

		FOR BHF USE					

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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: 0052266

Facility Name: Flora Rehab & Hlth Care Ctr

Address: 232 Given Street Flora 62839
Number City Zip Code

County: Clay

Telephone Number: (618) 662-8381 Fax # (618) 662-8231

HFS ID Number:

Date of Initial License for Current Owners: 12/17/2004

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 Rehab & Hlth Care Ctr

0052266 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	99	Skilled (SNF)	99	36,135
2		Skilled Pediatric (SNF/PED)		
3		Intermediate (ICF)		
4		Intermediate/DD		
5		Sheltered Care (SC)		
6		ICF/DD 16 or Less		
7	99	TOTALS	99	36,135

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	11,189	2,429	3,062	16,680
9	SNF/PED				
10	ICF				
11	ICF/DD				
12	SC				
13	DD 16 OR LESS				
14	TOTALS	11,189	2,429	3,062	16,680

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 46.16%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES ☒ NO ☐

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 12/17/2004

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

YES ☒ Date 12/17/2004 NO ☐

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

YES ☒ NO ☐ If YES, enter number of beds certified 99 and days of care provided 3,021

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 Rehab & Hlth Care Ctr # 0052266 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	141,270	13,725	2,242	157,237		157,237	4,049	161,286			1
2	Food Purchase		127,466		127,466		127,466	(10,143)	117,323			2
3	Housekeeping	84,106	20,467		104,573		104,573	71	104,644			3
4	Laundry	57,753	7,689		65,442		65,442		65,442			4
5	Heat and Other Utilities			100,336	100,336		100,336	236	100,572			5
6	Maintenance	36,089	10,906	24,887	71,882		71,882	2,211	74,093			6
7	Other (specify):* <u>Home Office Ben. Allocation</u>											7
8	TOTAL General Services	319,218	180,253	127,465	626,936		626,936	(3,576)	623,360			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	895,510	100,967	14,207	1,010,684		1,010,684	(2,727)	1,007,957			10
10a	Therapy			360,113	360,113		360,113		360,113			10a
11	Activities	52,605	37	94	52,736		52,736	(7,297)	45,439			11
12	Social Services	31,902			31,902		31,902		31,902			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	980,017	101,004	380,414	1,461,435		1,461,435	(10,024)	1,451,411			16
	C. General Administration											
17	Administrative			248,200	248,200		248,200	(191,172)	57,028			17
18	Directors Fees											18
19	Professional Services			(1,042)	(1,042)		(1,042)	28,571	27,529			19
20	Dues, Fees, Subscriptions & Promotions			8,858	8,858		8,858	431	9,289			20
21	Clerical & General Office Expenses	31,331	3,526	13,423	48,280		48,280	47,008	95,288			21
22	Employee Benefits & Payroll Taxes			180,364	180,364		180,364	26,959	207,323			22
23	Inservice Training & Education			240	240		240	91	331			23
24	Travel and Seminar							44	44			24
25	Other Admin. Staff Transportation			6,536	6,536		6,536	3,714	10,250			25
26	Insurance-Prop.Liab.Malpractice			3,836	3,836		3,836	53,462	57,298			26
27	Other (specify):* <u>Home Office Ben. Allocation</u>											27
28	TOTAL General Administration	31,331	3,526	460,415	495,272		495,272	(30,892)	464,380			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,330,566	284,783	968,294	2,583,643		2,583,643	(44,492)	2,539,151			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			6,725	6,725		6,725	87,439	94,164			30
31	Amortization of Pre-Op. & Org.							6,036	6,036			31
32	Interest							148,812	148,812			32
33	Real Estate Taxes							77,298	77,298			33
34	Rent-Facility & Grounds			401,071	401,071		401,071	(401,071)				34
35	Rent-Equipment & Vehicles			22,045	22,045		22,045	849	22,894			35
36	Other (specify):*											36
37	TOTAL Ownership			429,841	429,841		429,841	(80,637)	349,204			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		76,575		76,575		76,575		76,575			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			137,782	137,782		137,782		137,782			42
43	Other (specify):*			128,722	128,722		128,722	(128,722)				43
44	TOTAL Special Cost Centers		76,575	266,504	343,079		343,079	(128,722)	214,357			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,330,566	361,358	1,664,639	3,356,563		3,356,563	(253,851)	3,102,712			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	(10,217)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,493)	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	(23,970)	30		9
10	Interest and Other Investment Income	6	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(661)	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	(23,037)	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	(81,600)	43		24
25	Fund Raising, Advertising and Promotional	(2,376)	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	(25,899)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (173,247)		\$	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)	(80,604)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (80,604)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (253,851)		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	\$ (3,534)	43	1
2	X-Rays-Part A	(10,095)	43	2
3	Offset Miscellaneous Nursing Supplies Revenue	(2,847)	10	3
4	Offset Transportation Revenue	(7,297)	11	4
5	Offset Miscellaneous Office Supplies Revenue	(200)	21	5
6	Disallowed Special Events	(87)	43	6
7	Pet Expense	(1,352)	43	7
8	Resident Flowers	(487)	43	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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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	(25,899)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Flora Rehab & Hlth Care Ctr# 0052266

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	4,049	0	0	0	0	0	0	0	0	0	4,049	1
2	Food Purchase	(10,217)	74	0	0	0	0	0	0	0	0	0	(10,143)	2
3	Housekeeping	0	71	0	0	0	0	0	0	0	0	0	71	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	236	0	0	0	0	0	0	0	0	0	236	5
6	Maintenance	0	2,211	0	0	0	0	0	0	0	0	0	2,211	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(10,217)	6,641	0	0	0	0	0	0	0	0	0	(3,576)	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	(2,847)	120	0	0	0	0	0	0	0	0	0	(2,727)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(7,297)	0	0	0	0	0	0	0	0	0	0	(7,297)	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	(10,144)	120	0	0	0	0	0	0	0	0	0	(10,024)	16
	C. General Administration													
17	Administrative	0	(191,172)	0	0	0	0	0	0	0	0	0	(191,172)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	10,312	0	12,349	5,910	0	0	0	0	0	0	28,571	19
20	Fees, Subscriptions & Promotions	0	0	431	0	0	0	0	0	0	0	0	431	20
21	Clerical & General Office Expenses	(200)	0	47,208	0	0	0	0	0	0	0	0	47,008	21
22	Employee Benefits & Payroll Taxes	0	0	26,397	562	0	0	0	0	0	0	0	26,959	22
23	Inservice Training & Education	0	0	91	0	0	0	0	0	0	0	0	91	23
24	Travel and Seminar	0	0	44	0	0	0	0	0	0	0	0	44	24
25	Other Admin. Staff Transportation	0	0	3,714	0	0	0	0	0	0	0	0	3,714	25
26	Insurance-Prop.Liab.Malpractice	0	0	523	0	52,939	0	0	0	0	0	0	53,462	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(200)	(180,860)	78,408	12,911	58,849	0	0	0	0	0	0	(30,892)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(20,561)	(174,099)	78,408	12,911	58,849	0	0	0	0	0	0	(44,492)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Flora Rehab & Hlth Care Ctr # 0052266 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	(23,970)	0	10,447	856	100,106	0	0	0	0	0	0	87,439	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	6,036	0	0	0	0	0	0	6,036	31
32	Interest	6	0	307	30,568	117,931	0	0	0	0	0	0	148,812	32
33	Real Estate Taxes	0	0	240	0	77,058	0	0	0	0	0	0	77,298	33
34	Rent-Facility & Grounds	0	0	0	0	(401,071)	0	0	0	0	0	0	(401,071)	34
35	Rent-Equipment & Vehicles	0	0	849	0	0	0	0	0	0	0	0	849	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(23,964)	0	11,843	31,424	(99,940)	0	0	0	0	0	0	(80,637)	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):*	(128,722)	0	0	0	0	0	0	0	0	0	0	(128,722)	43
44	TOTAL Special Cost Centers	(128,722)	0	0	0	0	0	0	0	0	0	0	(128,722)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(173,247)	(174,099)	90,251	44,335	(41,091)	0	0	0	0	0	0	(253,851)	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%	\$ 4,049	\$ 4,049	1
2	V	2	Food		Petersen Health Care Management, Inc.	100.00%	74	74	2
3	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	71	71	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	236	236	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	2,211	2,211	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%	120	120	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	248,200	Petersen Health Care Management, Inc.	100.00%	57,028	(191,172)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	10,312	10,312	12
13	V								13
14	Total			\$ 248,200			\$ 74,101	\$ * (174,099)	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%	\$ 431	\$ 431	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	47,208	47,208	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	26,397	26,397	17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	91	91	18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	44	44	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	3,714	3,714	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	523	523	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%	10,447	10,447	23
24	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	307	307	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	240	240	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	849	849	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			\$			\$ 90,251	\$ * 90,251	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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	1 Dietary	\$	Petersen Management Company, LLC	100.00%	\$ 0	\$	15
16	V	2 Food		Petersen Management Company, LLC	100.00%	0		16
17	V	3 Housekeeping		Petersen Management Company, LLC	100.00%	0		17
18	V	4 Laundry		Petersen Management Company, LLC	100.00%	0		18
19	V	5 Utilities		Petersen Management Company, LLC	100.00%	0		19
20	V	6 Maintenance		Petersen Management Company, LLC	100.00%	0		20
21	V	7 Mgmt. Allocation of Benefits		Petersen Management Company, LLC	100.00%	0		21
22	V	10 Nursing and Medical Records		Petersen Management Company, LLC	100.00%	0		22
23	V	15 Mgmt. Allocation of Benefits		Petersen Management Company, LLC	100.00%	0		23
24	V	17 Administrative		Petersen Management Company, LLC	100.00%	0		24
25	V	19 Professional Services		Petersen Management Company, LLC	100.00%	12,349	12,349	25
26	V	20 Dues, Fees, Subs & Promotions		Petersen Management Company, LLC	100.00%	0		26
27	V	21 Clerical and General Office		Petersen Management Company, LLC	100.00%	0		27
28	V	22 Employee Benefits & Payroll		Petersen Management Company, LLC	100.00%	562	562	28
29	V	23 Inservice Training & Education		Petersen Management Company, LLC	100.00%	0		29
30	V	24 Travel and Seminar		Petersen Management Company, LLC	100.00%	0		30
31	V	25 Other Admin. Staff Transport.		Petersen Management Company, LLC	100.00%	0		31
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Management Company, LLC	100.00%	0		32
33	V	30 Depreciation		Petersen Management Company, LLC	100.00%	856	856	33
34	V	31 Amortization		Petersen Management Company, LLC	100.00%	0		34
35	V	32 Interest		Petersen Management Company, LLC	100.00%	30,568	30,568	35
36	V	33 Real Estate Taxes		Petersen Management Company, LLC	100.00%	0		36
37	V	34 Rent-Facility and Grounds		Petersen Management Company, LLC	100.00%	0		37
38	V	35 Rent-Equipment & Vehicles		Petersen Management Company, LLC	100.00%	0		38
39	Total		\$			\$ 44,335	\$ * 44,335	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional Services	\$	Petersen 26, LLC	100.00%	\$ 5,910	\$ 5,910	15
16	V	26	Insurance-Property		Petersen 26, LLC	100.00%	30,173	30,173	16
17	V	26	Insurance-MIP		Petersen 26, LLC	100.00%	22,766	22,766	17
18	V	30	Depreciation		Petersen 26, LLC	100.00%	100,106	100,106	18
19	V	31	Amortization		Petersen 26, LLC	100.00%	6,036	6,036	19
20	V	32	Interest	466	Petersen 26, LLC	100.00%	118,397	117,931	20
21	V	33	Real Estate Taxes		Petersen 26, LLC	100.00%	77,058	77,058	21
22	V	34	Rent-Income and Grounds	401,071	Petersen 26, LLC	100.00%	0	(401,071)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 401,537			\$ 360,446	\$ * (41,091)	39

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

Facility Name & ID Number

Flora Rehab & Hlth Care Ctr

0052266

Report Period Beginning:

1/1/2016

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 Rehab & Hlth Care Ctr

0052266

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 Rehab & Hlth Care Ctr

0052266

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

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 Rehab & Hlth Care Ctr # 0052266 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 Rehab & Hlth Care Ctr# 0052266

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, 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	19,714	\$ 4,049	1
2	2	Food	Resident Days	75	5,673	0	19,714	74	2
3	3	Housekeeping	Resident Days	75	5,456	2,897	19,714	71	3
4	5	Utilities	Resident Days	75	18,209	0	19,714	236	4
5	6	Maintenance	Resident Days	75	170,632	137,057	19,714	2,211	5
6	7	Mgmt. Allocation of Benefits	Resident Days	75	0	0	19,714	0	6
7	9	Medical Director	Resident Days	75	0	0	19,714	0	7
8	10	Nursing and Medical Records	Resident Days	75	9,261	1,782,521	19,714	120	8
9	10A	Therapy	Resident Days	75	0	0	19,714	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	75	0	0	19,714	0	10
11	17	Administrative	Resident Days	75	4,899,467	5,473,961	19,714	57,028	11
12	19	Professional Services	Resident Days	75	795,918	0	19,714	10,312	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	75	33,278	0	19,714	431	13
14	21	Clerical and General Office	Resident Days	75	3,643,535	3,756,135	19,714	47,208	14
15	22	Employee Benefits and Payroll Tax	Resident Days	75	2,037,314	0	19,714	26,397	15
16	23	Inservice Training & Education	Resident Days	75	6,986	0	19,714	91	16
17	24	Travel and Seminar	Resident Days	75	3,389	0	19,714	44	17
18	25	Other Admin. Staff Transport.	Resident Days	75	286,637	0	19,714	3,714	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	75	40,378	0	19,714	523	19
20	27	Mgmt. Allocation of Benefits	Resident Days	75	0	0	19,714	0	20
21	30	Depreciation	Resident Days	75	806,271	0	19,714	10,447	21
22	32	Interest	Resident Days	75	23,686	0	19,714	307	22
23	33	Real Estate Taxes	Resident Days	75	18,560	0	19,714	240	23
24	35	Rent-Equipment & Vehicles	Resident Days	75	65,550	0	19,714	849	24
25	TOTALS				\$ 13,182,740	\$ 11,510,481		\$ 164,352	25

Facility Name & ID Number Flora Rehab & Hlth Care Ctr# 0052266

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 Management Company, LLC

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309)691-8113

Fax Number

(309)691-8622

	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	170,636	6	\$	\$	19,714	\$	1
2	2	Food	Resident Days	170,636	6			19,714		2
3	3	Housekeeping	Resident Days	170,636	6			19,714		3
4	4	Laundry	Resident Days	170,636	6			19,714		4
5	5	Utilities	Resident Days	170,636	6			19,714		5
6	6	Maintenance	Resident Days	170,636	6			19,714		6
7	7	Mgmt. Allocation of Benefits	Resident Days	170,636	6			19,714		7
8	10	Nursing and Medical Records	Resident Days	170,636	6			19,714		8
9	15	Mgmt. Allocation of Benefits	Resident Days	170,636	6			19,714		9
10	17	Administrative	Resident Days	170,636	6			19,714		10
11	19	Professional Services	Resident Days	170,636	6	106,890		19,714	12,349	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	170,636	6			19,714		12
13	21	Clerical and General Office	Resident Days	170,636	6			19,714		13
14	22	Employee Benefits & Payroll	Resident Days	170,636	6	4,868		19,714	562	14
15	23	Inservice Training & Education	Resident Days	170,636	6			19,714		15
16	24	Travel and Seminar	Resident Days	170,636	6			19,714		16
17	25	Other Admin. Staff Transport.	Resident Days	170,636	6			19,714		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	170,636	6			19,714		18
19	30	Depreciation	Resident Days	170,636	6	7,413		19,714	856	19
20	31	Amortization	Resident Days	170,636	6			19,714		20
21	32	Interest	Resident Days	170,636	6	264,585		19,714	30,568	21
22	33	Real Estate Taxes	Resident Days	170,636	6			19,714		22
23	34	Rent-Facility and Grounds	Resident Days	170,636	6			19,714		23
24	35	Rent-Equipment & Vehicles	Resident Days	170,636	6			19,714		24
25	TOTALS					\$ 383,756	\$		\$ 44,335	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	1st Merit		X	HUD Loan	Varies	5/1/13	3,824,000	\$ 3,453,018	4/30/38	Varies	\$ 118,397	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 3,824,000	\$ 3,453,018			\$ 118,397	9	
	B. Non-Facility Related*												
10								Interest Income Offset			(460)	10	
11								Home Office Allocation-PMC			30,568	11	
12								Home Office Allocation-PHCM			307	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ 30,415	14	
15	TOTALS (line 9+line14)						\$ 3,824,000	\$ 3,453,018			\$ 148,812	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 Rehab & Hlth Care Ctr	COUNTY	Clay
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CONTACT PERSON REGARDING THIS REPORT MIKE KOCHER

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	

B. Real Estate Tax Cost Allocations

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.)

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

Page 10A

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

24,488

B. General Construction Type:

Exterior Brick

Frame Steel

Number of Stories

1

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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

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

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

150,897

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

25

3. Current Period Amortization:

6,036

4. Dates Incurred:

January-December 2013

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

XI. OWNERSHIP COSTS:

1		2		3		4	
Use		Square Feet		Year Acquired		Cost	
1	Facility	278,784		2004		\$ 129,000	
2							
3	TOTALS	278,784				\$ 129,000	

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	99		2004	1973	\$ 2,214,200	\$	35	\$ 63,263	\$ 63,263	\$ 764,428
5										
6										
7										
8										
	Improvement Type**									
9	Sidewalks		2006		3,605		15	240	240	2,520
10	Front Door Repair		2008		5,090		25	204	204	1,734
11	B-Unit Shower Units		2008		14,000		25	560	560	4,760
12	Roof Replacement		2010		52,985		25	2,120	2,120	13,780
13	Replacement of Kitchen and Dining Room Flooring & Painting		2011		19,985		15	1,332	1,332	7,326
14	Replacement of Kitchen and Dining Room Flooring & Painting		2012		2,405		15	160	160	720
15	Air Conditioner-Roof Top		2012		6,341		15	422	422	1,899
16	Roof Replacement		2013		102,805		25	4,112	4,112	14,392
17	Air Conditioner		2013		12,675		15	846	846	2,961
18	Parking Lot Install		2014		11,625		25	465	465	1,163
19	Water Heater		2014		3,850		7	550	550	1,375
20	Water Heater		2014		4,042		7	577	577	1,443
21	Water Heater		2014		3,918		7	560	560	1,400
22	Air Conditioners-2 Rooftop Units		2016		11,826		15	394	394	394
23	B-Hall Painting and Remodeling		2016		12,085		15	403	403	403
24										
25										
26										
27										
28										
29										
30	Land Improvements Booked					240			(240)	
31	Building Booked					88,621			(88,621)	
32	Building Improvement Booked					12,590			(12,590)	
33										
34	2016-Home Office Allocation-Building Improvements				8,704			209	209	
35	2016-Home Office Allocation-Land Improvements				801			52	52	
36										

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Flora Rehab & Hlth Care Ctr

0052266

Report Period Beginning:

1/1/2016

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)		\$ 2,490,942	\$ 101,451		\$ 76,469	\$ (24,982)	\$ 820,698	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	\$ 70,410	\$ 4,760	\$ 5,860	\$ 1,100	5-10 yrs.	\$ 36,628	71
72	Current Year Purchases	4,340	620	793	173	7 yrs.	793	72
73	Fully Depreciated Assets	610,135					610,135	73
74	Home Office Allocation			11,042	11,042			74
75	TOTALS	\$ 684,885	\$ 5,380	\$ 17,695	\$ 12,315		\$ 647,556	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	2005 Ford	2004	\$ 33,217	\$	\$	\$		\$ 33,217	76
77										77
78										78
79										79
80	TOTALS			\$ 33,217	\$	\$	\$		\$ 33,217	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)	\$ 3,338,044	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 106,831	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 94,164	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (12,667)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,501,471	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?
- X

YES

NO
16. Rental Amount for movable equipment: \$

22,894
- 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.	/2017	\$
13.	/2018	\$
14.	/2019	\$

* 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 Rehab & Hlth Care Ctr
0052266
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	\$	17,779
Dishwasher		704
Copier		3,562
Home Office Allocation		849
		<u>22,894</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)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		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	\$	10,065	\$ 150,973	\$	10,065	\$ 150,973	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		5,683	85,246		5,683	85,246	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		8,260	123,894		8,260	123,894	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				76,575		76,575	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			\$	24,008	\$ 360,113	\$ 76,575	24,008	\$ 436,688	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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 970,899	\$ 970,899	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 109,587)	948,518	948,518	3
4	Supply Inventory (priced at Cost)	15,982	15,982	4
5	Short-Term Investments			5
6	Prepaid Insurance	27,191	39,333	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)		35,234	8
9	Other(specify): <u>Prepaid Management Fees</u>	249,978	249,978	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,212,568	\$ 2,259,944	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		129,000	13
14	Buildings, at Historical Cost		2,222,904	14
15	Leasehold Improvements, at Historical Cost	23,895	268,038	15
16	Equipment, at Historical Cost	76,795	718,102	16
17	Accumulated Depreciation (book methods)	(52,259)	(1,501,471)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		150,897	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(22,132)	20
21	Restricted Funds		507,584	21
22	Other Long-Term Assets (specify) <u>Goodwill</u>	18,710	18,710	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 67,141	\$ 2,491,632	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,279,709	\$ 4,751,576	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 457,068	\$ 476,481	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	104,870	104,870	30
31	Accrued Taxes Payable (excluding real estate taxes)	40,327	40,327	31
32	Accrued Real Estate Taxes(Sch.IX-B)		76,716	32
33	Accrued Interest Payable		9,726	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	3,572	3,572	36
37	<u>Accrued Management Fees</u>	(6,803)	(6,803)	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 599,034	\$ 704,889	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,453,018	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Intercompany Loans</u>	2,037,917	433,597	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,037,917	\$ 3,886,615	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,636,951	\$ 4,591,504	46
47	TOTAL EQUITY(page 18, line 24)	\$ (357,242)	\$ 160,072	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,279,709	\$ 4,751,576	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (311,455)	1
2	Restatements (describe):		2
3	Prior Period Adjustments Made After Cost Report Was Filed	(43,735)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (355,190)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,052)	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)	\$ (2,052)	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)	\$ (357,242)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Flora Rehab & Hlth Care Ctr

0052266

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	\$ 2,753,484	1
2	Discounts and Allowances for all Levels	(272,018)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,481,466	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	673,480	6
7	Oxygen	3,149	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 676,629	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	10,217	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	125,882	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	32,700	20
21	Other Medical Services	17,279	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 186,078	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	(6)	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ (6)	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation Revenue</u>	7,297	28
28a	<u>Miscellaneous Revenue</u>	3,047	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 10,344	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,354,511	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	626,936	31
32	Health Care	1,461,435	32
33	General Administration	495,272	33
	B. Capital Expense		
34	Ownership	429,841	34
	C. Ancillary Expense		
35	Special Cost Centers	205,297	35
36	Provider Participation Fee	137,782	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,356,563	40
41	Income before Income Taxes (line 30 minus line 40)**	(2,052)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (2,052)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,479,468	44
45	Private Pay - Net Inpatient Revenue	347,216	45
46	Medicare - Net Inpatient Revenue	647,402	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	7,380	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,481,466	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	2,159	2,159	\$ 59,667	\$ 27.64	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,852	3,884	92,078	23.71	3
4	Licensed Practical Nurses	11,170	11,846	229,294	19.36	4
5	CNAs & Orderlies	36,458	37,903	464,204	12.25	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,038	2,080	25,688	12.35	9
10	Activity Assistants	3	3	29	9.67	10
11	Social Service Workers	1,993	1,993	31,902	16.01	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	25,710	12.36	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,086	12,663	115,560	9.13	15
16	Dishwashers					16
17	Maintenance Workers	1,930	2,118	36,089	17.04	17
18	Housekeepers	8,688	9,376	84,106	8.97	18
19	Laundry	5,651	6,078	57,753	9.50	19
20	Administrator	2,080	2,080	57,028	27.42	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,866	2,070	31,331	15.14	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: CPC	2,426	2,626	50,267	19.14	32
33	Other(specify) Transportation	1,900	2,036	26,888	13.21	33
34	TOTAL (lines 1 - 33)	96,380	100,995	\$ 1,387,594 *	\$ 13.74	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	37	\$ 2,242	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	3,624	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)	37	\$ 11,866		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.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	% Ownership	Amount
Jodi Sanders	Administrator	0	\$ 19,833
Karla Smith	Administrator	0	37,195
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 57,028
B. Administrative - Other			
Description			Amount
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 248,200
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 248,200
C. Professional Services			
Vendor/Payee	Type		Amount
E-Health Data Solutions	Computer Services		\$ 3,680
Frontier	Computer Services		741
Honkamp, Krueger and Company	Accounting Fees		240
Ability Network	Computer Services		102
Clay Co Circuit Clerk	Legal Fees		10
ProTitle USA	Legal Fees		95
Capital Fiance Group	Refund of Refinance Fees		(5,910)
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ (1,042)
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 33,919
Unemployment Compensation Insurance			28,759
FICA Taxes			99,170
Employee Health Insurance			11,594
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Employee Relations			6,244
Employee Retirement			678
Home Office Allocation			26,959
TOTAL (agree to Schedule V, line 22, col.8)			\$ 207,323
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
			\$
N/A			
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$ 3,980
Advertising: Employee Recruitment			595
Health Care Worker Background Check (Indicate # of checks performed)	57		823
Patient Background Checks	42		596
Miscellaneous Licenses & Permits			625
Miscellaneous Dues & Subscriptions			2,067
Home Office Allocation			431
Less: Public Relations Expense		(	)
Non-allowable advertising			172
Yellow page advertising		(	)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 9,289
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			
Seminar Expense			
Home Office Allocation			44
Entertainment Expense		(	)
TOTAL (agree to Sch. V, line 24, col. 8)			\$ 44

*** Attach copy of IMRF notifications**

****See instructions.**

Flora Rehab & Hlth Care Ctr
0052266
Period Beginning1/1/2016
Period End12/31/2016

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		(1,042)
Home Office Allocation		
Lucie, Scalf, and Bougher	Legal	46
Miscellaneous	Legal	17
Miller Hall and Triggs	Legal	80
Healthcare Resources International	Legal	397
Hunziker Law	Legal	95
Lexis Nexis	Legal	8
First Merit Bank	Legal	250
CliftonLarson Allen	Accountants	1,222
Ginoli & Co.	Accountants	6,190
First Merit Bank	Accountants	5,660
Miscellaneous	Computer Services	52
Change Healthcare	Computer Services	8
PTC Select	Computer Services	5
Advanced Answers on Demand	Computer Services	3,630
Stratus Networks	Computer Services	369
Kemper Technology	Computer Services	243
AT&T	Computer Services	5
Ability Network	Computer Services	1,548
CIAN	Computer Services	185
Comcast	Computer Services	30
CCH	Computer Services	12
Charter Communications	Computer Services	36
Allscripts	Computer Services	540
ATS	Computer Services	243
Allpayer Exchange	Computer Services	12
Optimizer	Other Prof Fees	37
Ankura	Other Prof Fees	282
David Budde	Other Prof Fees	32
Bruner, Cooper, Zuck	Other Prof Fees	82
Marotta, Gund, Budd, Dzerda	Other Prof Fees	7,208
Professional Software and Services	Other Prof Fees	20
Hughes Valuation Services	Other Prof Fees	25
Alan Litwiller	Other Prof Fees	2

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

27,529

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.

Yes
IHCA \$2000
- (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.

\$ 21,724 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.

\$ 137,782
- (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. \$ 10,217
- (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
\$ 7,297

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

No

RECONCILIATION REPORT			Flora Rehab & Hlth Car		10:06 AM	7/7/2017							
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	-253,851	equal to	-253,851	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	148,812	equal to	148,812	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	77,298	equal to	77,298	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	6,036	equal to	6,036	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	94,164	equal to	94,164	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	22,894	equal to	22,894	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	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	360,113	equal to	360,113	0	O.K.	Pg16 Z12+Z14..	N/A,B	1-4,40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	76,575	equal to	76,575	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	626,936	equal to	626,936	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	1,461,435	equal to	1,461,435	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	495,272	equal to	495,272	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	429,841	equal to	429,841	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	205,297	equal to	205,297	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..,H24+I	N/A	38to41+43	4
Income Stat. Prov. Partic.	137,782	equal to	137,782	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	895,510	equal to	895,510	0	O.K.	Pg20 K11..,K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	52,605	equal to	52,605	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	31,902	equal to	31,902	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	141,270	equal to	141,270	0	O.K.	Pg20 K22..,K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	36,089	equal to	36,089	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	84,106	equal to	84,106	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	57,753	equal to	57,753	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	57,028	equal to	57,028	0	O.K.	Pg20 K30..,K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	31,331	equal to	31,331	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 Wages	1,387,594	equal to	1,330,566	57,028	FAILED	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	2,242	< or = to	2,242	0	FAILED	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 & contractors	3,624	< or = to	14,207	-10,583	O.K.	Pg20 X14..,X16+	B. & C.	7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	94	-94	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to		0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	57,028	equal to	57,028	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	248,200	equal to	248,200	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	-1,042	equal to	-1,042	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	207,323	equal to	207,323	0	FAILED	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched. of dues..	9,289	equal to	9,289	0	FAILED	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	44	equal to	44	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	137,782	equal to	137,782	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	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 provided	3,021	equal to	3,062	-41	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-80,604	equal to	-80,604	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4I	B.	14	8
Total loan balance	3,453,018	equal to	3,453,018	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	76,716	equal to	76,716	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	129,000	equal to	129,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	2,490,942	equal to	2,490,942	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	718,102	equal to	718,102	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	1,501,471	equal to	1,501,471	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	-357,242	equal to	-357,242	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	-2,052	equal to	-2,052	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..,I	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	2,279,709	equal to	2,279,709	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	Adjusted Total
1. Dietary	141,270	13,725	2,242	157,237	0	157,237	4,049	161,286
2. Food Purchase	-	127,466	-	127,466	0	127,466	-10,143	117,323
3. Housekeeping	84,106	20,467	-	104,573	0	104,573	71	104,644
4. Laundry	57,753	7,689	-	65,442	0	65,442	0	65,442
5. Heat and Other Utilities	-	-	100,336	100,336	0	100,336	236	100,572
6. Maintenance	36,089	10,906	24,887	71,882	0	71,882	2,211	74,093
7. Other (specify)*	-	-	-	0	0	0	0	0
8. Total General Services	319,218	180,253	127,465	626,936	0	626,936	-3,576	623,360
9. Medical Director	-	-	6,000	6,000	0	6,000	0	6,000
10. Nursing & Medical Records	895,510	100,967	14,207	1,010,684	0	1,010,684	-2,727	#####
10a. Therapy	-	-	360,113	360,113	0	360,113	0	360,113
11. Activities	52,605	37	94	52,736	0	52,736	-7,297	45,439
12. Social Services	31,902	-	-	31,902	0	31,902	0	31,902
13. Nurse Aide Training	-	-	-	0	0	0	0	0
14. Program Transportation	-	-	-	0	0	0	0	0
15. Other (specify)*	-	-	-	0	0	0	0	0
16. Total Health Care & Programs	980,017	101,004	380,414	1,461,435	0	1,461,435	-10,024	#####
17. Administrative	-	-	248,200	248,200	0	248,200	-191,172	57,028
18. Directors Fees	-	-	-	0	0	0	0	0
19. Professional Services	-	-	(1,042)	-1,042	0	-1,042	28,571	27,529
20. Fees, Subscriptions & Promotion	-	-	8,858	8,858	0	8,858	431	9,289
21. Clerical & General Office	31,331	3,526	13,423	48,280	0	48,280	47,008	95,288
22. Employee Benefits & Payroll	-	-	180,364	180,364	0	180,364	26,959	207,323
23. Inservice Training & Education	-	-	240	240	0	240	91	331
24. Travel and Seminar	-	-	-	0	0	0	44	44
25. Other Admin. Staff Trans	-	-	6,536	6,536	0	6,536	3,714	10,250
26. Insurance-Prop.Liab.Malpractice	-	-	3,836	3,836	0	3,836	53,462	57,298
27. Other (specify)*	-	-	-	0	0	0	0	0
28. Total General Adminis	31,331	3,526	460,415	495,272	0	495,272	-30,892	464,380
29. Total General Administrative	#####	284,783	968,294	2,583,643	0	2,583,643	-44,492	#####
30. Depreciation	-	-	6,725	6,725	0	6,725	87,439	94,164
31. Amortization of Pre-Op. & Org.	-	-	-	0	0	0	6,036	6,036
32. Interest	-	-	-	0	0	0	148,812	148,812
33. Real Estate	-	-	-	0	0	0	77,298	77,298
34. Rent - Facility & Grounds	-	-	401,071	401,071	0	401,071	-401,071	0
35. Rent - Equipment & Vehicles	-	-	22,045	22,045	0	22,045	849	22,894
36. Other (specify):*	-	-	-	0	0	0	0	0
37. Total Ownership	-	-	429,841	429,841	0	429,841	-80,637	349,204
38. Medically Necessary T	-	-	-	0	0	0	0	0
39. Ancillary Service Cent	-	76,575	-	76,575	0	76,575	0	76,575
40. Barber and Beauty Shop	-	-	-	0	0	0	0	0
41. Coffee and Gift Shops	-	-	-	0	0	0	0	0
42	-	-	137,782	137,782	0	137,782	0	137,782
43. Other (specify):*	-	-	128,722	128,722	0	128,722	-128,722	0
44. Total Special Cost Ce	-	76,575	266,504	343,079	0	343,079	-128,722	214,357
45. Grand Total	#####	361,358	#####	3,356,563	0	3,356,563	-253,851	#####

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	970,899	970,899
2. Cash - Patient Deposits	-	0
3. Accounts & Notes Recievable	948,518	948,518
4. Supply Inventory	15,982	15,982
5. Short-Term Investments	-	0
6. Prepaid Insurance	27,191	39,333
7. Other Prepaid Expenses	-	0
8. Accounts Receivable-Owner/Related Party	-	35,234
9. Other (specify):	249,978	249,978
10. Total current assets	#####	2,259,944
LONG TERM ASSETS		
11. Long-Term Notes Receivable	-	0
12. Long-Term Investments	-	0
13. Land	-	129,000
14. Buildings, at Historical Cost	-	2,222,904
15. Leasehold Improvements, Historical Cost	23,895	268,038
16. Equipment, at Historical Cost	76,795	718,102
17. Accumulated Depreciation (book methods)	(52,259)	-1,501,471
18. Deferred Charges	-	0
19. Organization & Pre-Operating Costs	-	150,897
20. Accum Amort - Org/Pre-Op Costs	-	-22,132
21. Restricted Funds	-	507,584
22. Other Long-Term Assets (specify):	18,710	18,710
23. other (specify):	-	0
24. Total Long-Term Assets	67,141	2,491,632
25. Total Assets	#####	4,751,576
CURRENT LIABILITIES		
26. Accounts Payable	457,068	476,481
27. Officer's Accounts Payable	-	0
28. Accounts Payable-Patients Deposits	-	0
29. Short-Term Notes Payable	-	0
30. Accrued Salaries Payable	104,870	104,870
31. Accrued Taxes Payable	40,327	40,327
32. Accrued Real Estate Taxes	-	76,716
33. Accrued Interest Payable	-	9,726
34. Deferred Compensation	-	0
35. Federal and State Income Taxes	-	0
36. Other Current Liabilities (specify):	3,572	3,572
37. Other Current Liabilities (specify):	(6,803)	-6,803
38. Total Current Liabilities	599,034	704,889
LONG TERM LIABILITES		
39.Long-Term Notes Payable	-	0
40.Mortgage Payable	-	3,453,018
41.Bonds Payable	-	0
42.Deferred Compensation	-	0
43.Other Long-Term Liabilities (specify):	#####	433,597
44.Other Long-Term Liabilities (specify):	-	0
45.Total Long-Term Liabilities	#####	3,886,615
46.Total Liabilities	#####	4,591,504
47.Total Equity	#####	160,072
48.Total Liabilities and Equity	#####	4,751,576

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,753,484
2. Discounts and Allowances for all Levels	(272,018)
Subtotal - Inpatient Care	2,481,466
4. Day Care	-
5. Other Care for Outpatients	-
6. Therapy	673,480
7. Oxygen	3,149
Subtotal - Anciliary Revenue	676,629
9. Payments for Education	-
10. Other Governmental Grants	-
11. Nurses Aide Training Reimbursements	-
12. Gift and Coffee Shop	-
13. Barber and Beauty Care	-
14. Non-Patient Meals	10,217
15. Telephone, Television, and Radio	-
16. Rental of Facility Space	-
17. Sale of Drugs	125,882
18. Sale of Supplies to Non-Patients	-
19. Laboratory	-
20. Radiology and X-Ray	32,700
21. Other Medical Services	17,279
22. Laundry	-
Subtotal - Other Operating Revenue	186,078
24. Contributions	-
25. Interest and Other Investments Income	(6)
Subtotal - Non-Operating Revenue	(6)
27. Other Revenue (specify):	7,297
28. Other Revenue (specify):	3,047
Subtotal - Other Revenue	10,344
30. Total Revenue	3,354,511
31. General Services	667,320
32. Health Care	1,700,147
33. General Administration	526,366
34. Ownership	449,095
35. Special Cost Centers	133,717
35. Provider Participation Fee	152,482
37. Other	-
40. Total Expenses	3,629,127
41. Income Before Income Taxes	(274,616)
42. Income Taxes	-
43. Net Income or Loss for the Year	(274,616)