

		FOR BHF USE					

LL1

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0050666

Facility Name: Flora Gardens Care Center

Address: 701 Shadwell Avenue, PO Box 309 Flora 62839
Number City Zip Code

County: Clay

Telephone Number: (618) 662-8361 Fax # (618) 662-2811

HFS ID Number:

Date of Initial License for Current Owners: 01/31/2007

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☒ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Mike Kocher Telephone Number: (309) 689-5850
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2012 to 12/31/2012 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) Mark B. Petersen
(Title) Chief Executive Officer

Paid
Preparer

(Signed) _____ (Date) _____
(Print Name and Title) _____
(Firm Name & Address) _____
(Telephone) () Fax # ()

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Flora Gardens Care Center# 0050666 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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 bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>56</u>	Skilled (SNF)	<u>56</u>	<u>20,440</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>51</u>	Intermediate (ICF)	<u>51</u>	<u>18,615</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>107</u>	TOTALS	<u>107</u>	<u>39,055</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			<u>1,463</u>	<u>1,463</u>	8
9	SNF/PED					9
10	ICF	<u>13,461</u>	<u>3,350</u>		<u>16,811</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>13,461</u>	<u>3,350</u>	<u>1,463</u>	<u>18,274</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 46.79%

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?

YesG. 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 1/31/2007

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

YES

☒Date 1/31/2007

NO

☐

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

YES

☒

NO

☐

If YES, enter number

of beds certified

56

and days of care provided

1,463Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL

☒

MODIFIED

CASH*

☐

CASH*

☐

Is your fiscal year identical to your tax year?

YES

☒NO ☐Tax Year: 12/31/12 Fiscal Year: 12/31/12

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

	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	125,886	8,762		134,648		134,648	3,325	137,973			1
2	Food Purchase		103,184		103,184		103,184	(703)	102,481			2
3	Housekeeping	65,285	14,450		79,735		79,735	26	79,761			3
4	Laundry	31,061	5,678		36,739		36,739	5	36,744			4
5	Heat and Other Utilities			73,478	73,478		73,478	262	73,740			5
6	Maintenance	52,705	9,069	11,864	73,638		73,638	2,057	75,695			6
7	Other (specify):* Home Off. Ben. All.							443	443			7
8	TOTAL General Services	274,937	141,143	85,342	501,422		501,422	5,415	506,837			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	966,122	42,838	3,179	1,012,139		1,012,139	32	1,012,171			10
10a	Therapy			182,262	182,262		182,262		182,262			10a
11	Activities	47,205	18	(1,743)	45,480		45,480	(7,105)	38,375			11
12	Social Services	38,705	52		38,757		38,757	(27)	38,730			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Off. Ben. All.											15
16	TOTAL Health Care and Programs	1,052,032	42,908	189,698	1,284,638		1,284,638	(7,100)	1,277,538			16
	C. General Administration											
17	Administrative			286,800	286,800		286,800	(223,300)	63,500			17
18	Directors Fees											18
19	Professional Services			7,156	7,156		7,156	21,073	28,229			19
20	Dues, Fees, Subscriptions & Promotions			9,852	9,852		9,852	125	9,977			20
21	Clerical & General Office Expenses	29,247	5,690	8,466	43,403		43,403	37,352	80,755			21
22	Employee Benefits & Payroll Taxes			194,920	194,920		194,920	606	195,526			22
23	Inservice Training & Education							63	63			23
24	Travel and Seminar							6	6			24
25	Other Admin. Staff Transportation			7,733	7,733		7,733	6,366	14,099			25
26	Insurance-Prop.Liab.Malpractice			35,909	35,909		35,909	711	36,620			26
27	Other (specify):* Home Off. Ben. All.							8,879	8,879			27
28	TOTAL General Administration	29,247	5,690	550,836	585,773		585,773	(148,119)	437,654			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,356,216	189,741	825,876	2,371,833		2,371,833	(149,804)	2,222,029			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	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			118,795	118,795		118,795	(18,962)	99,833			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			90,972	90,972		90,972	31,683	122,655			32
33	Real Estate Taxes			44,670	44,670		44,670	470	45,140			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			4,933	4,933		4,933	576	5,509			35
36	Other (specify):*											36
37	TOTAL Ownership			259,370	259,370		259,370	13,767	273,137			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		82,011		82,011		82,011		82,011			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			240,041	240,041		240,041		240,041			42
43	Other (specify):* Non-allowable Costs		208	30,092	30,300		30,300	(30,300)				43
44	TOTAL Special Cost Centers		82,219	270,133	352,352		352,352	(30,300)	322,052			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,356,216	271,960	1,355,379	2,983,555		2,983,555	(166,337)	2,817,218			45

