%			6,920	26	
27	V	20 Dues, Fees, Subs & Promotions		Petersen Health Care Management, Inc.	100.00%			56	27	
28	V	21 Clerical and General Office		Petersen Health Care Management, Inc.	100.00%			50,515	28	
29	V	22 Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%			17,426	29	
30	V	23 Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%			17	30	
31	V	24 Travel and Seminar		Petersen Health Care Management, Inc.	100.00%			19	31	
32	V	25 Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%			1,718	32	
33	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%			145	33	
34	V	27 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%			0	34	
35	V	30 Depreciation		Petersen Health Care Management, Inc.	100.00%			221	35	
36	V	32 Interest		Petersen Health Care Management, Inc.	100.00%			294	36	
37	V	33 Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%			124	37	
38	V	35 Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%			385	38	
39	Total		\$			\$	0	\$ *	84,292	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	19 Professional Services	\$	Flora Land Company	100.00%	\$	\$	4,353	15	
16	V	30 Depreciation		Flora Land Company	100.00%			103,177	16	
17	V	31 Amortization Of Pre-Op & org		Flora Land Company	100.00%			6,036	17	
18	V	32 Interest		Flora Land Company	100.00%			125,472	18	
19	V	33 Real Estate Taxes		Flora Land Company	100.00%			78,617	19	
20	V	34 Rental - Facility & Grounds	409,571	Flora Land Company	100.00%			(409,571)	20	
21	V	35 Rent - Equipment & Vehicles		Flora Land Company	100.00%			0	21	
22	V	26 Insurance		Flora Land Company	100.00%			46,979	22	
23	V								23	
24	V								24	
25	V								25	
26	V								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		\$ 409,571			\$	0	\$ *	(44,937)	39

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

Facility Name & ID Number

Flora Rehab & Hlth Care Ctr

0052266

Report Period Beginning:

1/1/14

Ending:

12/31/14

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Aledo Health Care Center	Aledo	Petersen Companies, I	Peoria	Mgmt/Bookkeeping	1
2			Arcola Health Care Center	Arcola	Petersen Health Care J	Peoria	Mgmt/Bookkeeping	2
3			Aspen Rehab & Health Care	Silvis	Petersen Health Care,	Peoria	Mgmt/Bookkeeping	3
4			Batavia Rehab & Health Care Center	Batavia	Petersen Health Enter	Peoria	Mgmt/Bookkeeping	4
5			Bement Health Care Center	Bement	Petersen Health Opera	Peoria	Mgmt/Bookkeeping	5
6			Benton Rehab & Health Care Center	Benton	Petersen Health Syste	Peoria	Mgmt/Bookkeeping	6
7			Bloomington Rehab & Health Care Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality	7
8			Casey Health Care Center	Casey	Petersen Restaurants,	Peoria	Restaurant	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Health Care	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Care	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care	Peoria	Mgmt/Bookkeeping	13
14			Decatur Rehab & Health Care Center	Decatur	Petersen Health Care	Peoria	Lessor	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Osage Beach,	Osage Beach, MO	Lessor	15
16			Eastview Terrace	Sullivan	Petersen West Frankf	West Frankfort	Lessor	16
17			El Paso Health Care Center	El Paso	Midwest Health Care,	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Poplar Bluff Health C	Poplar Bluff, MO	Lessor	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Roseville, LL	Roseville	Lessor	19
20			Flanagan Rehab & Health Care Center	Flanagan	Petersen Health Juncti	Peoria	Mgmt/Bookkeeping	20
21			Flora Gardens Care Center	Flora	Petersen Health Qualit	Peoria	Mgmt/Bookkeeping	21
22			Flora Health Care Center	Flora	Petersen Health and W	Peoria	Mgmt/Bookkeeping	22
23			Fondulac Rehab & Health Care Center	East Peoria				23
24			Havana Health Care Center	Havana				24
25			Illini Heritage Rehab & Health Care	Champaign				25
26			Jonesboro Rehab & Health Care Center	Jonesboro				26
27			Kewanee Care Home	Kewanee				27
28			LaHarpe Davier Health Care Center	LaHarpe				28
29			Lebanon Care Center	Lebanon				29
30			Marigold Rehab & Health Care Center	Galesburg				30

