

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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: <u>0052266</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Flora Rehab Health Care Ctr</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2020</u> to <u>12/31/2020</u> 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.																							
Address: <u>232 Givens Street</u> <u>Flora</u> <u>62839</u>																									
Number City Zip Code																									
County: <u>Clay</u>																									
Telephone Number: <u>(618) 662-8381</u> Fax # <u>(618) 662-8231</u>																									
HFS ID Number: _____		<table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Type or Print Name) <u>Mark Petersen</u></td></tr><tr><td>(Title) <u>Chief Executive Officer</u></td></tr><tr><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	Paid Preparer	(Type or Print Name) <u>Mark Petersen</u>	(Title) <u>Chief Executive Officer</u>	(Signed) _____	(Date) _____														
Officer or Administrator of Provider	(Signed) _____																								
	(Date) _____																								
Paid Preparer	(Type or Print Name) <u>Mark Petersen</u>																								
	(Title) <u>Chief Executive Officer</u>																								
	(Signed) _____																								
	(Date) _____																								
Date of Initial License for Current Owners: <u>12/17/2004</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td>_____</td></tr><tr><td></td><td>☐ Other _____</td><td>_____</td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☒ Limited Liability Co.	_____		☐ Trust	_____		☐ Other _____	_____
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	☒ Limited Liability Co.	_____																							
	☐ Trust	_____																							
	☐ Other _____	_____																							
In the event there are further questions about this report, please contact:		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																							
Name: <u>Mike Kocher</u> Telephone Number: <u>(309)689-5850</u>																									
Email Address: _____																									

Facility Name & ID Number Flora Rehab Health Care Ctr

0052266 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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>99</u>	Skilled (SNF)	<u>99</u>	<u>36,135</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>99</u>	TOTALS	<u>99</u>	<u>36,135</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>12,623</u>	<u>1,238</u>	<u>2,269</u>	<u>16,130</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>12,623</u>	<u>1,238</u>	<u>2,269</u>	<u>16,130</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 44.64%

D. How many bed reserve days during this year were paid by the Department? None (Do not include bed reserve 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 2,268

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: 12/31/2020 Fiscal Year: 12/31/2020
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Flora Rehab Health Care Ctr # 0052266 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	142,266	14,769		157,035		157,035	4,295	161,330			1
2	Food Purchase		130,741		130,741		130,741	(2,808)	127,933			2
3	Housekeeping	96,433	18,049		114,482		114,482	83	114,565			3
4	Laundry	45,227	7,356		52,583		52,583		52,583			4
5	Heat and Other Utilities			118,666	118,666		118,666	293	118,959			5
6	Maintenance	35,631	7,706	27,148	70,485		70,485	2,579	73,064			6
7	Other (specify):*											7
8	TOTAL General Services	319,557	178,621	145,814	643,992		643,992	4,442	648,434			8
	B. Health Care and Programs											
9	Medical Director			13,200	13,200		13,200		13,200			9
10	Nursing and Medical Records	766,015	74,454	128,593	969,062		969,062	2,193	971,255			10
10a	Therapy			220,127	220,127		220,127		220,127			10a
11	Activities	40,676	154		40,830		40,830	(1,349)	39,481			11
12	Social Services	34,362			34,362		34,362		34,362			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	841,053	74,608	361,920	1,277,581		1,277,581	844	1,278,425			16
	C. General Administration											
17	Administrative	68,004		172,400	240,404		240,404	(148,515)	91,889			17
18	Directors Fees											18
19	Professional Services			7,867	7,867		7,867	42,182	50,049			19
20	Dues, Fees, Subscriptions & Promotions			5,386	5,386		5,386	2,027	7,413			20
21	Clerical & General Office Expenses	37,949	3,407	13,991	55,347		55,347	28,476	83,823			21
22	Employee Benefits & Payroll Taxes			160,434	160,434		160,434	7,310	167,744			22
23	Inservice Training & Education							44	44			23
24	Travel and Seminar							14	14			24
25	Other Admin. Staff Transportation			5,806	5,806		5,806	3,077	8,883			25
26	Insurance-Prop.Liab.Malpractice			3,833	3,833		3,833	36,819	40,652			26
27	Other (specify):*											27
28	TOTAL General Administration	105,953	3,407	369,717	479,077		479,077	(28,566)	450,511			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,266,563	256,636	877,451	2,400,650		2,400,650	(23,280)	2,377,370			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			10,489	10,489		10,489	85,394	95,883			30
31	Amortization of Pre-Op. & Org.							6,036	6,036			31
32	Interest			615	615		615	87,557	88,172			32
33	Real Estate Taxes							74,265	74,265			33
34	Rent-Facility & Grounds			265,869	265,869		265,869	(265,869)				34
35	Rent-Equipment & Vehicles			13,056	13,056		13,056	84,278	97,334			35
36	Other (specify):*											36
37	TOTAL Ownership			290,029	290,029		290,029	71,661	361,690			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		32,492		32,492		32,492		32,492			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			138,298	138,298		138,298		138,298			42
43	Other (specify):*			56,768	56,768		56,768	(56,768)				43
44	TOTAL Special Cost Centers		32,492	195,066	227,558		227,558	(56,768)	170,790			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,266,563	289,128	1,362,546	2,918,237		2,918,237	(8,387)	2,909,850			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	(2,808)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,650)	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	(26,605)	30		9
10	Interest and Other Investment Income	(30)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(232)	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	(17,982)	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	(18,000)	43		24
25	Fund Raising, Advertising and Promotional	(1,005)	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	(19,226)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (93,538)		\$	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)	85,151	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 85,151		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (8,387)		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	\$ (9,383)	43	1
2	X-Rays-Part A	(2,309)	43	2
3	Offset Transportation Revenue	(1,349)	11	3
4	Disallowed Special Events	(662)	43	4
5	Offset Miscellaneous Office Supplies Revenue	(171)	21	5
6	Resident Flowers	(265)	43	6
7	Offset Miscellaneous Nursing Supplies Revenue	(4,141)	11	7
8	Chamber of Commerce Dues	(172)	20	8
9	Pet Expense	(774)	43	9
10				10
11				11
12				12
13				13
14				14
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40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(19,226)		49

