		FOR BHF USE					

LL1

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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 Rehabilitation & Health Care Center

Address: 232 Givens Street (Number) Flora (City) 62839 (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	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2018 to 12/31/2018 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

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

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

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

Facility Name & ID Number Flora Rehabilitation & Health Care Center # 0052266 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	99	Skilled (SNF)	99	36,135	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	99	TOTALS	99	36,135	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	11,499	1,540	2,823	15,862	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,499	1,540	2,823	15,862	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 43.90%

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 [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

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 [X] Date _____ NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 99 and days of care provided 2,680

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number Flora Rehabilitation & Health Care Center # 0052266 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	129,766	11,702		141,468		141,468	3,852	145,320			1
2	Food Purchase		117,475		117,475		117,475	(5,714)	111,761			2
3	Housekeeping	88,097	21,853		109,950		109,950	61	110,011			3
4	Laundry	53,260	4,461		57,721		57,721		57,721			4
5	Heat and Other Utilities			110,935	110,935		110,935	197	111,132			5
6	Maintenance	36,402	9,584	18,877	64,863		64,863	1,511	66,374			6
7	Other (specify):* Home Office Ben. Allocation											7
8	TOTAL General Services	307,525	165,075	129,812	602,412		602,412	(93)	602,319			8
	B. Health Care and Programs											
9	Medical Director			13,475	13,475		13,475		13,475			9
10	Nursing and Medical Records	847,373	113,220	11,316	971,909		971,909	2,444	974,353			10
10a	Therapy			409,779	409,779		409,779		409,779			10a
11	Activities	53,126	83	796	54,005		54,005	(7,858)	46,147			11
12	Social Services	28,943			28,943		28,943		28,943			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Office Ben. Allocation											15
16	TOTAL Health Care and Programs	929,442	113,303	435,366	1,478,111		1,478,111	(5,414)	1,472,697			16
	C. General Administration											
17	Administrative			232,400	232,400		232,400	(172,150)	60,250			17
18	Directors Fees											18
19	Professional Services			2,041	2,041		2,041	33,380	35,421			19
20	Dues, Fees, Subscriptions & Promotions			5,983	5,983		5,983	2,686	8,669			20
21	Clerical & General Office Expenses	33,678	2,841	9,830	46,349		46,349	39,398	85,747			21
22	Employee Benefits & Payroll Taxes			138,623	138,623		138,623	16,602	155,225			22
23	Inservice Training & Education							97	97			23
24	Travel and Seminar							2	2			24
25	Other Admin. Staff Transportation			6,303	6,303		6,303	2,933	9,236			25
26	Insurance-Prop.Liab.Malpractice			4,684	4,684		4,684	49,989	54,673			26
27	Other (specify):* Home Office Ben. Allocation											27
28	TOTAL General Administration	33,678	2,841	399,864	436,383		436,383	(27,063)	409,320			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,270,645	281,219	965,042	2,516,906		2,516,906	(32,570)	2,484,336			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.

Facility Name & ID Number Flora Rehabilitation & Health Care Center #0052266 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			7,331	7,331		7,331	89,106	96,437			30
31	Amortization of Pre-Op. & Org.							6,118	6,118			31
32	Interest							129,614	129,614			32
33	Real Estate Taxes							71,801	71,801			33
34	Rent-Facility & Grounds			401,711	401,711		401,711	(401,711)				34
35	Rent-Equipment & Vehicles			33,020	33,020		33,020	847	33,867			35
36	Other (specify):*											36
37	**TOTAL Ownership**			442,062	442,062		442,062	(104,225)	337,837			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		53,554		53,554		53,554		53,554			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			133,483	133,483		133,483		133,483			42
43	Other (specify):* **Miscellaneous**			107,671	107,671		107,671	(107,671)				43
44	**TOTAL Special Cost Centers**		53,554	241,154	294,708		294,708	(107,671)	187,037			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,270,645	334,773	1,648,258	3,253,676		3,253,676	(244,466)	3,009,210			45

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

Facility Name & ID Number Flora Rehabilitation & Health Care Center # 0052266 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	(5,750)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,726)	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	(26,161)	30		9
10	Interest and Other Investment Income	(730)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(371)	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	(25,002)	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	(44,000)	43		24
25	Fund Raising, Advertising and Promotional	(653)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,097)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(38,205)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (148,695)		$	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)	(95,771)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (95,771)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (244,466)		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

Flora Rehabilitation & Health Care Center

ID# 0052266

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	$ (7,341)	43	1
2	X-Rays-Part A	(20,726)	43	2
3	Offset Miscellaneous Nursing Supplies Revenue	(222)	10	3
4	Offset Transportation Revenue	(7,858)	11	4
5	Offset Miscellaneous Office Supplies Revenue	(131)	21	5
6	Disallowed Special Events	59	43	6
7	Pet Expense	(1,213)	43	7
8	Resident Flowers	(601)	43	8
9	Disallowed Chamber of Commerce Dues	(172)	20	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**	(38,205)		49

Facility Name & ID Number Flora Rehabilitation & Health Care Center # 0052266 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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. [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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	$	Petersen Health Care Management, Inc.	100.00%	$ 3,852	$ 3,852	1
2	V	2	Food		Petersen Health Care Management, Inc.	100.00%	36	36	2
3	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	61	61	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	197	197	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	1,511	1,511	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%	2,666	2,666	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	160,400	Petersen Health Care Management, Inc.	100.00%	60,250	(100,150)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	11,660	11,660	12
13	V								13
14	Total			$ 160,400			$ 80,233	$ * (80,167)	14