Facility Name & ID Number

Flora Rehab & Hlth Care Ctr

0052266

Report Period Beginning:

1/1/14

Ending:

12/31/14

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Mason Point	Sullivan				1
2			McLeansboro Rehab & Health Care Center	McLeansboro				2
3			Mt. Vernon Health Care Center	Mt. Vernon				3
4			Newman Rehab & Health Care Center	Newman				4
5			Nokomis Rehab & Health Care Center	Nokomis				5
6			North Aurora Care Center	North Aurora				6
7			Orchard View Rehab & Health Care Center	Princeton				7
8			Palm Terrace of Mattoon	Mattoon				8
9			Piper City Rehab & Living Center	Piper City				9
10			Pleasant View Rehab & Health Care Center	Morrison				10
11			Polo Rehabilitation & Health Care Center	Polo				11
12			Prairie City Rehab & Health Care Center	Prairie City				12
13			Robings Manor Nursing Home	Brighton				13
14			Rochelle Gardens	Rochelle				14
15			Rochelle Rehab & Health Care Center	Rochelle				15
16			Rock Falls Rehab & Health Care Center	Rock Falls				16
17			Arrow Wood Independent Living	Rock Falls				17
18			Roseville Rehab and Health Care Center	Roseville				18
19			Rosiclare Rehab & Health Care Center	Rosiclare				19
20			Royal Oaks Care Center	Kewanee				20
21			Sandwich Rehab & Health Care Center	Sandwich				21
22			Iron Wood Independent Living	Sandwich				22
23			Shawnee Rose Care Center	Harrisburg				23
24			Shelbyville Rehab & Health Care Center	Shelbyville				24
25			South Elgin Rehab & Health Care Center	South Elgin				25
26			Sugar Creek Care Center	Watseka				26
27			Sullivan Health Care Center	Sullivan				27
28			Sunset Manor Nursing Home	Canton				28
29			Swansea Rehab & Health Care	Swansea				29
30			Timbercreek Rehab & Health Center	Pekin				30

Facility Name & ID Number

Flora Rehab & Hlth Care Ctr

0052266

Report Period Beginning:

1/1/14

Ending:

12/31/14

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Toulon Health Care Center	Toulon				1
2			Tuscola Health Care Center	Tuscola				2
3			Twin Lakes Rehab & Health Care Center	Paris				3
4			Vandalia Rehab & Health Care Center	Vandalia				4
5			Watseka Health Care Center	Watseka				5
6			Westside Rehab & Care Center	West Frankfort				6
7			Whispering Oaks	Rosiclare				7
8			White Oak Rehab & Health Care Center	Mt. Vernon				8
9			Willow Rose Rehab & Health Care Center	Jerseyville				9
10			Sheldon Health Care Center	Sheldon				10
11			Tuscola Health Care Center	Tuscola				11
12			Effingham Health Care Center	Effingham				12
13			Collinsville Health Care Center	Collinsville				13
14			Ozark Rehab & Health Care Center	Osage Beach, MO				14
15			South Shore Health Care, LLC	Gary, IN				15
16			Cedargate Skilled Nursing Facility	Poplar Bluff, MO				16
17			Tarkio Rehab & Health Care Center	Tarkio, MO				17
18			Shangri-la Rehab & Living Center	Blue Springs, MO				18
19			Prairie Rose Care Center	Pana				19
20			Illini Heritage Rehab & Health Center	Champaign				20
21			Courtyard Estates of Kewanee	Kewanee				21
22			Courtyard Estates of Bradford	Bradford				22
23			Courtyard Estates of Galva	Galva				23
24			Courtyard Estates of Walcott	Walcott				24
25			Courtyard Village of Kewanee	Kewanee				25
26			Lakewood Village	Charleston				26
27			Courtyard Estates of Monmouth	Monmouth				27
28			Riverview Estates	Havana				28
29			Simple Blessings	Casey				29
30			Courtyard Estates of Bushnell	Bushnell				30

Facility Name & ID Number

Flora Rehab & Hlth Care Ctr

0052266

Report Period Beginning:

1/1/14

Ending:

12/31/14

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Courtyard Estates of Canton	Canton				1
2			Legacy Estates of Monmouth	Monmouth				2
3			Courtyard Estates of Sullivan	Sullivan				3
4			Courtyard Estates of Peoria	Peoria				4
5			Cornerstone Health and Rehabilitation	Peoria				5
6			Rock River Gardens	Peoria				6
7			Sauk Valley Senior Living & Rehabilitation	Peoria				7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Flora Rehab & Hlth Care Ctr # 0052266 Report Period Beginning: 1/1/14 Ending: 12/31/14

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									\$	1
2										2
3										3
4										4
5										5
6	N/A									6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	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 Rehab & Hlth Care Ctr

0052266

Report Period Beginning:

1/1/14

Ending: 12/31/14

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	1,572,338	77	\$ 231,473	\$ 220,289	24,127	\$ 3,552	1
2	2	Food	Resident Days	1,572,338	77	5,537	0	24,127	85	2
3	3	Housekeeping	Resident Days	1,572,338	77	1,187	0	24,127	18	3
4	5	Utilities	Resident Days	1,572,338	77	15,618	0	24,127	240	4
5	6	Maintenance	Resident Days	1,572,338	77	87,839	72,289	24,127	1,348	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77	0	0	24,127	0	6
7	9	Medical Director	Resident Days	1,572,338	77	1,878	0	24,127	29	7
8	10	Nursing and Medical Records	Resident Days	1,572,338	77	71	0	24,127	1	8
9	10A	Therapy	Resident Days	1,572,338	77	0	0	24,127	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77	0	0	24,127	0	10
11	17	Administrative	Resident Days	1,572,338	77	0	0	24,127	0	11
12	19	Professional Services	Resident Days	1,572,338	77	199,631	0	24,127	3,063	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,572,338	77	11,115	0	24,127	171	13
14	21	Clerical and General Office	Resident Days	1,572,338	77	2,605,685	2,406,945	24,127	39,983	14
15	22	Employee Benefits and Payroll Tax	Resident Days	1,572,338	77	118,476	0	24,127	1,818	15
16	23	Inservice Training & Education	Resident Days	1,572,338	77	1,316	0	24,127	20	16
17	24	Travel and Seminar	Resident Days	1,572,338	77	811	0	24,127	12	17
18	25	Other Admin. Staff Transport.	Resident Days	1,572,338	77	210,720	0	24,127	3,233	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,572,338	77	37,141	0	24,127	570	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77	0	0	24,127	0	20
21	30	Depreciation	Resident Days	1,572,338	77	212,800	0	24,127	3,265	21
22	32	Interest	Resident Days	1,572,338	77	135,328	0	24,127	2,077	22
23	33	Real Estate Taxes	Resident Days	1,572,338	77	10,451	0	24,127	160	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,572,338	77	53,540	0	24,127	822	24
25	TOTALS					\$ 3,940,617	\$ 2,699,523		\$ 60,467	25

Facility Name & ID Number Flora Rehab & Hlth Care Ctr

0052266

Report Period Beginning:

1/1/14

Ending: 12/31/14

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 Management Company, 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	176,988	6	\$	24,127	\$	1
2	2	Food	Resident Days	176,988	6		24,127		2
3	3	Housekeeping	Resident Days	176,988	6		24,127		3
4	4	Laundry	Resident Days	176,988	6		24,127		4
5	5	Utilities	Resident Days	176,988	6		24,127		5
6	6	Maintenance	Resident Days	176,988	6		24,127		6
7	7	Mgmt. Allocation of Benefits	Resident Days	176,988	6		24,127		7
8	10	Nursing and Medical Records	Resident Days	176,988	6		24,127		8
9	15	Mgmt. Allocation of Benefits	Resident Days	176,988	6		24,127		9
10	17	Administrative	Resident Days	176,988	6		24,127		10
11	19	Professional Services	Resident Days	176,988	6	118,256	24,127	16,121	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	176,988	6	1,380	24,127	188	12
13	21	Clerical and General Office	Resident Days	176,988	6	6,062	24,127	826	13
14	22	Employee Benefits & Payroll	Resident Days	176,988	6		24,127		14
15	23	Inservice Training & Education	Resident Days	176,988	6		24,127		15
16	24	Travel and Seminar	Resident Days	176,988	6		24,127		16
17	25	Other Admin. Staff Transport.	Resident Days	176,988	6		24,127		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	176,988	6		24,127		18
19	27	Mgmt. Allocation of Benefits	Resident Days	176,988	6		24,127		19
20	30	Depreciation	Resident Days	176,988	6	15,225	24,127	2,075	20
21	32	Interest	Resident Days	176,988	6	212,111	24,127	28,915	21
22	33	Real Estate Taxes	Resident Days	176,988	6		24,127		22
23	34	Rent-Facility and Grounds	Resident Days	176,988	6		24,127		23
24	35	Rent-Equipment & Vehicles	Resident Days	176,988	6		24,127		24
25	TOTALS					\$ 353,034	\$	\$ 48,125	25