VII. RELATED PARTIES

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

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

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

☒ YES

☐ NO

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

1		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%	\$ 4,295	\$ 4,295	1
2	V	2	Food		Petersen Health Care Management, Inc.	100.00%	0		2
3	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	83	83	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	293	293	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	2,579	2,579	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%	4,024	4,024	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	172,400	Petersen Health Care Management, Inc.	100.00%	23,885	(148,515)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	14,109	14,109	12
13	V								13
14	Total			\$ 172,400			\$ 49,268	\$ * (123,132)	14

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

VII. RELATED PARTIES (continued)

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

☒ X

 YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	Dues, Fees, Subs & Promotions	\$	Petersen Health Care Management, Inc.	100.00%	\$ 2,199	\$ 2,199	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	26,630	26,630	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	7,310	7,310	17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	44	44	18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	14	14	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	3,077	3,077	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	469	469	21
22	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	4,348	4,348	22
23	V	31	Amortization		Petersen Health Care Management, Inc.	100.00%	0		23
24	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	212	212	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	169	169	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	1,559	1,559	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			\$			\$ 46,031	\$ * 46,031	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	\$	Petersen Health Care Management, Inc.	100.00%	\$ 0	\$	15
16	V	2	Food		Petersen Health Care Management, Inc.	100.00%	0		16
17	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	0		17
18	V	4	Laundry		Petersen Health Care Management, Inc.	100.00%	0		18
19	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	0		19
20	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	0		20
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		21
22	V	10	Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	2,310	2,310	22
23	V	15	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		23
24	V	17	Administrative		Petersen Health Care Management, Inc.	100.00%	0		24
25	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	21,373	21,373	25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Care Management, Inc.	100.00%	0		26
27	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	0		27
28	V	22	Employee Benefits & Payroll		Petersen Health Care Management, Inc.	100.00%			28
29	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	0		29
30	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	0		30
31	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	0		31
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	0		32
33	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	1,610	1,610	33
34	V	31	Amortization		Petersen Health Care Management, Inc.	100.00%	0		34
35	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	252	252	35
36	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	0		36
37	V	34	Rent-Facility and Grounds		Petersen Health Care Management, Inc.	100.00%	0		37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	82,719	82,719	38
39	Total			\$			\$ 108,264	\$ * 108,264	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	6	Maintenance	\$	Petersen 26, LLC	100.00%	\$	\$	15
16	V	19	Professional Services	\$	Petersen 26, LLC	100.00%	6,700	6,700	16
17	V	21	Equipment		Petersen 26, LLC	100.00%	2,017	2,017	17
18	V	26	Insurance-Property		Petersen 26, LLC	100.00%	11,638	11,638	18
19	V	26	Insurance-Liability		Petersen 26, LLC	100.00%	4,960	4,960	19
20	V	26	Insurance-Mortgage Insurance		Petersen 26, LLC	100.00%	19,752	19,752	20
21	V	30	Depreciation		Petersen 26, LLC	100.00%	106,041	106,041	21
22	V	31	Amortization		Petersen 26, LLC	100.00%	6,036	6,036	22
23	V	32	Interest	687	Petersen 26, LLC	100.00%	87,810	87,123	23
24	V	33	Real Estate Taxes		Petersen 26, LLC	100.00%	74,096	74,096	24
25	V	34	Rent-Income and Grounds	265,869	Petersen 26, LLC	100.00%		(265,869)	25
26	V	43	Service Charges		Petersen 26, LLC	100.00%	1,494	1,494	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			\$ 266,556			\$ 320,544	\$ * 53,988	39

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

Facility Name & ID Number

Flora Rehab Health Care Ctr

0052266

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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 Health Care Ctr

0052266

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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 Health Care Ctr

0052266

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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 Rehab Health Care Ctr

0052266

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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			Betty's Garden	Kewanee				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 Health Care Ctr # 0052266 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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 Health Care Ctr# 0052266

Report Period Beginning:

1/1/2020Ending: 2/31/2020

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	\$ 341,562	\$ 398,718	16,130	\$ 4,295	1
2	2	Food	Resident Days	75	0	0	16,130	0	2
3	3	Housekeeping	Resident Days	75	6,607	3,056	16,130	83	3
4	5	Utilities	Resident Days	75	23,320	0	16,130	293	4
5	6	Maintenance	Resident Days	75	205,132	187,746	16,130	2,579	5
6	7	Mgmt. Allocation of Benefits	Resident Days	75	0	0	16,130	0	6
7	9	Medical Director	Resident Days	75	0	0	16,130	0	7
8	10	Nursing and Medical Records	Resident Days	75	320,057	736,064	16,130	4,024	8
9	10A	Therapy	Resident Days	75	0	0	16,130	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	75	0	0	16,130	0	10
11	17	Administrative	Resident Days	75	1,899,565	7,673,667	16,130	23,885	11
12	19	Professional Services	Resident Days	75	1,122,028	0	16,130	14,109	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	75	174,863	0	16,130	2,199	13
14	21	Clerical and General Office	Resident Days	75	2,117,880	2,195,755	16,130	26,630	14
15	22	Employee Benefits and Payroll Ta	Resident Days	75	581,393	0	16,130	7,310	15
16	23	Inservice Training & Education	Resident Days	75	3,513	0	16,130	44	16
17	24	Travel and Seminar	Resident Days	75	1,094	0	16,130	14	17
18	25	Other Admin. Staff Transport.	Resident Days	75	244,700	0	16,130	3,077	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	75	37,297	0	16,130	469	19
20	30	Depreciation	Resident Days	75	345,756	0	16,130	4,348	20
21	31	Amortization	Resident Days	75	0	0	16,130	0	21
22	32	Interest	Resident Days	75	16,842	0	16,130	212	22
23	33	Real Estate Taxes	Resident Days	75	13,451	0	16,130	169	23
24	35	Rent-Equipment & Vehicles	Resident Days	75	124,017	0	16,130	1,559	24
25	TOTALS				\$ 7,579,077	\$ 11,195,006		\$ 95,299	25

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

Report Period Beginning:

1/1/2020Ending: 2/31/2020

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	130,685	6	\$	\$	16,130	\$	1
2	2	Food	Resident Days	130,685	6			16,130		2
3	3	Housekeeping	Resident Days	130,685	6			16,130		3
4	4	Laundry	Resident Days	130,685	6			16,130		4
5	5	Utilities	Resident Days	130,685	6			16,130		5
6	6	Maintenance	Resident Days	130,685	6			16,130		6
7	7	Mgmt. Allocation of Benefits	Resident Days	130,685	6			16,130		7
8	10	Nursing and Medical Records	Resident Days	130,685	6	18,718		16,130	2,310	8
9	15	Mgmt. Allocation of Benefits	Resident Days	130,685	6			16,130		9
10	17	Administrative	Resident Days	130,685	6			16,130		10
11	19	Professional Services	Resident Days	130,685	6	173,161		16,130	21,373	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	130,685	6			16,130		12
13	21	Clerical and General Office	Resident Days	130,685	6			16,130		13
14	22	Employee Benefits & Payroll	Resident Days	130,685	6			16,130		14
15	23	Inservice Training & Education	Resident Days	130,685	6			16,130		15
16	24	Travel and Seminar	Resident Days	130,685	6			16,130		16
17	25	Other Admin. Staff Transport.	Resident Days	130,685	6			16,130		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	130,685	6			16,130		18
19	30	Depreciation	Resident Days	130,685	6	13,046		16,130	1,610	19
20	31	Amortization	Resident Days	130,685	6			16,130		20
21	32	Interest	Resident Days	130,685	6	2,043		16,130	252	21
22	33	Real Estate Taxes	Resident Days	130,685	6			16,130		22
23	34	Rent-Facility and Grounds	Resident Days	130,685	6			16,130		23
24	35	Rent-Equipment & Vehicles	Resident Days	130,685	6	670,184		16,130	82,719	24
25	TOTALS					\$ 877,152	\$		\$ 108,264	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	Huntington Bank		X	HUD Loan	Varies	5/1/13	3,824,000	2,981,024	4/30/38	Varies	\$ 87,810	1
2	Dodge		X	Facility Van	Vareis	6/29/20	39,027	36,053	6/28/25	Varies	615	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$ 3,863,027	\$ 3,017,077			\$ 88,425	9
	B. Non-Facility Related*											
10								Interest Income Offset			(717)	10
11								Home Office Allocation-PMC			212	11
12								Home Office Allocation-PHCM			252	12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ (253)	14
15	TOTALS (line 9+line14)						\$ 3,863,027	\$ 3,017,077			\$ 88,172	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 19,752 Line # 26

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2019 report.			\$	72,864	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	72,392	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(472)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	74,568	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	169	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	74,265	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2015	74,478	8	
		2016	72,641	9	
		2017	72,086	10	
		2018	70,739	11	
		2019	72,392	12	
Accrual based on prior year tax bill.					

		FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	\$		13
14	PLUS APPEAL COST FROM LINE 5	\$		14
15	LESS REFUND FROM LINE 6	\$		15
16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

NOTES:

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

FACILITY NAME Flora Rehabilitation & Health Care Center COUNTY Clay

FACILITY IDPH LICENSE NUMBER 0052266

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 2019 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 2019.

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: 24,488

B. General Construction Type: Exterior BrickFrame 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:

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

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	99		2004	1973	\$ 2,214,200	\$	35	\$ 63,263	\$ 63,263	\$ 1,017,480
5										
6										
7										
8										
	Improvement Type**									
9	Sidewalks		2006		3,605		15	240	240	3,480
10	Front Door Repair		2008		5,090		25	204	204	2,550
11	B-Unit Shower Units		2008		14,000		25	560	560	7,000
12	Roof Replacement		2010		52,985		25	2,120	2,120	22,260
13	Replacement of Kitchen and Dining Room Flooring & Painting		2011		19,985		15	1,332	1,332	12,654
14	Replacement of Kitchen and Dining Room Flooring & Painting		2012		2,405		15	160	160	1,360
15	Air Conditioner-Roof Top		2012		6,341		15	422	422	3,587
16	Roof Replacement		2013		102,805		25	4,112	4,112	30,840
17	Air Conditioner		2013		12,675		15	846	846	6,345
18	Parking Lot Install		2014		11,625		25	465	465	3,023
19	Water Heater		2014		3,850		7	550	550	3,575
20	Water Heater		2014		4,042		7	577	577	3,751
21	Water Heater		2014		3,918		7	560	560	3,640
22	Air Conditioners-2 Rooftop Units		2016		11,826		15	788	788	3,546
23	B-Hall-Painting, Repair and Replace Drywall and Floor Base		2016		12,085		15	806	806	3,627
24	Painting and Wall Repair of Hallway A		2017		11,300		15	754	754	2,639
25	Painting and Wall Repair of Hallway C		2017		7,887		15	526	526	1,841
26	Air Conditioner-Roof Top		2017		6,699		15	446	446	1,561
27	Electrical System Repairs		2018		4,851		7	694	694	1,735
28										
29										
30	Land Improvements Booked					240			(240)	
31	Building Booked					88,621			(88,621)	
32	Building Improvement Booked					15,943			(15,943)	
33										
34	2020-Home Office Allocation-Building Improvements				8,156			196	196	
35	2020-Home Office Allocation-Land Improvements				818			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

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
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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)		\$ 2,521,148	\$ 104,804		\$ 79,673	\$ (25,131)	\$ 1,136,494	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	\$ 57,234	\$ 7,823	\$ 6,598	\$ (1,225)	5-10 yrs.	\$ 37,139	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	636,967					636,967	73
74	Home Office Allocation			5,710	5,710			74
75	TOTALS	\$ 694,201	\$ 7,823	\$ 12,308	\$ 4,485		\$ 674,106	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
77	Facility	2019 Dodge Caravan	2020	39,027	3,903	3,902	(1)	5 yrs.	3,902
78									
79									
80	TOTALS			\$ 72,244	\$ 3,903	\$ 3,902	\$ (1)		\$ 37,119

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)			\$	3,416,593
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	116,530
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	95,883
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	(20,647)
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	1,847,719

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		\$	\$	
87				
88	N/A			
89				
90				
91	TOTALS	\$	\$	

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
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: \$ 97,334 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					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

Flora Rehab Health Care Ctr
0052266
Period Beginning 1/1/2020
Period End 12/31/2020

Schedule 14A

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

Medical Equipment	\$	6,959
Dishwasher		701
Copier		5,396
Home Office Allocation		84,278
		<u>97,334</u>

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

		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)	\$			

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

\$

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

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

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

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

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

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

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

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
	Service	Schedule V Line & Column Reference	2	3	4		5	6	7	8
			Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	5,461	\$ 81,921	\$	5,461	\$ 81,921	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,581	23,718		1,581	23,718	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		7,633	114,488		7,633	114,488	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				32,492		32,492	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			\$	14,675	\$ 220,127	\$ 32,492	14,675	\$ 252,619	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	\$ 292,085	\$ 292,085	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 14,561)	1,209,448	1,209,448	3
4	Supply Inventory (priced at Cost)	15,982	15,982	4
5	Short-Term Investments			5
6	Prepaid Insurance	17,892	28,073	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)		32,493	8
9	Other(specify): <u>Prepaid Management Fees</u>	3,305	3,305	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,538,712	\$ 1,581,386	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		2,222,356	14
15	Leasehold Improvements, at Historical Cost	23,061	298,792	15
16	Equipment, at Historical Cost	104,721	766,445	16
17	Accumulated Depreciation (book methods)	(84,521)	(1,847,719)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		150,897	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(46,275)	20
21	Restricted Funds		437,434	21
22	Other Long-Term Assets (specify): <u>Goodwill</u>	18,710	18,710	22
23	Other(specify): <u>Intercompany Loans</u>	519,101	565,693	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 581,072	\$ 2,695,333	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,119,784	\$ 4,276,719	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 984,002	\$ 984,362	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	82,673	82,673	30
31	Accrued Taxes Payable (excluding real estate taxes)	69,292	69,292	31
32	Accrued Real Estate Taxes(Sch.IX-B)		74,568	32
33	Accrued Interest Payable		6,856	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	1,298	1,298	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,137,265	\$ 1,219,049	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	36,053	36,053	39
40	Mortgage Payable		2,981,024	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	<u>Loan Payable-MCAD Adv. Payment</u>	60,000	60,000	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 96,053	\$ 3,077,077	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,233,318	\$ 4,296,126	46
47	TOTAL EQUITY (page 18, line 24)	\$ 886,466	\$ (19,407)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,119,784	\$ 4,276,719	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,977,989)	1
2	Restatements (describe):		2
3	Adjustments Made After Cost Reports Were Filed	1,422,977	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (555,012)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,441,478	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)	\$ 1,441,478	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)	\$ 886,466	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Flora Rehab Health Care Ctr

0052266

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,149,993	1
2	Discounts and Allowances for all Levels	(221,383)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,928,610	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	433,992	6
7	Oxygen	770	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 434,762	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	2,808	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	57,069	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	10,355	20
21	Other Medical Services	5,276	21
22	Laundry	174	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 75,682	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	30	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 30	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation Revenue</u>	1,349	28
28a	<u>Miscellaneous and COVID Stimulus Revenue</u>	919,282	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 920,631	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,359,715	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	643,992	31
32	Health Care	1,277,581	32
33	General Administration	479,077	33
	B. Capital Expense		
34	Ownership	290,029	34
	C. Ancillary Expense		
35	Special Cost Centers	89,260	35
36	Provider Participation Fee	138,298	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,918,237	40
41	Income before Income Taxes (line 30 minus line 40)**	1,441,478	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,441,478	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,882,884	44
45	Private Pay - Net Inpatient Revenue	186,503	45
46	Medicare - Net Inpatient Revenue	852,618	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	6,605	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,928,610	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	997	997	\$ 36,000	\$ 36.11	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,081	5,300	139,611	26.34	3
4	Licensed Practical Nurses	6,536	6,825	147,929	21.67	4
5	CNAs & Orderlies	20,789	21,322	339,748	15.93	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,675	1,706	23,231	13.62	9
10	Activity Assistants					10
11	Social Service Workers	2,158	2,246	34,362	15.30	11
12	Dietician					12
13	Food Service Supervisor	2,144	2,224	32,262	14.51	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,436	12,033	110,004	9.14	15
16	Dishwashers					16
17	Maintenance Workers	1,857	1,960	35,631	18.18	17
18	Housekeepers	8,236	8,511	96,433	11.33	18
19	Laundry	3,153	3,370	45,227	13.42	19
20	Administrator	2,072	2,080	68,004	32.69	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,407	2,620	37,949	14.48	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	2,383	2,501	60,336	24.12	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Page 20A	2,707	2,733	59,836	21.89	33
34	TOTAL (lines 1 - 33)	73,631	76,428	\$ 1,266,563 *	\$ 16.57	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	13,200	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,896	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)		\$ 18,096		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	943	\$ 44,630	L10,C3	50
51	Licensed Practical Nurses	739	20,997	L10,C3	51
52	Certified Nurse Assistants/Aides	618	58,070	L10,C3	52
53	TOTAL (lines 50 - 52)	2,300	\$ 123,697		53

Flora Rehab Health Care Ctr
0052266
Period Beginning 1/1/2020
Period End 12/31/2020

Schedule 20A

XVIII. Staffing and Salary Costs

		Reporting Period		Average Hourly Wage
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	
Care Plan Coordinator		1,448	1,461	29.02
Transportation		1,259	1,272	13.71
	TOTAL	2,707	2,733	

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description	Amount	
Lisa Davis	Administrator	0	\$ 43,337	Workers' Compensation Insurance	\$	24,077	IDPH License Fee	\$ 3,980	
Laura Kissee	Administrator	0	24,667	Unemployment Compensation Insurance		15,322	Advertising: Employee Recruitment		
				FICA Taxes		89,764	Health Care Worker Background Check		
				Employee Health Insurance		16,317	(Indicate # of checks performed 12)		
				Employee Meals			Patient Background Checks	31 943	
				Illinois Municipal Retirement Fund (IMRF)*			Miscellaneous Licenses & Permits	291	
				Employee Relations		694	Miscellaneous Dues & Subscriptions	172	
				Home Office Allocation		7,310	Home Office Allocation	2,199	
				Employee Retirement		664			
				Administrator Benefits		13,596			
TOTAL (agree to Schedule V, line 17, col. 1)							Less: Public Relations Expense	(172)	
(List each licensed administrator separately.)			\$ 68,004				Non-allowable advertising	()	
B. Administrative - Other							Yellow page advertising	()	
Description			Amount	TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)		
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 172,400	\$ 167,744			\$ 7,413		
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 172,400	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
(Attach a copy of any management service agreement)									
C. Professional Services									
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
Frontier	Computer Services	\$	843			\$	Out-of-State Travel	\$	
Clay County Sheriff	Legal Filing Fees-1/15/20		38						
Ability Network	Computer Services		6,736						
L. Kaye DeSelms Dent	Legal Fees-1/15/20		250				In-State Travel		
				N/A					
							Seminar Expense		
							Home Office Allocation	14	
							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)			\$ 7,867	\$			TOTAL 14		

*** Attach copy of IMRF notifications**

****See instructions.**

Flora Rehab Health Care Ctr
0052266
Period Beginning 1/1/2020
Period End 12/31/2020

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		7,867
Home Office Allocation		
Baker Tilly Virchow Krause LLP	Legal	248
Duane Morris	Legal	5,320
Lexis Nexis	Legal	7
Livingston, Barger, Brant, Schroeder	Legal	1,896
Miller, Hall, Triggs	Legal	43
Miscellaneous	Legal	16
SB2	Legal	128
SmithAmundsen LLC	Legal	794
Sorling Northrup	Legal	226
Mauer and Madoff	Legal	370
Illinois Secretary of State	Legal	112
Sedgwick Claims Management	Legal	6,171
Huntington Bank	Legal	300
CliftonLarsonAllen	Accounting	4,799
Ginoli & Co.	Accounting	7,415
Ability Network	Computer Services	2,532
Allscripts	Computer Services	400
AOD Matrix Care	Computer Services	4,447
AT&T	Computer Services	5
ATS	Computer Services	242
CCH	Computer Services	14
Charter Communications	Computer Services	22
Citrix Systems	Computer Services	76
Comcast	Computer Services	26
ITSavvy	Computer Services	117
Kemper Technology	Computer Services	578
Miscellaneous	Computer Services	112
Pearl Technology	Computer Services	105
Stratus Networks	Computer Services	459
TR Professional	Computer Services	10
David Budde	Other Prof Fees	10
DJ Howard and Associates	Other Prof Fees	19
Getzler Henrich & Associates	Other Prof Fees	78
LRI Consulting Services	Other Prof Fees	76
McQuellon Consulting	Other Prof Fees	48
Miscellaneous	Other Prof Fees	92
Optimizer	Other Prof Fees	41
Registered Agent Solutions	Other Prof Fees	23
RSM McGladrey	Other Prof Fees	251
SB2	Other Prof Fees	1,864
Sedgwick CMS	Other Prof Fees	2,630
Tarver Program Consultants	Other Prof Fees	60
Total (agree to Schedule V, line 19, column 8)		50,049

Flora Rehab Health Care Ctr
0052266
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Schedule 21B

25. Administrative and Staff Transportation

Gas	\$	1,399
Auto Repairs		4,334
Hotels-Travel		73
Home Office Allocation		<u>3,077</u>
		<u>8,883</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?

No

If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization?

No

If YES, have these costs been properly adjusted out of the cost report?

N/A

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

No

If YES, what is the capacity?

N/A

(5) Have you properly capitalized all major repairs and equipment purchases?

Yes

What was the average life used for new equipment added during this period?

7 yrs.

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

\$ 15,995

Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes

If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.

N/A

(9) Are you presently operating under a sublease agreement?

YES

X

NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

X

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 138,298

This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

No

If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

No

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$ 0

Has any meal income been offset against related costs?

Yes

Indicate the amount.

\$ 2,808

(16) Travel and Transportation

a. Are there costs included for out-of-state travel?

No

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

Yes

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$ 1,349

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

100

d. Have vehicle usage logs been maintained?

Yes

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?

No

Indicate the amount of income earned from providing such transportation during this reporting period.

\$

(17) Has an audit been performed by an independent certified public accounting firm?

Yes

Firm Name:

Ginoli and Company

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.

No

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