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

		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	(815)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,720)	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	(22,304)	30		9
10	Interest and Other Investment Income	(641)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(54)	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	(14,935)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,944)	43		24
25	Fund Raising, Advertising and Promotional	(2,228)	43		25
	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	(17,548)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (63,189)		\$	30

BHF USE ONLY							
48		49		50		51	52

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

		1 Amount	2 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)	(103,148)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (103,148)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (166,337)		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 Yes	2 No	3 Amount	4 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

Flora Gardens Care Center

ID# 0050666

Report Period Beginning: 1/1/2012

Ending: 12/31/2012

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (5,037)	43	1
2	X-Rays-Part A	(3,316)	43	2
3	Offset Miscellaneous Office Supplies Revenue	(1,732)	21	3
4	Disallow Special Events	34	43	4
5	Offset Transportation Revenue	(7,087)	11	5
6	Offset Chamber of Commerce Dues	(265)	20	6
7	Offset Barber & Beuty Revenue Activity Sup	(18)	11	7
8	Offset Miscellaneous Contribution	(100)	43	8
9	Offset Barber & Beuty Revenue Soc Services Sup	(27)	12	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
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	(17,548)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Flora Gardens Care Center

0050666

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	3,325	0	0	0	0	0	0	0	0	0	3,325	1
2	Food Purchase	(815)	112	0	0	0	0	0	0	0	0	0	(703)	2
3	Housekeeping	0	26	0	0	0	0	0	0	0	0	0	26	3
4	Laundry	0	5	0	0	0	0	0	0	0	0	0	5	4
5	Heat and Other Utilities	0	262	0	0	0	0	0	0	0	0	0	262	5
6	Maintenance	0	1,844	0	213	0	0	0	0	0	0	0	2,057	6
7	Other (specify):*	0	443	0	0	0	0	0	0	0	0	0	443	7
8	TOTAL General Services	(815)	6,017	0	213	0	0	0	0	0	0	0	5,415	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	32	0	0	0	0	0	0	0	0	0	32	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(7,105)	0	0	0	0	0	0	0	0	0	0	(7,105)	11
12	Social Services	(27)	0	0	0	0	0	0	0	0	0	0	(27)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(7,132)	32	0	0	0	0	0	0	0	0	0	(7,100)	16
	C. General Administration													
17	Administrative	0	(223,300)	0	0	0	0	0	0	0	0	0	(223,300)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	17,960	0	0	0	0	0	0	0	0	0	17,960	19
20	Fees, Subscriptions & Promotions	(265)	0	256	3,113	0	0	0	0	0	0	0	3,104	20
21	Clerical & General Office Expenses	(1,732)	0	37,636	134	0	0	0	0	0	0	0	36,038	21
22	Employee Benefits & Payroll Taxes	0	0	0	1,448	0	0	0	0	0	0	0	1,448	22
23	Inservice Training & Education	0	0	63	606	0	0	0	0	0	0	0	669	23
24	Travel and Seminar	0	0	6	0	0	0	0	0	0	0	0	6	24
25	Other Admin. Staff Transportation	0	0	4,313	2,053	0	0	0	0	0	0	0	6,366	25
26	Insurance-Prop.Liab.Malpractice	0	0	711	0	0	0	0	0	0	0	0	711	26
27	Other (specify):*	0	0	8,879	0	0	0	0	0	0	0	0	8,879	27
28	TOTAL General Administration	(1,997)	(205,340)	51,864	7,354	0	0	0	0	0	0	0	(148,119)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(9,944)	(199,291)	51,864	7,567	0	0	0	0	0	0	0	(149,804)	29

