

		FOR BHF USE					

LL1

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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 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) 673-3009
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 1/1/2016 to 12/31/2016 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)
(Type or Print Name) Mark B. Petersen
(Title) Chief Executive Officer

Paid
Preparer

(Signed)
(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: 1/1/2016 Ending: 12/31/2016

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds

N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>105</u>	Skilled (SNF)	<u>105</u>	<u>38,325</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>2</u>	Intermediate (ICF)	<u>2</u>	<u>730</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>11,804</u>	<u>2,606</u>	<u>2,428</u>	<u>16,838</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>11,804</u>	<u>2,606</u>	<u>2,428</u>	<u>16,838</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 43.11%

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 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 97 and days of care provided 2,222

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number Flora Gardens Care Center # 0050666 Report Period Beginning: 1/1/2016 Ending: 12/31/2016
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	117,159	11,155	1,552	129,866		129,866	3,459	133,325			1
2	Food Purchase		112,307		112,307		112,307	(1,773)	110,534			2
3	Housekeeping	115,363	15,068		130,431		130,431	60	130,491			3
4	Laundry		7,695		7,695		7,695		7,695			4
5	Heat and Other Utilities			76,158	76,158		76,158	202	76,360			5
6	Maintenance	28,823	21,635	18,610	69,068		69,068	1,888	70,956			6
7	Other (specify):* <u>Home Office Ben. Allocation</u>											7
8	TOTAL General Services	261,345	167,860	96,320	525,525		525,525	3,836	529,361			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,027,412	84,735	9,517	1,121,664		1,121,664	19	1,121,683			10
10a	Therapy			329,046	329,046		329,046		329,046			10a
11	Activities	50,939	53	8	51,000		51,000	(8,104)	42,896			11
12	Social Services	41,222	85		41,307		41,307		41,307			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* <u>Home Office Ben. Allocation</u>											15
16	TOTAL Health Care and Programs	1,119,573	84,873	344,571	1,549,017		1,549,017	(8,085)	1,540,932			16
	C. General Administration											
17	Administrative			242,700	242,700		242,700	(131,033)	111,667			17
18	Directors Fees											18
19	Professional Services			52,370	52,370		52,370	14,019	66,389			19
20	Dues, Fees, Subscriptions & Promotions			8,834	8,834		8,834	208	9,042			20
21	Clerical & General Office Expenses	27,058	3,565	15,437	46,060		46,060	40,296	86,356			21
22	Employee Benefits & Payroll Taxes			178,360	178,360		178,360	22,546	200,906			22
23	Inservice Training & Education			450	450		450	77	527			23
24	Travel and Seminar							38	38			24
25	Other Admin. Staff Transportation			6,090	6,090		6,090	3,172	9,262			25
26	Insurance-Prop.Liab.Malpractice			32,564	32,564		32,564	447	33,011			26
27	Other (specify):* <u>Home Office Ben. Allocation</u>											27
28	TOTAL General Administration	27,058	3,565	536,805	567,428		567,428	(50,230)	517,198			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,407,976	256,298	977,696	2,641,970		2,641,970	(54,479)	2,587,491			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			94,610	94,610		94,610	7,585	102,195			30
31	Amortization of Pre-Op. & Org.							8,087	8,087			31
32	Interest			65,251	65,251		65,251	10,462	75,713			32
33	Real Estate Taxes			50,094	50,094		50,094	205	50,299			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			10,286	10,286		10,286	725	11,011			35
36	Other (specify):*											36
37	TOTAL Ownership			220,241	220,241		220,241	27,064	247,305			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		79,808		79,808		79,808		79,808			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			147,669	147,669		147,669		147,669			42
43	Other (specify):*		410	53,962	54,372		54,372	(54,372)				43
44	TOTAL Special Cost Centers		80,218	201,631	281,849		281,849	(54,372)	227,477			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,407,976	336,516	1,399,568	3,144,060		3,144,060	(81,787)	3,062,273			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,836)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,949)	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	(1,623)	30		9
10	Interest and Other Investment Income	(5)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(96)	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	(6,107)	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	(35,800)	43		24
25	Fund Raising, Advertising and Promotional	(1,835)	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	(15,957)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (66,208)		\$	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)	(15,579)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (15,579)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (81,787)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (2,910)	43	1
2	X-Rays-Part A	(3,875)	43	2
3	Offset Transportation Revenue	(8,104)	11	3
4	Disallowed Special Events	(718)	43	4
5	Offset Miscellaneous Office Supplies Revenue	(25)	21	5
6	Resident Flowers	(82)	43	6
7	Disallowed Chamber of Commerce Dues	(160)	20	7
8	Offset Miscellaneous Nursing Supplies Revenue	(83)	11	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
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	(15,957)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Flora Gardens Care Center# 0050666