Facility Name & ID Number Flora Rehab & Hlth Care Ctr

0052266 Report Period Beginning: 1/1/14

Ending: 12/31/14

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 Management, 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	1,572,338	77	\$ 299,961	\$ 294,997	24,127	\$ 4,603	1
2	2	Food	Resident Days	1,572,338	77	675		24,127	10	2
3	3	Housekeeping	Resident Days	1,572,338	77	2,074	558	24,127	32	3
4	5	Utilities	Resident Days	1,572,338	77	4,349		24,127	67	4
5	6	Maintenance	Resident Days	1,572,338	77	111,954	94,000	24,127	1,718	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77			24,127		6
7	9	Medical Director	Resident Days	1,572,338	77			24,127		7
8	10	Nursing and Medical Records	Resident Days	1,572,338	77	1,457		24,127	22	8
9	10A	Therapy	Resident Days	1,572,338	77			24,127		9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77			24,127		10
11	17	Administrative	Resident Days	1,572,338	77	4,576,674	4,576,674	24,127	65,225	11
12	19	Professional Services	Resident Days	1,572,338	77	450,944		24,127	6,920	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,572,338	77	3,620		24,127	56	13
14	21	Clerical and General Office	Resident Days	1,572,338	77	3,292,039	3,146,898	24,127	50,515	14
15	22	Employee Benefits and Payroll Tax	Resident Days	1,572,338	77	1,135,672		24,127	17,426	15
16	23	Inservice Training & Education	Resident Days	1,572,338	77	1,074		24,127	17	16
17	24	Travel and Seminar	Resident Days	1,572,338	77	1,245		24,127	19	17
18	25	Other Admin. Staff Transport.	Resident Days	1,572,338	77	111,953		24,127	1,718	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,572,338	77	9,420		24,127	145	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77			24,127		20
21	30	Depreciation	Resident Days	1,572,338	77	14,419		24,127	221	21
22	32	Interest	Resident Days	1,572,338	77	19,133		24,127	294	22
23	33	Real Estate Taxes	Resident Days	1,572,338	77	8,076		24,127	124	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,572,338	77	25,085		24,127	385	24
25	TOTALS					\$ 10,069,824	\$ 8,113,127		\$ 149,517	25

Facility Name & ID Number

Flora Rehab & Hlth Care Ctr

0052266

Report Period Beginning:

1/1/14

Ending:

12/31/14

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	Name of Lender	2		3	4	5	6		8	9	10	11						
		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	1st Merit		X	HUD Loan	Varies	5/1/13	3,824,000	\$ 3,665,596	4/30/38	Varies	\$ 125,472	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6												6						
7												7						
8												8						
9	TOTAL Facility Related						\$ 3,824,000	\$ 3,665,596			\$ 125,472	9						
B. Non-Facility Related*																		
10										Home Office Allocation-PHCM	294	10						
11										Interest Income Offset	(2,590)	11						
12										Home Office Allocation-PHC	2,077	12						
13										Home Office Allocation-PMC	28,915	13						
14	TOTAL Non-Facility Related						\$	\$			\$ 28,696	14						
15	TOTALS (line 9+line14)						\$ 3,824,000	\$ 3,665,596			\$ 154,168	15						