Summary B

12/31/2012

Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	(to Sch V, col.7)	
Depreciation	(22,304)	0	3,195	147	0	0	0	0	0	0	0	(18,962)	30	
Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31	
Interest	(641)	0	6,351	25,973	0	0	0	0	0	0	0	31,683	32	
Real Estate Taxes	0	0	470	0	0	0	0	0	0	0	0	470	33	
Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34	
Rent-Equipment & Vehicles	0	0	468	108	0	0	0	0	0	0	0	576	35	
Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36	
TOTAL Ownership	(22,945)	0	10,484	26,228	0	0	0	0	0	0	0	13,767	37	
Ancillary Expense														
E. Special Cost Centers														
Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38	
Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39	
Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40	
Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41	
Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42	
Other (specify):*	(30,300)	0	0	0	0	0	0	0	0	0	0	(30,300)	43	
TOTAL Special Cost Centers	(30,300)	0	0	0	0	0	0	0	0	0	0	(30,300)	44	
GRAND TOTAL COST (sum of lines 29, 37 & 44)	(63,189)	(199,291)	62,348	33,795	0	0	0	0	0	0	0	(166,337)	45	

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%	\$ 3,325	\$ 3,325	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	112	112	2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	26	26	3
4	V	4	Laundry		Petersen Health Care, Inc.	100.00%	5	5	4
5	V	5	Utilities		Petersen Health Care, Inc.	100.00%	262	262	5
6	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	1,844	1,844	6
7	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	443	443	7
8	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	32	32	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	286,800	Petersen Health Care, Inc.	100.00%	63,500	(223,300)	11
12	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	17,960	17,960	12
13	V								13
14	Total			\$ 286,800			\$ 87,509	\$ * (199,291)	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.

☒ X

 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%	\$ 256	\$ 256	15
16	V	21	Clerical and General Office		Petersen Health Care, Inc.	100.00%	37,636	37,636	16
17	V	23	Inservice Training & Education		Petersen Health Care, Inc.	100.00%	63	63	17
18	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	6	6	18
19	V	25	Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	4,313	4,313	19
20	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	711	711	20
21	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	8,879	8,879	21
22	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	3,195	3,195	22
23	V	32	Interest		Petersen Health Care, Inc.	100.00%	6,351	6,351	23
24	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	470	470	24
25	V	34	Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0		25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	468	468	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			\$			\$ 62,348	\$ * 62,348	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	\$	Petersen Health Network, LLC	100.00%	\$ 0	\$	15
16	V	2	Food		Petersen Health Network, LLC	100.00%	0		16
17	V	3	Housekeeping		Petersen Health Network, LLC	100.00%	0		17
18	V	4	Laundry		Petersen Health Network, LLC	100.00%	0		18
19	V	5	Utilities		Petersen Health Network, LLC	100.00%	0		19
20	V	6	Maintenance		Petersen Health Network, LLC	100.00%	213	213	20
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%	0		21
22	V	10	Nursing and Medical Records		Petersen Health Network, LLC	100.00%	0		22
23	V	12	Social Services		Petersen Health Network, LLC	100.00%	0		23
24	V	17	Administrative		Petersen Health Network, LLC	100.00%	0		24
25	V	19	Professional Services		Petersen Health Network, LLC	100.00%	0		25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Network, LLC	100.00%	3,113	3,113	26
27	V	21	Clerical and General Office		Petersen Health Network, LLC	100.00%	134	134	27
28	V	22	Employee Benefits & Payroll		Petersen Health Network, LLC	100.00%	1,448	1,448	28
29	V	23	Inservice Training & Education		Petersen Health Network, LLC	100.00%	606	606	29
30	V	24	Travel and Seminar		Petersen Health Network, LLC	100.00%	0		30
31	V	25	Other Admin. Staff Transport.		Petersen Health Network, LLC	100.00%	2,053	2,053	31
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Network, LLC	100.00%	0		32
33	V	27	Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%	0		33
34	V	30	Depreciation		Petersen Health Network, LLC	100.00%	147	147	34
35	V	32	Interest		Petersen Health Network, LLC	100.00%	25,973	25,973	35
36	V	33	Real Estate Taxes		Petersen Health Network, LLC	100.00%	0		36
37	V	34	Rent-Facility and Grounds		Petersen Health Network, LLC	100.00%	0		37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Network, LLC	100.00%	108	108	38
39	Total			\$			\$ 33,795	\$ * 33,795	39