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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	3,459	0	0	0	0	0	0	0	0	0	3,459	1
2	Food Purchase	(1,836)	63	0	0	0	0	0	0	0	0	0	(1,773)	2
3	Housekeeping	0	60	0	0	0	0	0	0	0	0	0	60	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	202	0	0	0	0	0	0	0	0	0	202	5
6	Maintenance	0	1,888	0	0	0	0	0	0	0	0	0	1,888	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,836)	5,672	0	0	0	0	0	0	0	0	0	3,836	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	102	0	0	0	0	0	0	0	0	0	102	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(8,187)	0	0	0	0	0	0	0	0	0	0	(8,187)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	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	(8,187)	102	0	0	0	0	0	0	0	0	0	(8,085)	16
	C. General Administration													
17	Administrative	0	(131,033)	0	0	0	0	0	0	0	0	0	(131,033)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	8,808	0	5,211	0	0	0	0	0	0	0	14,019	19
20	Fees, Subscriptions & Promotions	(160)	0	368	0	0	0	0	0	0	0	0	208	20
21	Clerical & General Office Expenses	(25)	0	40,321	0	0	0	0	0	0	0	0	40,296	21
22	Employee Benefits & Payroll Taxes	0	0	22,546	0	0	0	0	0	0	0	0	22,546	22
23	Inservice Training & Education	0	0	77	0	0	0	0	0	0	0	0	77	23
24	Travel and Seminar	0	0	38	0	0	0	0	0	0	0	0	38	24
25	Other Admin. Staff Transportation	0	0	3,172	0	0	0	0	0	0	0	0	3,172	25
26	Insurance-Prop.Liab.Malpractice	0	0	447	0	0	0	0	0	0	0	0	447	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(185)	(122,225)	66,969	5,211	0	0	0	0	0	0	0	(50,230)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(10,208)	(116,451)	66,969	5,211	0	0	0	0	0	0	0	(54,479)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Flora Gardens Care Center # 0050666 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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

	Capital Expense	PAGES	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)	
30	Depreciation	(1,623)	0	8,923	285	0	0	0	0	0	0	0	7,585	30
31	Amortization of Pre-Op. & Org.	0	0	0	8,087	0	0	0	0	0	0	0	8,087	31
32	Interest	(5)	0	262	10,205	0	0	0	0	0	0	0	10,462	32
33	Real Estate Taxes	0	0	205	0	0	0	0	0	0	0	0	205	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	725	0	0	0	0	0	0	0	0	725	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,628)	0	10,115	18,577	0	0	0	0	0	0	0	27,064	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(54,372)	0	0	0	0	0	0	0	0	0	0	(54,372)	43
44	TOTAL Special Cost Centers	(54,372)	0	0	0	0	0	0	0	0	0	0	(54,372)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(66,208)	(116,451)	77,084	23,788	0	0	0	0	0	0	0	(81,787)	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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	\$	Petersen Health Care Management, Inc.	100.00%	\$ 3,459	\$ 3,459	1
2	V	2	Food		Petersen Health Care Management, Inc.	100.00%	63	63	2
3	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	60	60	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	202	202	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	1,888	1,888	5
6	V	7	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		6
7	V	9	Medical Director		Petersen Health Care Management, Inc.	100.00%	0		7
8	V	10	Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	102	102	8
9	V	10A	Therapy		Petersen Health Care Management, Inc.	100.00%	0		9
10	V	15	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		10
11	V	17	Administrative	242,700	Petersen Health Care Management, Inc.	100.00%	111,667	(131,033)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	8,808	8,808	12
13	V								13
14	Total			\$ 242,700			\$ 126,249	\$ * (116,451)	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 Management, Inc.	100.00%	\$ 368	\$ 368	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	40,321	40,321	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	22,546	22,546	17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	77	77	18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	38	38	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	3,172	3,172	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	447	447	21
22	V	27	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		22
23	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	8,923	8,923	23
24	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	262	262	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	205	205	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	725	725	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			\$			\$ 77,084	\$ * 77,084	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%	0		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	15	Mgmt. Allocation of Benefits		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%	5,211	5,211	25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Network, LLC	100.00%	0		26
27	V	21	Clerical and General Office		Petersen Health Network, LLC	100.00%	0		27
28	V	22	Employee Benefits & Payroll		Petersen Health Network, LLC	100.00%	0		28
29	V	23	Inservice Training & Education		Petersen Health Network, LLC	100.00%	0		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%	0		31
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Network, LLC	100.00%	0		32
33	V	30	Depreciation		Petersen Health Network, LLC	100.00%	285	285	33
34	V	31	Amortization		Petersen Health Network, LLC	100.00%	8,087	8,087	34
35	V	32	Interest		Petersen Health Network, LLC	100.00%	10,205	10,205	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%	0		38
39	Total			\$			\$ 23,788	\$ * 23,788	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:

1/1/2016

Ending:

12/31/2016

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 Hospitality L	Peoria	Hospitality	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Management	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Busin	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	Lessor	13
14			Decatur Rehab & Health Care Center	Decatur	Midwest Health Opera	Peoria	Mgmt/Bookkeeping	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Health Prope	Peoria	Mgmt/Bookkeeping	15
16			Eastview Terrace	Sullivan	Petersen Roseville, LL	Roseville	Lessor	16
17			El Paso Health Care Center	El Paso	Petersen Health Juncti	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Petersen Health Qualit	Peoria	Mgmt/Bookkeeping	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Health and W	Peoria	Mgmt/Bookkeeping	19
20			Flanagan Rehab & Health Care Center	Flanagan	Petersen 24, LLC	Peoria	Hospitality	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:

1/1/2016

Ending:

12/31/2016

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			Palm Terrace of Mattoon	Mattoon				7
8			Piper City Rehab & Living Center	Piper City				8
9			Pleasant View Rehab & Health Care Center	Morrison				9
10			Polo Rehabilitation & Health Care Center	Polo				10
11			Prairie City Rehab & Health Care Center	Prairie City				11
12			Robings Manor Nursing Home	Brighton				12
13			Rochelle Gardens	Rochelle				13
14			Rochelle Rehab & Health Care Center	Rochelle				14
15			Rock Falls Rehab & Health Care Center	Rock Falls				15
16			Arrow Wood Independent Living	Rock Falls				16
17			Roseville Rehab and Health Care Center	Roseville				17
18			Rosiclare Rehab & Health Care Center	Rosiclare				18
19			Royal Oaks Care Center	Kewanee				19
20			Sandwich Rehab & Health Care Center	Sandwich				20
21			Iron Wood Independent Living	Sandwich				21
22			Shawnee Rose Care Center	Harrisburg				22
23			Shelbyville Rehab & Health Care Center	Shelbyville				23
24			South Elgin Rehab & Health Care Center	South Elgin				24
25			Sullivan Health Care Center	Sullivan				25
26			Sunset Manor Nursing Home	Canton				26
27			Swansea Rehab & Health Care	Swansea				27
28			Timbercreek Rehab & Health Center	Pekin				28
29			Toulon Health Care Center	Toulon				29
30			Tuscola Health Care Center	Tuscola				30

Facility Name & ID Number

Flora Gardens Care Center

0050666

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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			Twin Lakes Rehab & Health Care Center	Paris				1
2			Vandalia Rehab & Health Care Center	Vandalia				2
3			Watseka Health Care Center	Watseka				3
4			Westside Rehab & Care Center	West Frankfort				4
5			Whispering Oaks	Rosiclare				5
6			White Oak Rehab & Health Care Center	Mt. Vernon				6
7			Willow Rose Rehab & Health Care Center	Jerseyville				7
8			Sheldon Health Care Center	Sheldon				8
9			Tuscola Health Care Center	Tuscola				9
10			Effingham Health Care Center	Effingham				10
11			Collinsville Health Care Center	Collinsville				11
12			Ozark Rehab & Health Care Center	Osage Beach, MO				12
13			Tarkio Rehab & Health Care Center	Tarkio, MO				13
14			Shangri-la Rehab & Living Center	Blue Springs, MO				14
15			Prairie Rose Care Center	Pana				15
16			Illini Heritage Rehab & Health Center	Champaign				16
17			Courtyard Estates of Kewanee	Kewanee				17
18			Courtyard Estates of Bradford	Bradford				18
19			Courtyard Estates of Galva	Galva				19
20			Courtyard Estates of Walcott	Walcott				20
21			Courtyard Village of Kewanee	Kewanee				21
22			Lakewood Village	Charleston				22
23			Courtyard Estates of Monmouth	Monmouth				23
24			Riverview Estates	Havana				24
25			Simple Blessings	Casey				25
26			Courtyard Estates of Bushnell	Bushnell				26
27			Courtyard Estates of Canton	Canton				27
28			Legacy Estates of Monmouth	Monmouth				28
29			Courtyard Estates of Sullivan	Sullivan				29
30			Courtyard Estates of Peoria	Peoria				30

Facility Name & ID Number

Flora Gardens Care Center

0050666

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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			Cornerstone Health and Rehabilitation	Peoria				1
2			Rock River Gardens	Sterling				2
3			Sauk Valley Senior Living & Rehabilitation	Rock Falls				3
4			Courtyard Estates of Farmington	Farmington				4
5			Courtyard Estates of Knoxville	Knoxville				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: 1/1/2016 Ending: 12/31/2016

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	N/A										3
4											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:

1/1/2016Ending: 2/31/2016

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 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

1	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line	Item	(i.e., Days, Direct Cost, Square Feet)	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference				Allocated Among	Allocated	in Column 6			
1	1	Dietary	Resident Days	75	\$ 312,540	\$ 357,910	16,838	\$ 3,459	1
2	2	Food	Resident Days	75	5,673	0	16,838	63	2
3	3	Housekeeping	Resident Days	75	5,456	2,897	16,838	60	3
4	5	Utilities	Resident Days	75	18,209	0	16,838	202	4
5	6	Maintenance	Resident Days	75	170,632	137,057	16,838	1,888	5
6	7	Mgmt. Allocation of Benefits	Resident Days	75	0	0	16,838	0	6
7	9	Medical Director	Resident Days	75	0	0	16,838	0	7
8	10	Nursing and Medical Records	Resident Days	75	9,261	1,782,521	16,838	102	8
9	10A	Therapy	Resident Days	75	0	0	16,838	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	75	0	0	16,838	0	10
11	17	Administrative	Resident Days	75	4,806,228	5,473,961	16,838	111,667	11
12	19	Professional Services	Resident Days	75	795,918	0	16,838	8,808	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	75	33,278	0	16,838	368	13
14	21	Clerical and General Office	Resident Days	75	3,643,535	3,756,135	16,838	40,321	14
15	22	Employee Benefits and Payroll Ta	Resident Days	75	2,037,314	0	16,838	22,546	15
16	23	Inservice Training & Education	Resident Days	75	6,986	0	16,838	77	16
17	24	Travel and Seminar	Resident Days	75	3,389	0	16,838	38	17
18	25	Other Admin. Staff Transport.	Resident Days	75	286,637	0	16,838	3,172	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	75	40,378	0	16,838	447	19
20	27	Mgmt. Allocation of Benefits	Resident Days	75	0	0	16,838	0	20
21	30	Depreciation	Resident Days	75	806,271	0	16,838	8,923	21
22	32	Interest	Resident Days	75	23,686	0	16,838	262	22
23	33	Real Estate Taxes	Resident Days	75	18,560	0	16,838	205	23
24	35	Rent-Equipment & Vehicles	Resident Days	75	65,550	0	16,838	725	24
25	TOTALS				\$ 13,089,501	\$ 11,510,481		\$ 203,333	25