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

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2013 report.			\$ 66,768	1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2013		\$ 71,618	2	
3. Under or (over) accrual (line 2 minus line 1).			\$ 4,850	3	
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)			\$ 73,767	4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		Home Office Allocation	\$ 284	6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$ 78,901	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2009	<u>64,175</u>	8		
	2010	<u>66,134</u>	9		
	2011	<u>67,409</u>	10		
	2012	<u>64,828</u>	11		
	2013	<u>71,618</u>	12		
Accrual based on prior year tax bill.					
				FOR BHF USE ONLY	
				13	FROM R. E. TAX STATEMENT FOR 2013 \$
				14	PLUS APPEAL COST FROM LINE 5 \$
				15	LESS REFUND FROM LINE 6 \$
				16	AMOUNT TO USE FOR RATE CALCULATION \$

NOTES:

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

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

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

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

Facility Name & ID Number Flora Rehab & Hlth Care Ctr

0052266 Report Period Beginning:

1/1/14 Ending:

12/31/14

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: 150,897 2. Number of Years Over Which it is Being Amortized: 25
 3. Current Period Amortization: 6,036 4. Dates Incurred: January-December 2013

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	\$ 637,902	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Sidewalks		2006	3,605		15	240	240	2,040	9
10	Front Door Repair		2008	5,090		25	204	204	1,326	10
11	Rooftop A/C Repair		2008	2,619		15	174	174	1,131	11
12	B-Unit Shower Units		2008	14,000		25	560	560	3,640	12
13	Roof Replacement		2010	52,985		25	2,120	2,120	9,540	13
14	Replacement of Kitchen and Dining Room Flooring & Painting		2011	19,985		15	1,332	1,332	4,662	14
15	Replacement of Kitchen and Dining Room Flooring & Painting		2012	2,405		15	160	160	400	15
16	Water Heater		2012	5,846		15	390	390	975	16
17	Air Conditioner-Roof Top		2012	6,341		15	422	422	1,055	17
18	Roof Replacement		2013	102,805		25	4,112	4,112	6,168	18
19	Air Conditioner		2013	12,675		15	846	846	1,269	19
20	Parking Lot Install		2014	11,625		25	271	271	271	20
21	Water Heater		2014	3,850		7	504	504	504	21
22	Water Heater		2014	4,042		7	481	481	481	22
23	Water Heater		2014	3,918		7	420	420	420	23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

*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

Facility Name & ID Number Flora Rehab & Hlth Care Ctr

0052266

Report Period Beginning:

1/1/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
	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	Land Improvements Booked			240			(240)		63
64	Building Booked			88,621			(88,621)		64
65	Building Improvement Booked			11,455			(11,455)		65
66									66
67	2014-Home Office Allocation-Building Improvements		11,263			270	270		67
68	2014-Home Office Allocation-Land Improvements		1,051			58	58		68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,478,305	\$ 100,316		\$ 75,827	\$ (24,489)	\$ 671,784	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 665,370	\$ 7,824	\$ 61,985	\$ 54,161	5-10 yrs.	\$ 637,178	71
72	Current Year Purchases	7,574	673	673		10 yrs.	673	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			5,233	5,233			74
75	TOTALS	\$ 672,944	\$ 8,497	\$ 67,891	\$ 59,394		\$ 637,851	75

D. Vehicle Costs. (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	\$	\$	\$		\$ 33,216	76
77										77
78										78
79										79
80	TOTALS			\$ 33,216	\$	\$	\$		\$ 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)	\$ 3,313,465	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 108,813	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 143,718	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 34,905	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,342,851	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.

Facility Name & ID Number Flora Rehab & Hlth Care Ctr

0052266

Report Period Beginning: 1/1/14

Ending: 12/31/14

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

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. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

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: \$ 31,205 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	<u>N/A</u>				18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

0
0
Period Beginning 1/1/2014
Period End 12/31/2014

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$ 27,687
Dishwasher	
Laundry Equipment	
Copier	2,311
Home Office Allocation	1,207
	<u>31,205</u>

Facility Name & ID Number Flora Rehab & Hlth Care Ctr # 0052266 Report Period Beginning: 1/1/14 Ending: 12/31/14
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? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	15,575	\$ 233,619	\$	15,575	\$ 233,619	1	
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		7,788	116,824		7,788	116,824	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	10A(3)	hrs		17,248	258,726		17,248	258,726	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				115,601		115,601	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify):									12	
13	Other (specify): <u>Respiratory Therapy</u>	10A(3)			12	174		12	174	13	
14	TOTAL			\$	40,623	\$ 609,343	\$ 115,601	40,623	\$ 724,944	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 Rehab & Hlth Care Ctr