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

Facility Name & ID Number

Flora Gardens Care Center

0050666

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

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 I	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 Frankfo	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				20
21			Flora Gardens Care Center	Flora				21
22			Flora Health Care Center	Flora				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 Gardens Care Center

0050666

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

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 Gardens Care Center

0050666

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

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

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								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Flora Gardens Care Center # 0050666 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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	N/A										4
5											5
6											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 Gardens Care Center # 0050666 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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, 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	1,569,393	74	\$ 285,707	\$ 284,214	18,264	\$ 3,325	1
2	2	Food	Resident Days	1,569,393	74	9,632	0	18,264	112	2
3	3	Housekeeping	Resident Days	1,569,393	74	2,201	0	18,264	26	3
4	4	Laundry	Resident Days	1,569,393	74	397	0	18,264	5	4
5	5	Utilities	Resident Days	1,569,393	74	22,546	0	18,264	262	5
6	6	Maintenance	Resident Days	1,569,393	74	158,485	73,431	18,264	1,844	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,569,393	74	38,057	0	18,264	443	7
8	10	Nursing and Medical Records	Resident Days	1,569,393	74	2,750	0	18,264	32	8
9	10A	Therapy	Resident Days	1,569,393	74	0	0	18,264	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,569,393	74	0	0	18,264	0	10
11	17	Administrative	Resident Days	1,569,393	74	4,353,655	4,353,655	18,264	63,500	11
12	19	Professional Services	Resident Days	1,569,393	74	1,543,275	0	18,264	17,960	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,569,393	74	21,988	0	18,264	256	13
14	21	Clerical and General Office	Resident Days	1,569,393	74	3,233,970	2,816,787	18,264	37,636	14
15	23	Inservice Training & Education	Resident Days	1,569,393	74	5,397	0	18,264	63	15
16	24	Travel and Seminar	Resident Days	1,569,393	74	535	0	18,264	6	16
17	25	Other Admin. Staff Transport.	Resident Days	1,569,393	74	370,568	0	18,264	4,313	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,569,393	74	61,077	0	18,264	711	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,569,393	74	762,912	0	18,264	8,879	19
20	30	Depreciation	Resident Days	1,569,393	74	274,514	0	18,264	3,195	20
21	32	Interest	Resident Days	1,569,393	74	545,764	0	18,264	6,351	21
22	33	Real Estate Taxes	Resident Days	1,569,393	74	40,424	0	18,264	470	22
23	34	Rent-Facility and Grounds	Resident Days	1,569,393	74	0	0	18,264	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,569,393	74	40,223	0	18,264	468	24
25	TOTALS					\$ 11,774,077	\$ 7,528,087		\$ 149,857	25

Facility Name & ID Number Flora Gardens Care Center# 0050666 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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 Network, LLC
 Street Address 830 W. Trailcreek Drive
 City / State / Zip Code Peoria, IL 61614
 Phone Number (309) 691-8113
 Fax Number (309) 691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	207,636	12	\$	\$	18,264	\$	1
2	2	Food	Resident Days	207,636	12			18,264		2
3	3	Housekeeping	Resident Days	207,636	12			18,264		3
4	4	Laundry	Resident Days	207,636	12			18,264		4
5	5	Utilities	Resident Days	207,636	12			18,264		5
6	6	Maintenance	Resident Days	207,636	12	2,422		18,264	213	6
7	7	Mgmt. Allocation of Benefits	Resident Days	207,636	12			18,264		7
8	10	Nursing and Medical Records	Resident Days	207,636	12			18,264		8
9	10A	Therapy	Resident Days	207,636	12			18,264		9
10	15	Mgmt. Allocation of Benefits	Resident Days	207,636	12			18,264		10
11	17	Administrative	Resident Days	207,636	12			18,264		11
12	19	Professional Services	Resident Days	207,636	12	35,385		18,264	3,113	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	207,636	12	1,525		18,264	134	13
14	21	Clerical and General Office	Resident Days	207,636	12	16,458		18,264	1,448	14
15	22	Employee Benefits & Payroll	Resident Days	207,636	12	6,884		18,264	606	15
16	24	Travel and Seminar	Resident Days	207,636	12			18,264		16
17	25	Other Admin. Staff Transport.	Resident Days	207,636	12	23,340		18,264	2,053	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	207,636	12			18,264		18
19	27	Mgmt. Allocation of Benefits	Resident Days	207,636	12			18,264		19
20	30	Depreciation	Resident Days	207,636	12	1,668		18,264	147	20
21	32	Interest	Resident Days	207,636	12	295,279		18,264	25,973	21
22	33	Real Estate Taxes	Resident Days	207,636	12			18,264		22
23	34	Rent-Facility and Grounds	Resident Days	207,636	12			18,264		23
24	35	Rent-Equipment & Vehicles	Resident Days	207,636	12	1,227		18,264	108	24
25	TOTALS					\$ 384,188	\$		\$ 33,795	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	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	The Private Bank		X	Mortgage	Varies	11/1/09	1,298,046	\$ 1,228,395	10/31/14	Varies	\$ 90,972	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 1,298,046	\$ 1,228,395			\$ 90,972	9	
	B. Non-Facility Related*												
10												10	
11								Interest Income Offset			(641)	11	
12								Home Office Allocation-PHC			6,351	12	
13								Home Office Allocation-PHN			25,973	13	
14	TOTAL Non-Facility Related						\$	\$			\$ 31,683	14	
15	TOTALS (line 9+line14)						\$ 1,298,046	\$ 1,228,395			\$ 122,655	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2011 report.			\$	44,280	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.)		2011	\$	43,818	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(462)	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	45,132	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.				470	
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	45,140	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007	38,949	8	
		2008	41,056	9	
		2009	41,715	10	
		2010	42,990	11	
		2011	43,818	12	
Accrual based on prior year tax bill.					

FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011 \$	13
14	PLUS APPEAL COST FROM LINE 5 \$	14
15	LESS REFUND FROM LINE 6 \$	15
16	AMOUNT TO USE FOR RATE CALCULATION \$	16

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Flora Gardens Care Center

COUNTY

Clay

FACILITY IDPH LICENSE NUMBER

0050666

CONTACT PERSON REGARDING THIS REPORT

Mark Petersen

TELEPHONE

(309)691-8113

FAX #:

(309) 691-8622

A.
Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2011.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	10-25-200-005	Long-Term Care Facility	\$ 43,818.31	\$ 43,818.31
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 43,818.31	\$ 43,818.31

B.
Real Estate Tax Cost Allocations

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

If YES, attach an explanation 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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:	28,770	B. General Construction Type:	Exterior	Masonry	Frame	Concrete Block	Number of Stories	1
------------------------	---------------	--------------------------------------	-----------------	----------------	--------------	-----------------------	--------------------------	----------

C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO
If so, please complete the following:

1. Total Amount Incurred: _____ **2. Number of Years Over Which it is Being Amortized:** _____

3. Current Period Amortization: _____ **4. Dates Incurred:** _____

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	216,659	2006	\$ 50,000	1
2					2
3	TOTALS	216,659		\$ 50,000	3

Facility Name & ID Number Flora Gardens Care Center

0050666

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

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	110		2006	1970	\$ 1,615,000	\$	30	\$ 53,833	\$ 53,833	\$ 349,915
5										
6										
7										
8										
	Improvement Type**									
9	Original Land Improvements			2006	15,000		15	1,000	1,000	6,500
10	Awning			2006	1,026		15	68	68	442
11	Install Drains, Venting and Sewer Lines in Utility Room			2007	3,250		15	217	217	1,193
12	Install Sidewalks			2007	10,270		15	685	685	3,767
13	Carpeting for 3 Offices			2007	2,099		10	210	210	1,155
14	Gutter Replacement			2007	661		15	44	44	242
15	Paint Dining Room			2007	3,875		10	388	388	2,134
16	Window Treatments			2007	755		10	76	76	418
17	Air Conditioner			2007	4,300		15	287	287	1,578
18	Interior work-dementia unit (Drywall, Electrical, Demolition)			2009	27,500		20	1,376	1,376	4,816
19	Exterior work-dementia unit (Landscaping, Fencing, Concrete)			2009	37,430		20	1,872	1,872	6,552
20	Lock Installation			2009	9,265		7	1,324	1,324	4,634
21	Electrical Circuit			2009	2,700		7	386	386	1,351
22	Sprinkler System Repair			2010	34,900		10	3,490	3,490	8,725
23	Dry Pipe Valve Repair			2010	3,590		7	512	512	1,280
24	Exterior work on dementia unit (landscaping finish from 2009)			2010	1,093		20	54	54	135
25	Air Conditioner			2011	5,980		15	398	398	597
26	Roof Replacement on East 300 Wing			2011	21,242		25	850	850	1,275
27	Air Conditioner			2012	5,976		15	199	199	199
28										
29										
30	Land Improvements Booked					1,901			(1,901)	
31	Building Booked					64,600			(64,600)	
32	Building Improvement Booked					11,443			(11,443)	
33										
34	2012-Home Office Allocation-Land Improvements				797			51	51	
35	2012-Home Office Allocation-Building Improvements				8,542			205	205	
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 and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 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)		\$ 1,815,251	\$ 77,944		\$ 67,525	\$ (10,419)	\$ 396,908	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	\$ 282,009	\$ 39,831	\$ 28,202	\$ (11,629)	5-10 yrs.	\$ 165,911	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Home Office Allocation			3,086	3,086			74
75	TOTALS	\$ 282,009	\$ 39,831	\$ 31,288	\$ (8,543)		\$ 165,911	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	Facility	1997 Dodge Ram	2009	\$ 5,100	\$ 1,020	\$ 1,020	\$	5	\$ 3,570	76
77										77
78										78
79										79
80	TOTALS			\$ 5,100	\$ 1,020	\$ 1,020	\$		\$ 3,570	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,152,360 81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 118,795 82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 99,833 83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (18,962) 84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 566,389 85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								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: \$5,509
- 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.	/2013	\$
13.	/2014	\$
14.	/2015	\$

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

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

Flora Gardens Care Center
0048538

Period Beginning **1/1/2012**
Period End **12/31/2012**

Schedule 14A

XII. Rental Costs
B. Equipment
16. Description of rental amount for movable equipment

Medical Equipment	\$	246
Dishwasher		832
Laundry Equipment		-
Copier		3,855
Home Office Allocation		576
		<u>5,509</u>

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		1	2	3	4
		Facility			
		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)	\$			

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.)										
		1	2	3	4	5	6	7	8	
	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(3)	hrs	\$	5,190	\$ 77,850	\$	5,190	\$ 77,850	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,629	39,434		2,629	39,434	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		4,332	64,978		4,332	64,978	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				82,011		82,011	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	12,151	\$ 182,262	\$ 82,011	12,151	\$ 264,273	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.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 600	\$ 600	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 73,000)	735,385	735,385	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	35,354	35,354	6
7	Other Prepaid Expenses	10,064	10,064	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Security Deposit	3,538	3,538	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 784,941	\$ 784,941	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	78,520	50,000	13
14	Buildings, at Historical Cost	1,615,000	1,623,542	14
15	Leasehold Improvements, at Historical Cost	161,636	191,709	15
16	Equipment, at Historical Cost	287,865	287,109	16
17	Accumulated Depreciation (book methods)	(679,878)	(566,389)	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 (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,463,143	\$ 1,585,971	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,248,084	\$ 2,370,912	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,146,608	\$ 1,146,608	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	70,806	70,806	30
31	Accrued Taxes Payable (excluding real estate taxes)	22,087	22,087	31
32	Accrued Real Estate Taxes(Sch.IX-B)	45,132	45,132	32
33	Accrued Interest Payable	7,637	7,637	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	64,340	64,340	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,356,610	\$ 1,356,610	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,228,395	1,228,395	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,228,395	\$ 1,228,395	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,585,005	\$ 2,585,005	46
47	TOTAL EQUITY(page 18, line 24)	\$ (336,921)	\$ (214,093)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,248,084	\$ 2,370,912	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (139,236)	1
2	Restatements (describe):		2
3	Rounding	(4)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (139,240)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(197,681)	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)	\$ (197,681)	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)	\$ (336,921)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Flora Gardens Care Center# 0050666Report Period Beginning: 1/1/2012Ending: 12/31/2012

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		2
I. Revenue	Amount		
A. Inpatient Care			
1 Gross Revenue -- All Levels of Care	\$ 2,516,055	1	
2 Discounts and Allowances for all Levels	(206,331)	2	
3 SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,309,724	3	
B. Ancillary Revenue			
4 Day Care		4	
5 Other Care for Outpatients		5	
6 Therapy	312,552	6	
7 Oxygen	2,084	7	
8 SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 314,636	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	45	13	
14 Non-Patient Meals	815	14	
15 Telephone, Television and Radio		15	
16 Rental of Facility Space		16	
17 Sale of Drugs	119,085	17	
18 Sale of Supplies to Non-Patients		18	
19 Laboratory		19	
20 Radiology and X-Ray	29,636	20	
21 Other Medical Services	2,373	21	
22 Laundry		22	
23 SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 151,954	23	
D. Non-Operating Revenue			
24 Contributions		24	
25 Interest and Other Investment Income***	641	25	
26 SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 641	26	
E. Other Revenue (specify):****			
27 Settlement Income (Insurance, Legal, Etc.)		27	
28 Miscellaneous Revenue	1,832	28	
28a Transportation Revenue	7,087	28a	
29 SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 8,919	29	
30 TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,785,874	30	

	1		2
II. Expenses	Amount		
A. Operating Expenses			
31 General Services	501,422	31	
32 Health Care	1,284,638	32	
33 General Administration	585,773	33	
B. Capital Expense			
34 Ownership	259,370	34	
C. Ancillary Expense			
35 Special Cost Centers	112,311	35	
36 Provider Participation Fee	240,041	36	
D. Other Expenses (specify):			
37		37	
38		38	
39		39	
40 TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,983,555	40	
41 Income before Income Taxes (line 30 minus line 40)**	(197,681)	41	
42 Income Taxes		42	
43 NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (197,681)	43	

	1		2
III. Net Inpatient Revenue detailed by Payer Source	Amount		
44 Medicaid - Net Inpatient Revenue	\$ 1,623,295	44	
45 Private Pay - Net Inpatient Revenue	425,060	45	
46 Medicare - Net Inpatient Revenue	265,727	46	
47 Other-(specify) <u>Charity Therapy Allowance</u>	(3,848)	47	
48 Other-(specify) <u>Insurance Contractual Allowance</u>	(510)	48	
49 TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,309,724	49	

* 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.

*** 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.

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,346	1,346	\$ 34,230	\$ 25.43	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,992	11,212	248,043	22.12	3
4	Licensed Practical Nurses	6,908	7,213	129,814	18.00	4
5	CNAs & Orderlies	44,249	45,624	478,306	10.48	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,935	2,132	28,469	13.35	9
10	Activity Assistants					10
11	Social Service Workers	2,336	2,336	38,705	16.57	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	38,574	18.55	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,200	9,549	87,312	9.14	15
16	Dishwashers					16
17	Maintenance Workers	4,151	4,339	52,705	12.15	17
18	Housekeepers	6,557	6,892	65,285	9.47	18
19	Laundry	3,247	3,549	31,061	8.75	19
20	Administrator	2,080	2,080	63,500	30.53	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,109	2,319	29,247	12.61	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) See PG20A	5,614	5,685	94,465	16.62	33
34	TOTAL (lines 1 - 33)	102,804	106,356	\$ 1,419,716 *	\$ 13.35	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	6,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,310	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)		\$ 9,310		49

C. CONTRACT NURSES

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

Flora Gardens Care Center
0048538
Period Beginning 1/1/2012
Period End 12/31/2012

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	1,998	1,998	40,952	20.50
Alzheimer's Coordinator	1,644	1,644	34,777	21.15
Transportation	1,972	2,043	18,736	9.17
Marketing	-	-	-	
TOTAL	5,614	5,685	94,465	

STATE OF ILLINOIS

0050666

Report Period Beginning:

1/1/2012

Page 21

Ending: 12/31/2012

Facility Name & ID Number

Flora Gardens Care Center

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kathleen Carter	Administrator	0	\$ 63,500
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 63,500

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	\$ 286,800
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$ 286,800

C. Professional Services

Vendor/Payee	Type	Amount
E-Health Data Solutions	Computer Services	\$ 1,498
Honkamp, Krueger & Co.	Accounting Fees	1,312
Frontier	Computer Services	765
Sorling, Northrup, and Hanna	Legal Fees	3,581
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)		\$ 7,156

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 42,830
Unemployment Compensation Insurance	37,669
FICA Taxes	102,949
Employee Health Insurance	10,682
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	790
Home Office Allocation	606
TOTAL (agree to Schedule V, line 22, col.8)	\$ 195,526

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$ 7,978
Advertising: Employee Recruitment	244
Health Care Worker Background Check (Indicate # of checks performed)	
Patient Background Checks	89
Miscellaneous Licenses & Permits	397
Miscellaneous Dues & Subscriptions	340
Home Office Allocation	390
Less: Public Relations Expense	(265)
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 9,977

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	
Home Office Allocation	6
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 6

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

Flora Gardens Care Center
0048538
Period Beginning 1/1/2012
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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)		7,156

Home Office Allocation

Sorling Northrup	Legal	57
Ginoli & Company	Accountants	2,000
Miscellaneous	Computer Services	130
Nebo Systems	Computer Services	2
Advanced Answers on Demand	Computer Services	2775
Access 2 Go	Computer Services	117
Stratus Networks	Computer Services	115
Kemper Technology	Computer Services	189
CCH	Computer Services	10
Medifax	Computer Services	22
Vision Share/Ability Network	Computer Services	212
Barracuda	Computer Services	8
CIAN	Computer Services	58
Comcast	Computer Services	18
Postini	Computer Services	179
Optimizer Systems	Other Prof Fees	28
Marotta Gund Budd & Dzera	Other Prof Fees	12851
David Budde	Other Prof Fees	11
Courtney Bourban	Other Prof Fees	158
All Scripts	Other Prof Fees	485
Heritage Enterprises	Other Prof Fees	11
Miscellaneous Vendors	Other Prof Fees	3
Duane Morris	Legal	159
Peoria County Recorder	Legal	4
E-Health Data Solutions	Computer Services	43

Ability Network	Computer Services	364
Market Feasibility Advisors	Other Prof Fees	1064
Total (agree to Schedule V, line 19, column 8)		<u>28,229</u>

Period Beginning

1/1/2011

Period End

12/31/2011

Schedule 21B

XIX. SUPPORT SCHEDULE
Legal Fees

Facility			
Vendor/Payee	Invoice Total	Allocation %	Total
		100%	-
Home Office Allocation			
Heyl, Royster, Voelker, and Allen			-
GoffWilson			-
Jackson Lewis			-
Peter Gartelos			-
Miscellaneous Vendors			-
Total Legal Fees			-

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	Amount of Expense Amortized Per Year								
					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		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. _____
- (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. \$ 9,525 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. \$ 240,041
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. \$ 815
- (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. \$ 7,087
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? 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. \$ _____
- (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? No
Attach invoices and a summary of services for all architect and appraisal fees.