Facility Name & ID Number Flora Gardens Care Center# 0050666

Report Period Beginning:

1/1/2016Ending: 2/31/2016

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	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line	Item	(i.e., Days, Direct Cost, Square Feet)	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference				Allocated Among	Allocated	in Column 6			
1	1	Dietary	Resident Days	251,294	13	\$	16,838	\$	1
2	2	Food	Resident Days	251,294	13		16,838		2
3	3	Housekeeping	Resident Days	251,294	13		16,838		3
4	4	Laundry	Resident Days	251,294	13		16,838		4
5	5	Utilities	Resident Days	251,294	13		16,838		5
6	6	Maintenance	Resident Days	251,294	13		16,838		6
7	7	Mgmt. Allocation of Benefits	Resident Days	251,294	13		16,838		7
8	10	Nursing and Medical Records	Resident Days	251,294	13		16,838		8
9	15	Mgmt. Allocation of Benefits	Resident Days	251,294	13		16,838		9
10	17	Administrative	Resident Days	251,294	13		16,838		10
11	19	Professional Services	Resident Days	251,294	13	77,776	16,838	5,211	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	251,294	13		16,838		12
13	21	Clerical and General Office	Resident Days	251,294	13		16,838		13
14	22	Employee Benefits & Payroll	Resident Days	251,294	13		16,838		14
15	23	Inservice Training & Education	Resident Days	251,294	13		16,838		15
16	24	Travel and Seminar	Resident Days	251,294	13		16,838		16
17	25	Other Admin. Staff Transport.	Resident Days	251,294	13		16,838		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	251,294	13		16,838		18
19	30	Depreciation	Resident Days	251,294	13	4,252	16,838	285	19
20	31	Amortization	Resident Days	251,294	13	120,699	16,838	8,087	20
21	32	Interest	Resident Days	251,294	13	152,300	16,838	10,205	21
22	33	Real Estate Taxes	Resident Days	251,294	13		16,838		22
23	34	Rent-Facility and Grounds	Resident Days	251,294	13		16,838		23
24	35	Rent-Equipment & Vehicles	Resident Days	251,294	13		16,838		24
25	TOTALS					\$ 355,027	\$	23,788	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	Wells Fargo		X	Mortgage	Varies	1/1/15	\$ 1,418,067	\$ 1,262,080	12/31/34	Varies	\$ 65,251	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 1,418,067	\$ 1,262,080			\$ 65,251	9	
	B. Non-Facility Related*												
10								Interest Income Offset			(5)	10	
11								Home Office Allocation-PHN			10,205	11	
12								Home Office Allocation-PHCM			262	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ 10,462	14	
15	TOTALS (line 9+line14)						\$ 1,418,067	\$ 1,262,080			\$ 75,713	15	

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

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

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

FACILITY NAME Flora Gardens Care Center COUNTY Clay
FACILITY IDPH LICENSE NUMBER 0050666
CONTACT PERSON REGARDING THIS REPORT MIKE KOCHER
TELEPHONE (309)689-5850 FAX #: (309)691-8622

Enter the tax index number and real estate tax assessed for 2015 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 2015.

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: ExteriorMasonryFrameConcrete Block

Number of Stories1

C. Does the Operating Entity?

X(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?

X(a) Own the Equipment

(b) Rent equipment from a Related Organization.

X(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

XNO

If so, please complete the following:

1. Total Amount Incurred: 561,304

2. Number of Years Over Which it is Being Amortized: 20

3. Current Period Amortization: 8,087

4. Dates Incurred: 2013-2014

Nature of Costs:

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

XI. OWNERSHIP COSTS:

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

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	\$ 1,630,000	\$	30	\$ 53,833	\$ 53,833	\$ 565,247	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Install Drains, Venting and Sewer Lines in Utility Room			2007	3,250		15	217	217	1,844	9
10	Install Sidewalks			2007	10,270		15	685	685	5,822	10
11	Paint Dining Room			2007	3,875		10	388	388	3,298	11
12	Air Conditioner			2007	4,300		15	287	287	2,439	12
13	Interior work-dementia unit (Drywall, Electrical, Demolition)			2009	27,500		20	1,376	1,376	8,944	13
14	Exterior work-dementia unit (Landscaping, Fencing, Concrete)			2009	37,430		20	1,872	1,872	12,168	14
15	Lock Installation			2009	9,265		7	1,324	1,324	8,606	15
16	Sprinkler System Repair			2010	34,900		10	3,490	3,490	19,195	16
17	Dry Pipe Valve Repair			2010	3,590		7	512	512	2,816	17
18	Air Conditioner			2011	5,980		15	398	398	1,791	18
19	Roof Replacement on East 300 Wing			2011	21,242		25	850	850	3,825	19
20	Air Conditioner			2012	5,976		15	398	398	1,791	20
21	Roof Replacement on East Wing and West Wing			2014	182,902		25	7,316	7,316	18,290	21
22	Drywall, Ceiling			2014	4,635		7	662	662	1,655	22
23	Generator Repair			2015	2,925		7	418	418	627	23
24											24
25											25
26											26
27											27
28											28
29											29
30	Land Improvements Booked					1,901			(1,901)		30
31	Building Booked					64,600			(64,600)		31
32	Building Improvement Booked					20,520			(20,520)		32
33											33
34	2016-Home Office Allocation-Building Improvements				7,434			178	178		34
35	2016-Home Office Allocation-Land Improvements				684			44	44		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 Gardens Care Center

0050666

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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)		\$ 1,996,158	\$ 87,021		\$ 74,248	\$ (12,773)	\$ 658,358	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	\$ 293,924	\$ 7,169	\$ 18,361	\$ 11,192	5-10 yrs.	\$ 272,306	71
72	Current Year Purchases	8,397	420	600	180	7 yrs.	600	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			8,986	8,986			74
75	TOTALS	\$ 302,321	\$ 7,589	\$ 27,947	\$ 20,358		\$ 272,906	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		\$ 5,100	\$	\$	\$		\$ 5,100	76
77										77
78										78
79										79
80	TOTALS			\$ 5,100	\$	\$	\$		\$ 5,100	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)	\$ 2,353,579	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 94,610	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 102,195	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 7,585	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 936,364	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			93
94	N/A		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: \$ 11,011
- 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

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.	<u>/2017</u>	\$
13.	<u>/2018</u>	\$
14.	<u>/2019</u>	\$

* 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
0050666
Period Beginning 1/1/2016
Period End 12/31/2016

Schedule 14A

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

Medical Equipment	\$	7,246
Dishwasher		704
Copier		2,336
Home Office Allocation		725
		<u>11,011</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

ALLOCATION OF COSTS (d)

		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)	\$			

- (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.

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	

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	\$	8,935	\$ 134,028	\$	8,935	\$ 134,028	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		5,178	77,674		5,178	77,674	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		7,823	117,344		7,823	117,344	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				79,808		79,808	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			\$	21,936	\$ 329,046	\$ 79,808	21,936	\$ 408,854	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.

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	\$ 184,002	\$ 184,002	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 58,218)	929,852	929,852	3
4	Supply Inventory (priced at Cost)	10,064	10,064	4
5	Short-Term Investments			5
6	Prepaid Insurance	31,540	31,540	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Prepaid Expenses</u>	3,625	3,625	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,159,083	\$ 1,159,083	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	1,637,434	14
15	Leasehold Improvements, at Historical Cost	352,097	358,724	15
16	Equipment, at Historical Cost	307,421	307,421	16
17	Accumulated Depreciation (book methods)	(1,073,206)	(936,364)	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)	\$ 1,279,832	\$ 1,417,215	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,438,915	\$ 2,576,298	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 651,330	\$ 651,330	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	74,960	74,960	30
31	Accrued Taxes Payable (excluding real estate taxes)	26,363	26,363	31
32	Accrued Real Estate Taxes(Sch.IX-B)	49,872	49,872	32
33	Accrued Interest Payable	5,564	5,564	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	21,329	21,329	36
37	<u>Accrued Management Fees</u>	23,109	23,109	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 852,527	\$ 852,527	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,262,080	1,262,080	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)	\$ 1,262,080	\$ 1,262,080	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,114,607	\$ 2,114,607	46
47	TOTAL EQUITY(page 18, line 24)	\$ 324,308	\$ 461,691	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,438,915	\$ 2,576,298	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 171,051	1
2	Restatements (describe):		2
3	Rounding	2	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 171,053	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	153,255	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)	\$ 153,255	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)	\$ 324,308	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Flora Gardens Care Center

0050666

Report Period Beginning: 1/1/2016

Ending: 12/31/2016

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	\$ 2,787,830	1
2	Discounts and Allowances for all Levels	(269,297)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,518,533	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	607,780	6
7	Oxygen	1,665	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 609,445	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	1,836	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	127,548	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	23,868	20
21	Other Medical Services	7,691	21
22	Laundry	177	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 161,120	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation Revenue</u>	8,104	28
28a	<u>Miscellaneous Revenue</u>	108	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 8,212	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,297,315	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	525,525	31
32	Health Care	1,549,017	32
33	General Administration	567,428	33
	B. Capital Expense		
34	Ownership	220,241	34
	C. Ancillary Expense		
35	Special Cost Centers	134,180	35
36	Provider Participation Fee	147,669	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,144,060	40
41	Income before Income Taxes (line 30 minus line 40)**	153,255	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 153,255	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,629,570	44
45	Private Pay - Net Inpatient Revenue	399,700	45
46	Medicare - Net Inpatient Revenue	486,811	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	2,452	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,518,533	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.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,130	2,130	\$ 57,708	\$ 27.09	1
2	Assistant Director of Nursing					2
3	Registered Nurses	12,442	12,929	284,205	21.98	3
4	Licensed Practical Nurses	7,043	7,231	130,686	18.07	4
5	CNAs & Orderlies	39,761	40,768	468,494	11.49	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,960	2,080	31,310	15.05	9
10	Activity Assistants					10
11	Social Service Workers	2,080	2,080	41,222	19.82	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	25,335	12.18	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,661	10,005	91,824	9.18	15
16	Dishwashers					16
17	Maintenance Workers	1,843	1,964	28,823	14.68	17
18	Housekeepers	11,369	11,968	115,363	9.64	18
19	Laundry					19
20	Administrator	2,080	2,080	111,667	53.69	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,826	1,868	27,058	14.49	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>PG20A</u>	5,432	5,871	105,948	18.05	33
34	TOTAL (lines 1 - 33)	99,707	103,054	\$ 1,519,643 *	\$ 14.75	34

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	26	\$ 1,552	L1, C3	35
36	Medical Director	Monthly	6,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,671	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)	26	\$ 11,223		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

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

** See instructions.

Flora Gardens Care Center
0050666
Period Beginning 1/1/2016
Period End 12/31/2016

Schedule 20A

XVIII. Staffing and Salary Costs

		Reporting Period		
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries, Wages
				Average Hourly Wage
Care Plan Coordinator		1,840	1,980	49,547
Alzheimer's Coordinator		1,682	1,786	36,772
Transportation		1,910	2,105	19,629
	TOTAL	5,432	5,871	105,948

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	
Pamela Goodman		Administrator	0	\$ 111,667	Workers' Compensation Insurance		\$ 40,618	IDPH License Fee		\$ 1,990	
					Unemployment Compensation Insurance		29,623	Advertising: Employee Recruitment		511	
					FICA Taxes		104,938	Health Care Worker Background Check			
					Employee Health Insurance		2,256	(Indicate # of checks performed 33)		461	
					Employee Meals			Patient Background Checks 22		307	
					Illinois Municipal Retirement Fund (IMRF)*			Miscellaneous Licenses & Permits		420	
					Employee Relations		924	Miscellaneous Dues & Subscriptions		5,145	
					Home Office Allocation		22,546	Home Office Allocation		368	
TOTAL (agree to Schedule V, line 17, col. 1)											
(List each licensed administrator separately.)				\$ 111,667							
B. Administrative - Other											
Description				Amount				Less: Public Relations Expense		(160)	
Management Fees-See Page 6, Eliminated on P 3, C 7				\$ 242,700				Non-allowable advertising		()	
								Yellow page advertising		()	
TOTAL (agree to Schedule V, line 17, col. 3)				\$ 242,700	TOTAL (agree to Schedule V, line 22, col.8)		\$ 200,906				
(Attach a copy of any management service agreement)								TOTAL (agree to Sch. V, line 20, col. 8)		\$ 9,042	
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
E-Health Data Solutions		Computer Services		\$ 3,053					Out-of-State Travel		\$
Frontier		Computer Services		751							
Honkamp, Krueger & Co.		Accounting Fees		591	N/A						
Sorling Northrup		Legal Fees-Stanford Case		47,872					In-State Travel		
Ability Network		Computer Services		102							
									Seminar Expense		
									Home Office Allocation		38
									Entertainment Expense		()
TOTAL (agree to Schedule V, line 19, column 3)					TOTAL				(agree to Sch. V, line 24, col. 8)		
(For legal fee disclosure, see page 39 of instructions)				\$ 52,370					TOTAL		\$ 38

*** Attach copy of IMRF notifications**

****See instructions.**

Flora Gardens Care Center
0050666
Period Beginning 1/1/2016
Period End 12/31/2016

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		52,370
Home Office Allocation		
Lucie, Scalf, and Bougher	Legal	39
Miscellaneous	Legal	13
Miller Hall and Triggs	Legal	68
Healthcare Resources International	Legal	815
Hunziker Law	Legal	81
Lexis Nexis	Legal	7
Wells Fargo	Legal	373
CliftonLarson Allen	Accountants	353
Ginoli & Co.	Accountants	4,542
Wells Fargo	Accountants	974
Miscellaneous	Computer Services	45
Change Healthcare	Computer Services	7
PTC Select	Computer Services	4
Advanced Answers on Demand	Computer Services	3,101
Stratus Networks	Computer Services	315
Kemper Technology	Computer Services	208
AT&T	Computer Services	4
Ability Network	Computer Services	1,322
CIA/N	Computer Services	158
Comcast	Computer Services	26
CCH	Computer Services	10
Charter Communications	Computer Services	31
Allscripts	Computer Services	461
ATS	Computer Services	208
Allpayer Exchange	Computer Services	10
Optimizer	Other Prof Fees	32
Ankura	Other Prof Fees	241
David Budde	Other Prof Fees	27
Bruner, Cooper, Zuck	Other Prof Fees	70
Marotta, Gund, Budd, Dzerda	Other Prof Fees	433
Professional Software and Services	Other Prof Fees	17
Hughes Valuation Services	Other Prof Fees	22
Alan Litwiller	Other Prof Fees	2

Total (agree to Schedule V, line 19, column 8) 66,389

Flora Gardens Care Center
0050666
Period Beginning 1/1/2016
Period End 12/31/2016

Schedule 21A

XIX. SUPPORT SCHEDULE
Legal Fees

Home Office Allocation-PHN & PHCM

Lucie, Scalf, and Bougher	Legal	39
Miscellaneous	Legal	13
Miller Hall and Triggs	Legal	68
Healthcare Resources International	Legal	815
Hunziker Law	Legal	81
Lexis Nexis	Legal	7
Wells Fargo	Legal	373

Direct Facility Invoices

Sorling and Northrup-A. Stanford Case	3/7/2016	2,427
Sorling and Northrup-A. Stanford Case	4/7/2016	5,287
Sorling and Northrup-A. Stanford Case	5/6/2016	1,569
Sorling and Northrup-A. Stanford Case	6/8/2016	380
Reimbursement from Medicaid for Medical Record Copies	6/14/2017	(10)
Sorling and Northrup-A. Stanford Case	7/15/2016	1,480
Sorling and Northrup-A. Stanford Case	9/9/2016	12,116
Sorling and Northrup-A. Stanford Case	8/5/2016	8,344
Sorling and Northrup-A. Stanford Case	10/12/2016	7,198
Sorling and Northrup-A. Stanford Case	11/7/2016	5,559
Sorling and Northrup-A. Stanford Case	12/31/2016	3,523

Total Legal Fees (agree to Schedule V, line 19, column 8)	<u>49,268</u>
---	---------------

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?
If YES, give association name and amount.

No
IHCA \$4985

(3)

Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report?

No
N/A

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No
N/A

(5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

Yes
7 yrs.

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 21,493 Line 10

(7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?
If NO, attach a complete explanation.

Yes

(8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No
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.

(11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.
This amount is to be recorded on line 42 of Schedule V.

\$ 147,669

(12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

No

(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?
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.

No

(15)

Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V.
Has any meal income been offset against related costs?

\$ 0
Yes Indicate the amount. \$ 1,836

(16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

No

b.

Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

Yes \$ 8,104

c.

What percent of all travel expense relates to transportation of nurses and patients?

100

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?

Yes

g.

Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such transportation during this reporting period.

No
\$ N/A

(17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:

Yes
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.
Attach invoices and a summary of services for all architect and appraisal fees

Yes

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB- SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB- SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-81,787	equal to	-81,787	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	75,713	equal to	75,713	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Exper	50,299	equal to	50,299	0	FAILED	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-	8,087	equal to	8,087	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depr	102,195	equal to	102,195	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	11,011	equal to	11,011	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Pro	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to	0	0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	329,046	equal to	329,046	0	O.K.	Pg16 Z12+Z14..	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	79,808	equal to	79,808	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General S	525,525	equal to	525,525	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health C	1,549,017	equal to	1,549,017	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Adminins	567,428	equal to	567,428	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownershi	220,241	equal to	220,241	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special C	134,180	equal to	134,180	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+	N/A	38to41+43	4
Income Stat. Prov. Par	147,669	equal to	147,669	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	1,027,412	equal to	1,027,412	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Train	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapi	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	50,939	equal to	50,939	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Wor	41,222	equal to	41,222	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	117,159	equal to	117,159	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	28,823	equal to	28,823	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	115,363	equal to	115,363	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	0	equal to		#VALUE!	#VALUE!	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	111,667	equal to	111,667	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	27,058	equal to	27,058	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wa	1,519,643	equal to	1,407,976	111,667	FAILED	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	1,552	< or = to	1,552	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	6,000	< or = to	6,000	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contract	3,671	< or = to	9,517	-5,846	O.K.	Pg20 X14..X16+	B. & C.	17to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	8	-8	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consult	0	< or = to		0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin.	111,667	equal to	111,667	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin.	242,700	equal to	242,700	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Se	52,370	equal to	52,370	0	FAILED	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/	200,906	equal to	200,906	0	FAILED	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched c	9,042	equal to	9,042	0	FAILED	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched.	38	equal to	38	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fe	147,669	equal to	147,669	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee I	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare prov	2,222	equal to	2,428	-206	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related	-15,579	equal to	-15,579	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4I	B.	14	8
Total loan balance	1,262,080	equal to	1,262,080	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27.	N/A	29+39-41	2
Real estate tax accrual	49,872	equal to	49,872	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	50,000	equal to	50,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	1,996,158	equal to	1,996,158	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle	307,421	equal to	307,421	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	936,364	equal to	936,364	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	324,308	equal to	324,308	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	153,255	equal to	153,255	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred	0	equal to		0	O.K.	Pg22 F31-J31..J	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	2,438,915	equal to	2,438,915	0	O.K.	Pg17:H41	N/A	25	1	Pg17 S41	N/A	48	1

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Total
1. Dietary	117,159	11,155	1,552	129,866	0	129,866	3,459	133,325
2. Food Purchase	0	112,307	0	112,307	0	112,307	-1,773	110,534
3. Housekeeping	115,363	15,068	0	130,431	0	130,431	60	130,491
4. Laundry	0	7,695	0	7,695	0	7,695	0	7,695
5. Heat and Other Utilities	0	0	76,158	76,158	0	76,158	202	76,360
6. Maintenance	28,823	21,635	18,610	69,068	0	69,068	1,888	70,956
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	261,345	167,860	96,320	525,525	0	525,525	3,836	529,361
9. Medical Director	0	0	6,000	6,000	0	6,000	0	6,000
10. Nursing & Medical Records	1,027,412	84,735	9,517	1,121,664	0	1,121,664	19	#####
10a. Therapy	0	0	329,046	329,046	0	329,046	0	329,046
11. Activities	50,939	53	8	51,000	0	51,000	-8,104	42,896
12. Social Services	41,222	85	0	41,307	0	41,307	0	41,307
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	1,119,573	84,873	344,571	1,549,017	0	1,549,017	-8,085	#####
17. Administrative	0	0	242,700	242,700	0	242,700	-131,033	111,667
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	52,370	52,370	0	52,370	14,019	66,389
20. Fees, Subscriptions & Promotion	0	0	8,834	8,834	0	8,834	208	9,042
21. Clerical & General Office	27,058	3,565	15,437	46,060	0	46,060	40,296	86,356
22. Employee Benefits & Payroll	0	0	178,360	178,360	0	178,360	22,546	200,906
23. Inservice Training & Education	0	0	450	450	0	450	77	527
24. Travel and Seminar	0	0	0	0	0	0	38	38
25. Other Admin. Staff Trans	0	0	6,090	6,090	0	6,090	3,172	9,262
26. Insurance-Prop.Liab.Malpractice	0	0	32,564	32,564	0	32,564	447	33,011
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	27,058	3,565	536,805	567,428	0	567,428	-50,230	517,198
29. Total General Administrative	1,407,976	256,298	977,696	2,641,970	0	2,641,970	-54,479	#####
30. Depreciation	0	0	94,610	94,610	0	94,610	7,585	102,195
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	8,087	8,087
32. Interest	0	0	65,251	65,251	0	65,251	10,462	75,713
33. Real Estate	0	0	50,094	50,094	0	50,094	205	50,299
34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	10,286	10,286	0	10,286	725	11,011
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	220,241	220,241	0	220,241	27,064	247,305
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	79,808	0	79,808	0	79,808	0	79,808
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	147,669	147,669	0	147,669	0	147,669
43. Other (specify):*	0	410	53,962	54,372	0	54,372	-54,372	0
44. Total Special Cost Ce	0	80,218	201,631	281,849	0	281,849	-54,372	227,477
45. Grand Total	1,407,976	336,516	1,399,568	3,144,060	0	3,144,060	-81,787	#####

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	184,002	184,002
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	929,852	929,852
4. Supply Inventory	10,064	10,064
5. Short-Term Investments	0	0
6. Prepaid Insurance	31,540	31,540
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	3,625	3,625
10. Total current assets	1,159,083	1,159,083
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	78,520	50,000
14. Buildings, at Historical Cost	1,615,000	1,637,434
15. Leasehold Improvements, Historical Cost	352,097	358,724
16. Equipment, at Historical Cost	307,421	307,421
17. Accumulated Depreciation (book methods) #####		-936,364
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	1,279,832	1,417,215
25. Total Assets	2,438,915	2,576,298
CURRENT LIABILITIES		
26. Accounts Payable	651,330	651,330
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	74,960	74,960
31. Accrued Taxes Payable	26,363	26,363
32. Accrued Real Estate Taxes	49,872	49,872
33. Accrued Interest Payable	5,564	5,564
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	21,329	21,329
37. Other Current Liabilities (specify):	23,109	23,109
38. Total Current Liabilities	852,527	852,527
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	1,262,080	1,262,080
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	1,262,080	1,262,080
46.Total Liabilities	2,114,607	2,114,607
47.Total Equity	324,308	461,691
48.Total Liabilities and Equity	2,438,915	2,576,298

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,787,830
2. Discounts and Allowances for all Levels	-269,297
Subtotal - Inpatient Care	2,518,533
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	607,780
7. Oxygen	1,665
Subtotal - Ancillary Revenue	609,445
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	1,836
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	127,548
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	23,868
21. Other Medical Services	7,691
22. Laundry	177
Subtotal - Other Operating Revenue	161,120
24. Contributions	0
25. Interest and Other Investments Income	5
Subtotal - Non-Operating Revenue	5
27. Other Revenue (specify):	8,104
28. Other Revenue (specify):	108
Subtotal - Other Revenue	8,212
30. Total Revenue	3,297,315
31. General Services	542,337
32. Health Care	1,525,204
33. General Administration	532,791
34. Ownership	218,736
35. Special Cost Centers	104,608
35. Provider Participation Fee	157,050
37. Other	0
40. Total Expenses	3,080,726
41. Income Before Income Taxes	216,589
42. Income Taxes	0
43. Net Income or Loss for the Year	216,589