0052266

Report Period Beginning: 1/1/14

Ending:

12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14 (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 1,165,288	\$ 1,165,288	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>9,676</u>)	765,227	765,227	3
4	Supply Inventory (priced at _____)	15,982	15,982	4
5	Short-Term Investments			5
6	Prepaid Insurance	34,433	47,334	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)		36,024	8
9	Other(specify): <u>Prepaid Mgmt. Fees</u>	53,949	53,949	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,034,879	\$ 2,083,804	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		129,000	13
14	Buildings, at Historical Cost		2,225,463	14
15	Leasehold Improvements, at Historical Cost	11,810	252,842	15
16	Equipment, at Historical Cost	65,694	706,160	16
17	Accumulated Depreciation (book methods)	(39,206)	(1,342,851)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		436,514	21
22	Other Long-Term Assets (specify <u>Goodwill</u>)	18,710	159,547	22
23	Other(specify): _____			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 57,008	\$ 2,566,675	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,091,887	\$ 4,650,479	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 595,941	\$ 621,066	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	115,140	115,140	30
31	Accrued Taxes Payable (excluding real estate taxes)	76,855	76,855	31
32	Accrued Real Estate Taxes(Sch.IX-B)		73,767	32
33	Accrued Interest Payable		10,325	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Payroll Withholdings</u>	3,422	3,422	36
37	<u>Accrued Management Fees</u>			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 791,358	\$ 900,575	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,665,596	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>A/P Due To Due From</u>	1,855,834	258,583	43
44	_____			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,855,834	\$ 3,924,179	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,647,192	\$ 4,824,754	46
47	TOTAL EQUITY(page 18, line 24)	\$ (555,305)	\$ (174,275)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,091,887	\$ 4,650,479	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (765,670)	1
2	Restatements (describe):		2
3	Rounding		3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (765,670)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	210,365	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 210,365	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (555,305)	24 *

* This must agree with page 17, line 47.

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

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,586,280	1
2	Discounts and Allowances for all Levels	(496,696)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,089,584	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,094,332	6
7	Oxygen	950	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,095,282	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	7,244	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	212,089	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	51,824	20
21	Other Medical Services	5,275	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 276,432	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,590	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,590	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	2,902	28
28a	Transportation Revenue	4,379	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 7,281	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,471,169	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	734,529	31
32	Health Care	2,071,318	32
33	General Administration	653,357	33
B. Capital Expense			
34	Ownership	445,205	34
C. Ancillary Expense			
35	Special Cost Centers	168,861	35
36	Provider Participation Fee	187,534	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,260,804	40
41	Income before Income Taxes (line 30 minus line 40)**	210,365	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 210,365	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,934,084	44
45	Private Pay - Net Inpatient Revenue	455,784	45
46	Medicare - Net Inpatient Revenue	706,112	46
47	Other-(specify) <u>Veterans -Net Patient Revenue</u>		47
48	Other-(specify) <u>Charity and Insurance Contractual Allowance</u>	(6,396)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,089,584	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Flora Rehab & Hlth Care Ctr

0052266

Report Period Beginning:

1/1/14

Ending:

12/31/14

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	20,803	2,080	\$ 61,582	\$ 29.61	1
2	Assistant Director of Nursing	2,080	2,080	45,760	22.00	2
3	Registered Nurses	9,857	10,527	239,878	22.79	3
4	Licensed Practical Nurses	15,244	15,968	280,521	17.57	4
5	CNAs & Orderlies	43,367	46,082	521,987	11.33	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,990	2,118	24,111	11.38	9
10	Activity Assistants					10
11	Social Service Workers	1,948	2,164	33,892	15.66	11
12	Dietician					12
13	Food Service Supervisor	1,915	1,915	39,154	20.45	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,235	13,806	121,180	8.78	15
16	Dishwashers					16
17	Maintenance Workers	3,972	4,425	56,475	12.76	17
18	Housekeepers	10,566	10,817	97,738	9.04	18
19	Laundry	5,335	5,741	55,647	9.69	19
20	Administrator	2,080	2,080	65,225	31.36	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,133	2,352	32,439	13.79	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 PG20A</u>	4,679	5,015	84,822	16.91	33
34	TOTAL (lines 1 - 33)	139,204	127,170	\$ 1,760,411 *	\$ 13.84	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	10,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,075	L10, C3	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)		\$ 15,075		49