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

Facility Name & ID Number Flora Rehabilitation & Health Care Center # 0052266 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	Dues, Fees, Subs & Promotions	$	Petersen Health Care Management, Inc.	100.00%	$ 2,858	$ 2,858	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	39,529	39,529	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	16,602	16,602	17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	97	97	18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	2	2	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	2,933	2,933	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	735	735	21
22	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	9,349	9,349	22
23	V	31	Amortization		Petersen Health Care Management, Inc.	100.00%	85	85	23
24	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	2,459	2,459	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	291	291	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	847	847	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			$			$ 75,787	$ * 75,787	39

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

Facility Name & ID Number Flora Rehabilitation & Health Care Center # 0052266 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
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	72,000	Petersen Management Company, LLC	100.00%	0	(72,000)	24
25	V	19	Professional Services		Petersen Management Company, LLC	100.00%	16,305	16,305	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%	0		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%	1,456	1,456	33
34	V	31	Amortization		Petersen Management Company, LLC	100.00%	0		34
35	V	32	Interest		Petersen Management Company, LLC	100.00%	17,501	17,501	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			$ 72,000			$ 35,262	$ * (36,738)	39

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

Facility Name & ID Number Flora Rehabilitation & Health Care Center # 0052266 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional Services		Petersen 26, LLC	100.00%	5,415	$ 5,415	15
16	V	26	Insurance-Property		Petersen 26, LLC	100.00%	27,944	27,944	16
17	V	26	Insurance-Mortgage Insurance		Petersen 26, LLC	100.00%	21,310	21,310	17
18	V	30	Depreciation		Petersen 26, LLC	100.00%	104,462	104,462	18
19	V	31	Amortization		Petersen 26, LLC	100.00%	6,033	6,033	19
20	V	32	Interest	443	Petersen 26, LLC	100.00%	110,827	110,384	20
21	V	33	Real Estate Taxes		Petersen 26, LLC	100.00%	71,510	71,510	21
22	V	34	Rent-Income and Grounds	401,711	Petersen 26, LLC	100.00%		(401,711)	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			$ 402,154			$ 347,501	$ * (54,653)	39

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

Facility Name & ID Number Flora Rehabilitation & Health Care Center # 0052266 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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 Syster	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 Rehabilitation & Health Care Center # 0052266 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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 Bloomington Rehabilitation & Health Care Center # 0047415 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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 Bloomington Rehabilitation & Health Care Center # 0047415 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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 Rehabilitation & Health Care Center # 0052266 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4	N/A										4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Flora Rehabilitation & Health Care Center # 0052266 Report Period Beginning: 1/1/2018 Ending: 2/31/2018

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 [X] 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 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	1,411,762	75	$ 342,871	$ 393,211	15,862	$ 3,852	1
2	2	Food	Resident Days	1,411,762	75	3,216	0	15,862	36	2
3	3	Housekeeping	Resident Days	1,411,762	75	5,441	2,652	15,862	61	3
4	5	Utilities	Resident Days	1,411,762	75	17,524	0	15,862	197	4
5	6	Maintenance	Resident Days	1,411,762	75	134,460	148,272	15,862	1,511	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,411,762	75	0	0	15,862	0	6
7	9	Medical Director	Resident Days	1,411,762	75	0	0	15,862	0	7
8	10	Nursing and Medical Records	Resident Days	1,411,762	75	237,275	1,454,984	15,862	2,666	8
9	10A	Therapy	Resident Days	1,411,762	75	0	0	15,862	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,411,762	75	0	0	15,862	0	10
11	17	Administrative	Resident Days	1,411,762	75	4,940,583	5,658,897	15,862	60,250	11
12	19	Professional Services	Resident Days	1,411,762	75	1,037,806	0	15,862	11,660	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,411,762	75	254,355	0	15,862	2,858	13
14	21	Clerical and General Office	Resident Days	1,411,762	75	3,518,216	3,764,024	15,862	39,529	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,411,762	75	1,477,639	0	15,862	16,602	15
16	23	Inservice Training & Education	Resident Days	1,411,762	75	8,601	0	15,862	97	16
17	24	Travel and Seminar	Resident Days	1,411,762	75	174	0	15,862	2	17
18	25	Other Admin. Staff Transport.	Resident Days	1,411,762	75	261,018	0	15,862	2,933	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,411,762	75	65,437	0	15,862	735	19
20	30	Depreciation	Resident Days	1,411,762	75	832,087	0	15,862	9,349	20
21	31	Amortization	Resident Days	1,411,762	75	7,528	0	15,862	85	21
22	32	Interest	Resident Days	1,411,762	75	218,814	0	15,862	2,459	22
23	33	Real Estate Taxes	Resident Days	1,411,762	75	25,901	0	15,862	291	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,411,762	75	75,380	0	15,862	847	24
25	TOTALS					$ 13,464,326	$ 11,422,040		$ 156,020	25

Facility Name & ID Number Flora Rehabilitation & Health Care Center # 0052266 Report Period Beginning: 1/1/2018 Ending: 2/31/2018

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 [X] 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	157,836	6	$	$	15,862	$	1
2	2	Food	Resident Days	157,836	6			15,862		2
3	3	Housekeeping	Resident Days	157,836	6			15,862		3
4	4	Laundry	Resident Days	157,836	6			15,862		4
5	5	Utilities	Resident Days	157,836	6			15,862		5
6	6	Maintenance	Resident Days	157,836	6			15,862		6
7	7	Mgmt. Allocation of Benefits	Resident Days	157,836	6			15,862		7
8	10	Nursing and Medical Records	Resident Days	157,836	6			15,862		8
9	15	Mgmt. Allocation of Benefits	Resident Days	157,836	6			15,862		9
10	17	Administrative	Resident Days	157,836	6			15,862		10
11	19	Professional Services	Resident Days	157,836	6	162,247		15,862	16,305	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	157,836	6			15,862		12
13	21	Clerical and General Office	Resident Days	157,836	6			15,862		13
14	22	Employee Benefits & Payroll	Resident Days	157,836	6			15,862		14
15	23	Inservice Training & Education	Resident Days	157,836	6			15,862		15
16	24	Travel and Seminar	Resident Days	157,836	6			15,862		16
17	25	Other Admin. Staff Transport.	Resident Days	157,836	6			15,862		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	157,836	6			15,862		18
19	30	Depreciation	Resident Days	157,836	6	14,493		15,862	1,456	19
20	31	Amortization	Resident Days	157,836	6			15,862		20
21	32	Interest	Resident Days	157,836	6	174,141		15,862	17,501	21
22	33	Real Estate Taxes	Resident Days	157,836	6			15,862		22
23	34	Rent-Facility and Grounds	Resident Days	157,836	6			15,862		23
24	35	Rent-Equipment & Vehicles	Resident Days	157,836	6			15,862		24
25	TOTALS					$ 350,881	$		$ 35,262	25

Facility Name & ID Number Flora Rehabilitation & Health Care Center # 0052266 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Huntington Bank		X	HUD Loan	Varies	5/1/13	3,824,000	$ 3,225,595	4/30/38	Varies	$ 110,827	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 3,824,000	$ 3,225,595			$ 110,827	9
	B. Non-Facility Related*											
10								Interest Income Offset			(1,173)	10
11								Home Office Allocation-PMC			17,501	11
12								Home Office Allocation-PHCM			2,459	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 18,787	14
15	TOTALS (line 9+line14)						$ 3,824,000	$ 3,225,595			$ 129,614	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 21,310 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.)

Facility Name & ID Number Flora Rehabilitation & Health Care Center # 0052266 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	74,820	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.)	$	72,086	2
3. Under or (over) accrual (line 2 minus line 1).	$	(2,734)	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	$	74,244	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. **Home Office Allocation**		291	
TOTAL REFUND $ **For** **Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	71,801	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	71,618	8
	2014	71,981	9
	2015	74,478	10
	2016	72,641	11
	2017	72,086	12

Accrual based on prior year tax bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

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

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-23-400-014	Long-Term Care Facility	$ 72,086.26	$ 72,086.26
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 72,086.26	$ 72,086.26

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

Facility Name & ID Number Flora Rehabilitation & Health Care Center # 0052266 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

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

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

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

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

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] 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: 6,118
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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	278,784	2004	$ 129,000	1
2					2
3	TOTALS	278,784		$ 129,000	3

Facility Name & ID Number Flora Rehabilitation & Health Care Center # 0052266 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	99		2004	1973	$ 2,214,200	$	35	$ 63,263	$ 63,263	$ 890,954	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Sidewalks			2006	3,605		15	240	240	3,000	9
10	Front Door Repair			2008	5,090		25	204	204	2,142	10
11	B-Unit Shower Units			2008	14,000		25	560	560	5,880	11
12	Roof Replacement			2010	52,985		25	2,120	2,120	18,020	12
13	Replacement of Kitchen and Dining Room Flooring & Painting			2011	19,985		15	1,332	1,332	9,990	13
14	Replacement of Kitchen and Dining Room Flooring & Painting			2012	2,405		15	160	160	1,040	14
15	Air Conditioner-Roof Top			2012	6,341		15	422	422	2,743	15
16	Roof Replacement			2013	102,805		25	4,112	4,112	22,616	16
17	Air Conditioner			2013	12,675		15	846	846	4,653	17
18	Parking Lot Install			2014	11,625		25	465	465	2,093	18
19	Water Heater			2014	3,850		7	550	550	2,475	19
20	Water Heater			2014	4,042		7	577	577	2,597	20
21	Water Heater			2014	3,918		7	560	560	2,520	21
22	Air Conditioners-2 Rooftop Units			2016	11,826		15	788	788	1,970	22
23	B-Hall-Painting, Repair and Replace Drywall and Floor Base			2016	12,085		15	806	806	2,015	23
24	Painting and Wall Repair of Hallway A			2017	11,300		15	754	754	1,131	24
25	Painting and Wall Repair of Hallway C			2017	7,887		15	526	526	789	25
26	Air Conditioner-Roof Top			2017	6,699		15	446	446	669	26
27	Electrical System Repairs			2018	4,851		7	347	347	347	27
28											28
29											29
30	Land Improvements Booked					240			(240)		30
31	Building Booked					88,621			(88,621)		31
32	Building Improvement Booked					15,827			(15,827)		32
33											33
34	2018-Home Office Allocation-Building Improvements				7,461			179	179		34
35	2018-Home Office Allocation-Land Improvements				748			47	47		35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Flora Rehabilitation & Health Care Center # 0052266 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	$ 63,978	$ 6,846	$ 6,165	$ (681)	5-10 yrs.	$ 39,890	71
72	Current Year Purchases	5,443	259	389	130	7 yrs.	389	72
73	Fully Depreciated Assets	620,908					620,908	73
74	Home Office Allocation			10,579	10,579			74
75	TOTALS	$ 690,329	$ 7,105	$ 17,133	$ 10,028		$ 661,187	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 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,372,929	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 111,793	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 96,437	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (15,356)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,672,048	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Flora Rehabilitation & Health Care Center # 0052266 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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: ____ *

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.	/2019	$
13.	/2020	$
14.	/2021	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 33,867 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 Rehabilitation & Health Care Center
0052266
Period Beginning 1/1/2018
Period End 12/31/2018

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	$	27,343
Dishwasher		701
Copier		4,976
Home Office Allocation		847
		33,867

Facility Name & ID Number Flora Rehabilitation & Health Care Center # 0052266 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] 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.

Facility Name & ID Number Flora Rehabilitation & Health Care Center # 0052266 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A(3)	hrs	$	10,983	$ 164,751	$	10,983	$ 164,751	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		3,434	51,508		3,434	51,508	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		12,886	193,289		12,886	193,289	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				53,554		53,554	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Respiratory Therapy	10A(3)			15	231		15	231	12
13	Other (specify):									13
14	TOTAL			$	27,318	$ 409,779	$ 53,554	27,318	$ 463,333	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Flora Rehabilitation & Health Care Center # 0052266 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2018 (last day of reporting year)

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	$ 1,353,035	$ 1,384,236	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 101,078)	925,666	925,666	3
4	Supply Inventory (priced at Cost)	15,982	15,982	4
5	Short-Term Investments			5
6	Prepaid Insurance	46,868	57,932	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)		32,640	8
9	Other(specify): Prepaid Management Fees	143,798	143,798	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,485,349	$ 2,560,254	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		2,221,661	14
15	Leasehold Improvements, at Historical Cost	23,061	298,722	15
16	Equipment, at Historical Cost	65,694	723,546	16
17	Accumulated Depreciation (book methods)	(66,079)	(1,672,048)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		150,897	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(34,203)	20
21	Restricted Funds		502,926	21
22	Other Long-Term Assets (spe Goodwill	18,710	18,710	22
23	Other(specify): Intercompany Loans		40,879	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 41,386	$ 2,380,090	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,526,735	$ 4,940,344	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 746,548	$ 751,991	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	106,482	106,482	30
31	Accrued Taxes Payable (excluding real estate taxes)	300,176	300,176	31
32	Accrued Real Estate Taxes(Sch.IX-B)		74,244	32
33	Accrued Interest Payable		9,085	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	1,145	1,145	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,154,351	$ 1,243,123	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,225,595	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany Loans	1,850,522	273,156	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,850,522	$ 3,498,751	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,004,873	$ 4,741,874	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (478,138)	$ 198,470	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,526,735	$ 4,940,344	48

***(See instructions.)**

Facility Name & ID Number Flora Rehabilitation & Health Care Center # 0052266 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (486,686)	1
2	Restatements (describe):		2
3	Rounding	1	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (486,685)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(45,416)	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	53,963	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)**	$ 8,547	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)**	$ (478,138)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Flora Rehabilitation & Health Care Center # 0052266 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,603,893	1
2	Discounts and Allowances for all Levels	(365,309)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,238,584	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	791,097	6
7	Oxygen	1,876	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 792,973	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	5,750	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	108,262	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	40,289	20
21	Other Medical Services	13,305	21
22	Laundry	156	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 167,762	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	730	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 730	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Transportation Revenue	7,858	28
28a	Miscellaneous Revenue	353	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 8,211	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,208,260	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	602,412	31
32	Health Care	1,478,111	32
33	General Administration	436,383	33
	B. Capital Expense		
34	Ownership	442,062	34
	C. Ancillary Expense		
35	Special Cost Centers	161,225	35
36	Provider Participation Fee	133,483	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,253,676	40
41	**Income before Income Taxes (line 30 minus line 40)****	(45,416)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (45,416)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,565,269	44
45	Private Pay - Net Inpatient Revenue	161,791	45
46	Medicare - Net Inpatient Revenue	511,206	46
47	Other-(specify) Insurance Net Inpatient Revenue	318	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,238,584	49

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

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

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

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

Facility Name & ID Number Flora Rehabilitation & Health Care Center # 0052266 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,495	2,512	$ 62,652	$ 24.94	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,241	10,241	281,637	27.50	3
4	Licensed Practical Nurses	3,784	4,018	88,647	22.06	4
5	CNAs & Orderlies	19,658	19,753	370,567	18.76	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,938	2,002	25,040	12.51	9
10	Activity Assistants					10
11	Social Service Workers	2,011	2,011	28,943	14.39	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	27,270	13.11	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,453	10,977	102,496	9.34	15
16	Dishwashers					16
17	Maintenance Workers	1,996	2,091	36,402	17.41	17
18	Housekeepers	7,895	8,236	88,097	10.70	18
19	Laundry	5,263	5,587	53,260	9.53	19
20	Administrator	2,080	2,080	60,250	28.97	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,080	2,081	33,678	16.18	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	66	66	996	15.09	31
32	Other Health Care(specify)					32
33	Other(specify) Page 20A	4,523	4,773	70,960	14.87	33
34	TOTAL (lines 1 - 33)	76,563	78,508	$ 1,330,895 *	$ 16.95	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	13,475	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,315	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)		$ 17,790		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	16	373	L10, C3	52
53	TOTAL (lines 50 - 52)	16	$ 373		53

Flora Rehabilitation & Health Care Center
0052266
Period Beginning **1/1/2018**
Period End **12/31/2018**

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	2,699	2,807	42,874	15.27
Transportation	1,824	1,966	28,086	14.29
TOTAL	4,523	4,773	70,960	

Facility Name & ID Number Flora Rehabilitation & Health Care Center # 0052266 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Tabatha Sides	Administrator	0	$ 60,250
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 60,250

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 232,400
TOTAL (agree to Schedule V, line 17, col. 3)	$ 232,400
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frontier	Computer Services	$ 800
Fifth Third Bank	Legal Filing Fees	47
Ability Network	Computer Services	1,074
Insurance Administrative Solutions	Legal Filing Fees	19
U.S. Bank	Legal Filing Fees	55
Sorling Northrup	Legal Filing Fees	46
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 2,041

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 26,168
Unemployment Compensation Insurance	14,247
FICA Taxes	95,380
Employee Health Insurance	1,404
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	705
Home Office Allocation	16,602
Employee Retirement	719
TOTAL (agree to Schedule V, line 22, col.8)	$ 155,225

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	156
Health Care Worker Background Check	
(Indicate # of checks performed 16)	480
Patient Background Checks	582
Miscellaneous Licenses & Permits	613
Miscellaneous Dues & Subscriptions	172
Home Office Allocation	2,858
Less: Public Relations Expense	(172)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,669

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Home Office Allocation	2
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2

* Attach copy of IMRF notifications

**See instructions.

Flora Rehabilitation & Health Care Center
0052266
Period Beginning **1/1/2018**
Period End **12/31/2018**

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		2,041
Home Office Allocation		
MusilloUnkenholt, LLC	Legal	140
Arnstein & Lehr	Legal	945
SB2	Legal	594
Miscellaneous	Legal	11
Miller Hall and Triggs	Legal	150
Smith Amundsen	Legal	58
Healthcare Resources International	Legal	104
Hunziker Law	Legal	1
Lexis Nexis	Legal	6
Baker Tilly Virchow Krause	Legal	527
Capital Finance Group	Legal	5018
CliftonLarsonAllen	Accounting	1689
Ginoli & Co.	Accounting	2796
Baker Tilly Virchow Krause	Accounting	105
Capital Finance Group	Accounting	828
Miscellaneous	Computer Services	77
Change Healthcare	Computer Services	7
360 Networks	Computer Services	32
Matrix Care	Computer Services	2945
Stratus Networks	Computer Services	352
Kemper Technology	Computer Services	200
AT&T	Computer Services	5
Ability Network	Computer Services	217
CIAN	Computer Services	245
Comcast	Computer Services	14
CCH	Computer Services	12
Charter Communications	Computer Services	25
Allscripts	Computer Services	218
ATS	Computer Services	224
Citrix Systems	Computer Services	21
Optimizer	Other Prof Fees	39
Ankura	Other Prof Fees	634
David Budde	Other Prof Fees	30
Sargent Consulting	Other Prof Fees	15360
Alix Partners	Other Prof Fees	5178
Demonica Kemper	Other Prof Fees	26
Brad Barkley	Other Prof Fees	104
MPAC Healthcare	Other Prof Fees	16
Higgs Appraisal	Other Prof Fees	7
Alan Litwiller	Other Prof Fees	3
Total (agree to Schedule V, line 19, column 8)		41,004

Flora Rehabilitation & Health Care Center
0052266
Period Beginning 1/1/2018
Period End 12/31/2018

Schedule 14A

25. Adminsrative and Staff Transportation

Gas	$	3,291
Auto Repairs		2,943
Mileage-Travel		69
Home Office Allocation		2,933
		9,236

Facility Name & ID Number Flora Rehabilitation & Health Care Center # 0052266 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA-**

(3) 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. $ **19,139** 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. $ **133,483**
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. $ **5,750**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **Yes** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **7,858**
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? 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 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

RECONCILIATION REPORT **Flora Rehabilitation & H** **11:19 AM** **7/25/2019**

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	-244,466	equal to	-244,466	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	129,614	equal to	129,614	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	71,801	equal to	71,801	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening	6,118	equal to	6,118	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	96,437	equal to	96,437	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	33,867	equal to	33,867	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	409,779	equal to	409,779	0	O.K.	Pg16 Z12+Z14..	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	53,554	equal to	53,554	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	602,412	equal to	602,412	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	1,478,111	equal to	1,478,111	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	436,383	equal to	436,383	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	442,062	equal to	442,062	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	161,225	equal to	161,225	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+I	N/A	38to41+43	4
Income Stat. Prov. Partic.	133,483	equal to	133,483	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	847,373	equal to	847,373	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	53,126	equal to	53,126	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	28,943	equal to	28,943	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	129,766	equal to	129,766	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	36,402	equal to	36,402	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	88,097	equal to	88,097	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	53,260	equal to	53,260	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	60,250	equal to	60,250	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	33,678	equal to	33,678	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	1,330,895	equal to	1,270,645	60,250	FAILED	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	0	< or = to		#VALUE!	#VALUE!	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	13,475	< or = to	13,475	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	4,688	< or = to	11,316	-6,628	O.K.	Pg20 X14..X16	B. & C.	i7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	796	-796	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.	60,250	equal to	60,250	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	232,400	equal to	232,400	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	2,041	equal to	2,041	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	155,225	equal to	155,225	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	8,669	equal to	8,669	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	2	equal to	2	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	133,483	equal to	133,483	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	2,680	equal to	2,823	-143	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. cos	-95,771	equal to	-95,771	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4	B.	14	8
Total loan balance	3,225,595	equal to	3,225,595	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27.	N/A	29+39-41	2
Real estate tax accrual	74,244	equal to	74,244	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	2,520,383	equal to	2,520,383	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	723,546	equal to	723,546	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	1,672,048	equal to	1,672,048	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	-478,138	equal to	-478,138	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	-45,416	equal to	-45,416	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. co	0	equal to		0	O.K.	Pg22 F31-J31..I	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	2,526,735	equal to	2,526,735	0	O.K.	Pg17:H41	N/A	25	1	Pg17 S41	N/A	48	1

Enter Cost Cen **YOU HAVE CHOSEN THE SUPPORT CALC. THAT IS LINKED TO THE COST REPORT!!!!** 7/25/2019 11:19:55 AM

HSA Number: 4 Name: Casey Health Care Center

Cost report peri From: 1/1/2018 To: 12/31/2018 Base Number: 516
If this is an ICF/DD 16 facility, e N
Licensed bed d 25,185 Occupancy: 19,764 Pct. of occupan 78.48%

ıblic Aid Support Rate: $ ____

Genl Services S	295,611	Col 1, Line 8 ---Audit Adj:	
Genl Admin Sal	29,942	Col 1, Line 28 ---Audit Adj:	
Total Salary Wa	1,433,724	Col 1, Line 44 ---Audit Adj:	
Employee Bene	166,470	Col 8, Line 22 ---Audit Adj:	
Total General S	602,018	Col 8, Line 8 ---Audit Adj:	
Total General A	415,218	Col 8, Line 28 ---Audit Adj:	

Instructions and Calculation Steps

STEP I Adjust Support Service Costs to Include Correct Amounts of Fringe Benefits and Payroll Taxes.

Fringe benefits and payroll taxes are reported as a lump sum under General Administration expenses on your cost report (Page 3, Column 10, Line 22). You will need to take this amount out of General Administration expenses and calculate the correct portions of this lump sum to be added to your general services and General Administration expenses. This is done by proration.

A. General Services

1 Determine the proportion of general services wages to total wages.

2 Multiply the total lump sum fringe amount by this proportion to get the fringe amount for General Services.

3 Add the proportioned fringe amount to you total general services expenses to get your new total general services cost.

General Services Wages (Column 1, Line 8)	$295,611
Divided by Total Wages (Column 1, Line 44)	$1,433,724
General service wages as percent of total wages	20.6184%
Employee Benefits (Column 10, Line 22)	$166,470
Allocation of Employee Benefits to General Services Costs	$34,323
Plus Total General Services (Column 10, Line 8)	$602,018
New Total General Services Cost	$636,341

B. General Administration

1 Determine the proportion of General Administration wages to total wages.

2 Multiply the total lump sum fringe amount by this proportion to get the fringes amount for General Administration.

3 Add the proportioned fringe amount to your total General Administration expenses.

4 Subtract the total lump sum fringe amount from your General Administration expenses to get your new total General Administration Cost.

General Administration Wages (Column 1, Line 28).	$29,942
Divided by Total Wages (Column 1, Line 45)	$1,433,724
General administration wages as a percent of total wages	2.0884%
Employee Benefits (Column 10, Line 22)	$166,470
Allocation of Employee Benefits to General Admin. Costs	$3,477
Plus Total General Administration (Column 10, Line 28)	$415,218
Minus Total Fringe (Column 10, Line 22)	$166,470
New Total General Administration Cost	$252,225

STEP II Adjust Support Service Costs for Inflation

To calculate the impact of inflation, different inflation fators are used for the General Service and General Administration costs of your cost report. These inflation factors are listed in Table I, Inflation Multipliers. To select the appropriate inflation factors, you need to calculate your base number using the formula outlined below. Once you have calculated your base number, find it in Table I. Select the inflation factors which correspond with your base number and use these in updating your support cost.

A. Base Number Calculation

Convert the beginning and ending dates of your cost reporting period (page 1, Schedule II of your cost report) into numbers and apply the following formula:

Beginning Month + Ending Mon	13	divided by 2 =	6.5
Beginning Day + Ending Day =	32	divided by 60.8 =	0.526315789
Beginning Year + Ending Year =	236	multiplied by 6 =	1416
Sum of the three lines			1423.026316
Subtract from the sum			907.00
Base Number (expressed as a whole number, fraction dropped)			516

B. Select the Appropriate Inflation Multipliers

Refer to Table I, inflation Multipliers, and find the multipliers which correspond with the base number you have calculated.

General Services Multiplier:	1
General Administration Multiplier:	1

C. Apply Inflation Multipliers to Update Cost

1 Multiply New Total General Services Cost (from Step I-A) by the appropriate multiplier from Table I:

New Total General Service Cost (Step I-A)	$636,341	
General Services Multiplier (Step II-B)	1	
Updated General Services Cost		$636,341

2 Multiply New Total General Administration Cost (from Step I-B)by the appropriate multiplier from Table I:

New Total General Service Cost (Step I-B)	$252,225	
General Administration Multiplier (Step II-B)	1	
Updated General Services Cost		$252,225
3 Total Updated Support Costs (1 + 2)		$888,566

STEP III Convert Total Updated Support Costs (C-3) to Per Diem Costs

Use one of the two procedures below to compute per diem costs.

CALCULATED PER DIEM SUPPORT COSTS $42.35

A. If the occupancy (Cost Report, Page 2, Schedule III-C) is equal to or above 93 percent, divide your total updated support costs (Step II, C, 3, above) by the total patient days (Cost Report, Page 2, Schedule III-B, Column 5, Line 14).

Total Support Costs (Step II, C, 3, above)	$888,566
Total Patient Days (Cost Report)	19,764
Support Costs per Diem	$44.96

OR

B. If the occupancy is below 93 percent, calculate 93 percent of the licensed bed days (Cost Report, Page 2, Schedule III-A, Column 4, Line 7). Then subtract the total patient days (Cost Report, Page 2, Schedule III-B, Column 5, Line 14) from the result and calculate one-third of the difference. Then add the one-third difference to the total patient days to obtain your adjusted occupancy. Next divide your total updated Support Costs (Step II, C, 3 above) by your adjusted occupancy.

Licensed Bed Days	25,185
Multiplied by	0.93
	23,422
Minus total Patient Days	19,764
	3,658
One-third of difference	1,219
Plus Total Patient Days	19,764
Adjusted Occupancy	20,983
Total Support Costs (Step II, C, 3, above)	$888,566
Divided by Adjusted Occupany	20983
Support Costs Per Diem	$42.35

STEP IV Calculate Support Rate

The maximum allowable support reimbursement rate is the 75th percentile for your region. The 35th and 75th percentile rates by HSA are listed in Table II, support Rate Percentiles by HSA. Use one of the three procedures below and refer to Table II to calculate your support rate.

A. If your support costs per diem from STEP II is equal to or greater than the 75th percentile for your HSA, then your support rate is the 75th percentile rate listed in Table II.

B. If your support costs per diem from Step III is equal to or greater than the 35th percentile, but less than the 75th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate listed in Table II. Use the following procedure to calculate your rate:

75 Percentile Rate for your HSA	$47.44
Minus Support Costs Per Diem	$42.35
Difference	$5.09
Multiply the Difference by	0.5
One-Half of the Difference	$2.55
Plus Support Costs Per Diem	$42.35
Support Rate if costs are between 35th and 75th percentile	44.9

C. If your support cost per diem from Step III is below the 35th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate up to a ceiling. This ceiling is equal to 50 percent of the difference between the 35th and 75th percentiles plus $.05. The ceiling for each HSA is listed in Table II. Use the following procedure to calculate your rate:

75 Percentile Rate for your HSA	$47.44
Minus Support Costs Per Diem	$42.35
Difference	$5.09
Multiply the Difference by	0.5
One-Half of the Difference	$2.55
Compare one-half the difference to the profit ceiling for your HSA in Table II and	3.795
Enter the Lower of the Two Amounts	$2.550
Plus Support Costs Per Diem	$42.35
Support Rate if support costs less than 35th percentile	$44.90

D. YOUR FINAL TOTAL SUPPORT RATE from A, B, or C above **$44.90**

75th Percentile is	$47.44
35th Percentile is	$39.95

Table I
Inflation Multipliers

Base Number	General Services Multiplier	General Administration Multiplier
261	1.1187	1.1531
262	1.1182	1.1530
263	1.1178	1.1528
264	1.1071	1.1376
265	1.1067	1.1375
266	1.1062	1.1373
267	1.0975	1.1249
268	1.0971	1.1248
269	1.0966	1.1246
270	1.0887	1.1134
271	1.0882	1.1132
272	1.0877	1.1130
273	1.0815	1.1043
274	1.0811	1.1042
275	1.0806	1.1040
276	1.0730	1.0932
277	1.0725	1.0931
278	1.0720	1.0929
279	1.0666	1.0853
280	1.0661	1.0851
281	1.0657	1.0850
282	1.0588	1.0753
283	1.0583	1.0751
284	1.0579	1.0750
285	1.0535	1.0690
286	1.0531	1.0689
287	1.0527	1.0687
288	1.0413	1.0524
289	1.0409	1.0522
290	1.0404	1.0521
291	1.0321	1.0403
292	1.0317	1.0402
293	1.0313	1.0400
294	1.0254	1.0318
295	1.0250	1.0317
296	1.0246	1.0315
297	1.0228	1.0294
298	1.0224	1.0293
299	1.0219	1.0291
300	1.0166	1.0218
301	1.0162	1.0216
302	1.0158	1.0215
303	1.0076	1.0098
304	1.0072	1.0097
305	1.0067	1.0095
306	1.0000	1.0000

Table II
SupportRate percentiles by HSA

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceiling
1	48.45	39.86	4.345
2	47.44	39.95	3.795
3	41.84	34.67	3.635
4	47.44	39.95	3.795
5	41.31	34.45	3.645
6	52.64	38.99	6.875
7	52.64	38.99	6.875
8	52.64	38.99	6.875
9	49.92	38.30	5.860
10	48.45	39.86	4.345
11	43.93	35.79	4.120

Table II (For ICF/DD 16 Facilities)
SupportRate percentiles by HSA
Not updated with current figures

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceiling
1	34.86	27.19	3.885
2	33.30	25.97	3.715
3	32.74	25.54	3.650
4	33.30	25.97	3.715
5	30.46	23.75	3.405
6	40.44	31.54	4.500
7	40.44	31.54	4.500
8	40.44	31.54	4.500
9	37.60	29.32	4.190
10	34.86	27.19	3.885
11	32.73	25.52	3.655

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	129,766	11,702	-	141,468	0	141,468	3,852	145,320
2. Food Purchase	-	117,475	-	117,475	0	117,475	-5,714	111,761
3. Housekeeping	88,097	21,853	-	109,950	0	109,950	61	110,011
4. Laundry	53,260	4,461	-	57,721	0	57,721	0	57,721
5. Heat and Other Utilities	-	-	110,935	110,935	0	110,935	197	111,132
6. Maintenance	36,402	9,584	18,877	64,863	0	64,863	1,511	66,374
7. Other (specify)*	-	-	-	0	0	0	0	0
8. Total General Services	307,525	165,075	129,812	602,412	0	602,412	-93	602,319
9. Medical Director	-	-	13,475	13,475	0	13,475	0	13,475
10. Nursing & Medical Records	847,373	113,220	11,316	971,909	0	971,909	2,444	974,353
10a. Therapy	-	-	409,779	409,779	0	409,779	0	409,779
11. Activities	53,126	83	796	54,005	0	54,005	-7,858	46,147
12. Social Services	28,943	-	-	28,943	0	28,943	0	28,943
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	929,442	113,303	435,366	1,478,111	0	1,478,111	-5,414	#######
17. Administrative	-	-	232,400	232,400	0	232,400	-172,150	60,250
18. Directors Fees	-	-	-	0	0	0	0	0
19. Professional Services	-	-	2,041	2,041	0	2,041	33,380	35,421
20. Fees, Subscriptions & Promotion	-	-	5,983	5,983	0	5,983	2,686	8,669
21. Clerical & General Office	33,678	2,841	9,830	46,349	0	46,349	39,398	85,747
22. Employee Benefits & Payroll	-	-	138,623	138,623	0	138,623	16,602	155,225
23. Inservice Training & Education	-	-	-	0	0	0	97	97
24. Travel and Seminar	-	-	-	0	0	0	2	2
25. Other Admin. Staff Trans	-	-	6,303	6,303	0	6,303	2,933	9,236
26. Insurance-Prop.Liab.Malpractice	-	-	4,684	4,684	0	4,684	49,989	54,673
27. Other (specify)*	-	-	-	0	0	0	0	0
28. Total General Adminis	33,678	2,841	399,864	436,383	0	436,383	-27,063	409,320
29. Total General Administrative	#######	281,219	965,042	2,516,906	0	2,516,906	-32,570	#######
30. Depreciation	-	-	7,331	7,331	0	7,331	89,106	96,437
31. Amortization of Pre-Op. & Org.	-	-	-	0	0	0	6,118	6,118
32. Interest	-	-	-	0	0	0	129,614	129,614
33. Real Estate	-	-	-	0	0	0	71,801	71,801
34. Rent - Facility & Grounds	-	-	401,711	401,711	0	401,711	-401,711	0
35. Rent - Equipment & Vehicles	-	-	33,020	33,020	0	33,020	847	33,867
36. Other (specify):*	-	-	-	0	0	0	0	0
37. Total Ownership	-	-	442,062	442,062	0	442,062	-104,225	337,837
38. Medically Necessary T	-	-	-	0	0	0	0	0
39. Ancillary Service Cent	-	53,554	-	53,554	0	53,554	0	53,554
40. Barber and Beauty Shop	-	-	-	0	0	0	0	0
41. Coffee and Gift Shops	-	-	-	0	0	0	0	0
42	-	-	133,483	133,483	0	133,483	0	133,483
43. Other (specify):*	-	-	107,671	107,671	0	107,671	-107,671	0
44. Total Special Cost Ce	-	53,554	241,154	294,708	0	294,708	-107,671	187,037
45. Grand Total	#######	334,773	#######	3,253,676	0	3,253,676	-244,466	#######

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	#######	1,384,236
2. Cash - Patient Deposits	-	0
3. Accounts & Notes Recievable	925,666	925,666
4. Supply Inventory	15,982	15,982
5. Short-Term Investments	-	0
6. Prepaid Insurance	46,868	57,932
7. Other Prepaid Expenses	-	0
8. Accounts Receivable-Owner/Related Party	-	32,640
9. Other (specify):	143,798	143,798
10. Total current assets	#######	2,560,254
LONG TERM ASSETS		
11. Long-Term Notes Receivable	-	0
12. Long-Term Investments	-	0
13. Land	-	129,000
14. Buildings, at Historical Cost	-	2,221,661
15. Leasehold Improvements, Historical Cost	23,061	298,722
16. Equipment, at Historical Cost	65,694	723,546
17. Accumulated Depreciation (book methods)	(66,079)	-1,672,048
18. Deferred Charges	-	0
19. Organization & Pre-Operating Costs	-	150,897
20. Accum Amort - Org/Pre-Op Costs	-	-34,203
21. Restricted Funds	-	502,926
22. Other Long-Term Assets (specify):	18,710	18,710
23. other (specify):	-	40,879
24. Total Long-Term Assets	41,386	2,380,090
25. Total Assets	#######	4,940,344
CURRENT LIABILITIES		
26. Accounts Payable	746,548	751,991
27. Officer's Accounts Payable	-	0
28. Accounts Payable-Patients Deposits	-	0
29. Short-Term Notes Payable	-	0
30. Accrued Salaries Payable	106,482	106,482
31. Accrued Taxes Payable	300,176	300,176
32. Accrued Real Estate Taxes	-	74,244
33. Accrued Interest Payable	-	9,085
34. Deferred Compensation	-	0
35. Federal and State Income Taxes	-	0
36. Other Current Liabilities (specify):	1,145	1,145
37. Other Current Liabilities (specify):	-	0
38. Total Current Liabilities	#######	1,243,123
LONG TERM LIABILITES		
39.Long-Term Notes Payable	-	0
40.Mortgage Payable	-	3,225,595
41.Bonds Payable	-	0
42.Deferred Compensation	-	0
43.Other Long-Term Liabilities (specify):	#######	273,156
44.Other Long-Term Liabilities (specify):	-	0
45.Total Long-Term Liabilities	#######	3,498,751
46.Total Liabilities	#######	4,741,874
47.Total Equity	#######	198,470
48.Total Liabilities and Equity	#######	4,940,344

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,603,893
2. Discounts and Allowances for all Levels	(365,309)
Subtotal - Inpatient Care	2,238,584
4. Day Care	-
5. Other Care for Outpatients	-
6. Therapy	791,097
7. Oxygen	1,876
Subtotal - Anciliary Revenue	792,973
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	5,750
15. Telephone, Television, and Radio	-
16. Rental of Facility Space	-
17. Sale of Drugs	108,262
18. Sale of Supplies to Non-Patients	-
19. Laboratory	-
20. Radiologyand X-Ray	40,289
21. Other Medical Services	13,305
22. Laundry	156
Subtotal - Other Operating Revenue	167,762
24. Contributions	-
25. Interest and Other Investments Income	730
Subtotal - Non-Operating Revenue	730
27. Other Revenue (specify):	7,858
28. Other Revenue (specify):	353
Subtotal - Other Revenue	8,211
30. Total Revenue	3,208,260
31. General Services	599,392
32. Health Care	1,356,217
33. General Administration	440,486
34. Ownership	466,026
35. Special Cost Centers	177,286
35. Provider Participation Fee	135,985
37. Other	-
40. Total Expenses	3,175,392
41. Income Before Income Taxes	32,868
42. Income Taxes	-
43. Net Income or Loss for the Year	32,868