C. CONTRACT NURSES

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

Flora Rehab & Hlth Care Ctr

0052266

Period Beginning

1/1/2014

Period End

12/31/2014

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reportin g Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	2,739	2,899	57,617	19.88
Transportation	1,940	2,117	27,206	12.85
TOTAL	<u>4,679</u>	<u>5,015</u>	<u>84,822</u>	

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	
Jodi Sanders	Administrator	0	\$ 65,225	Workers' Compensation Insurance	\$ 67,143	IDPH License Fee	\$ 3,288	
				Unemployment Compensation Insurance	48,825	Advertising: Employee Recruitment	811	
				FICA Taxes	122,931	Health Care Worker Background Check		
				Employee Health Insurance	(11,157)	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	77	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	491	
				Employee Relations	9,967	Miscellaneous Dues & Subscriptions	3,333	
				Employee Retirement	647	Home Office Allocation	415	
				Home Office Allocation	19,244			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)								
			\$ 65,225			Less: Public Relations Expense	()	
B. Administrative - Other						Non-allowable advertising	()	
Description			Amount			Yellow page advertising	()	
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 301,600					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)								
			\$ 301,600					
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
Clay Co. Circuit Clerk	Filing Fees	\$ 122					Out-of-State Travel	\$
Frontier	Computer Services	864						
Honkamp, Krueger and Company	Accounting Fees	1,152						
Illinois Secretary of State	Filing Fees	35		N/A			In-State Travel	
IDPH	Filing Fees	1,430						
Nancy Gelsing	Consulting Fees	1,500					Seminar Expense	
E-Health Data Solutions	Computer Services	5,071					Home Office Allocation	31
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)								
			\$ 10,174	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 31

* Attach copy of IMRF notifications

**See instructions.

Flora Rehab & Hlth Care Ctr
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Period Beginning
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Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		10,174
Home Office Allocation-PHC, PHCM, & PMC		
Lexis Nexis	Legal	9
GoffWilson	Legal	562
Illinois Secretary of State	Legal	336
Bank of America	Legal	170
Healthcare Resources International	Legal	102
Miscellaneous	Legal	21
Addy, Bush	Legal	14
Hall, Rustom, and Fritz	Legal	17
Black, Hedin, Ballard	Legal	30
SmithAmundsen	Legal	30
CliftonLarson Allen	Accountants	1196
Ginoli & Co.	Accountants	5,200
Miscellaneous	Computer Services	22
Odessian LLC	Computer Services	7
Optimizer	Computer Services	48
Allpayer Exchange	Computer Services	15
CCH	Computer Services	25
Prism Software	Computer Services	76
Macquarie Technology Services	Computer Services	67
Advanced Answers on Demand	Computer Services	3544
Stratus Networks	Computer Services	466
Kemper Technology	Computer Services	1383
AT&T	Computer Services	6
Ability Network	Computer Services	535
Barracuda	Computer Services	122

CIAN
Comcast
Emdeon
Charter Communications
Crawford County Title Co.
Better Banks
David Budde
All Scripts
Miscellaneous
Marotta Gund Budd Derza
Total (agree to Schedule V, line 19, column 8)

Computer Services	146
Computer Services	37
Computer Services	95
Computer Services	6
Other Prof Fees	7
Other Prof Fees	4
Other Prof Fees	61
Other Prof Fees	9
Other Prof Fees	3
Other Prof Fees	<u>16,086</u>
	<u><u>40,631</u></u>

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4	N/A											
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Flora Rehab & Hlth Care Ctr

0052266

Report Period Beginning: 1/1/14

Ending: 12/31/14

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA-\$3,333
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 22,867 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 187,534
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. \$ 7,244
- (16) Travel and Transportation
 - a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
 - b. Do you have a separate contract with the Department to provide medical transportation for residents? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$
 - c. What percent of all travel expense relates to transportation of nurses and patients? N/A
 - d. Have vehicle usage logs been maintained? Adquate records have been maintained.
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
 - g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli and Company
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees.