

Facility Name & ID Number Twin Lakes Rehabilitation & Health Care

0048223 Report Period Beginning: 4/22/08 Ending: 12/31/2008

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>62</u>	Skilled (SNF)	<u>62</u>	<u>15,748</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>62</u>	TOTALS	<u>62</u>	<u>15,748</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>5,532</u>	<u>714</u>	<u>1,272</u>	<u>7,518</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>5,532</u>	<u>714</u>	<u>1,272</u>	<u>7,518</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 47.74%

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

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

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

None

F. Does the facility maintain a daily midnight census?

Yes

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

YES NO Non-allowable costs have been eliminated in Schedule V, Column 7

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

YES NO

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

Date started 4/22/08

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

YES Date 4/22/08 NO

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

YES NO If YES, enter number of beds certified 18 and days of care provided 1,272

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number Twin Lakes Rehabilitation & Health Care # 0048223 Report Period Beginning: 4/22/08 Ending: 12/31/2008

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	72,904	8,160		81,064		81,064	1,336	82,400		1
2	Food Purchase		44,685		44,685		44,685	(971)	43,714		2
3	Housekeeping	43,549	7,809		51,358		51,358	10	51,368		3
4	Laundry	16,209	5,398		21,607		21,607	1	21,608		4
5	Heat and Other Utilities			38,874	38,874		38,874	482	39,356		5
6	Maintenance	12,747	6,112	11,666	30,525		30,525	817	31,342		6
7	Other (specify):* <u>Home Off. Ben. All.</u>							329	329		7
8	TOTAL General Services	145,409	72,164	50,540	268,113		268,113	2,004	270,117		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	362,801	22,810	424	386,035		386,035	2,319	388,354		10
10a	Therapy	12,943	52	94,091	107,086		107,086		107,086		10a
11	Activities		56	14	70		70		70		11
12	Social Services		85		85		85		85		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Off. Ben. All.</u>							405	405		15
16	TOTAL Health Care and Programs	375,744	23,003	100,529	499,276		499,276	2,724	502,000		16
	C. General Administration										
17	Administrative	38,930		52,000	90,930		90,930	(41,597)	49,333		17
18	Directors Fees										18
19	Professional Services			4,585	4,585		4,585	2,738	7,323		19
20	Dues, Fees, Subscriptions & Promotions			5,724	5,724		5,724	793	6,517		20
21	Clerical & General Office Expenses		2,425	1,832	4,257		4,257	14,926	19,183		21
22	Employee Benefits & Payroll Taxes			76,065	76,065		76,065	261	76,326		22
23	Inservice Training & Education			176	176		176	79	255		23
24	Travel and Seminar							108	108		24
25	Other Admin. Staff Transportation			5,621	5,621		5,621	1,700	7,321		25
26	Insurance-Prop.Liab.Malpractice			(5,754)	(5,754)		(5,754)	471	(5,283)		26
27	Other (specify):* <u>Home Off. Ben. All.</u>							3,717	3,717		27
28	TOTAL General Administration	38,930	2,425	140,249	181,604		181,604	(16,804)	164,800		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	560,083	97,592	291,318	948,993		948,993	(12,076)	936,917		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

Twin Lakes Rehabilitation & Health Care

#0048223

Report Period Beginning:

4/22/08

Ending:

12/31/2008

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			16,126	16,126		16,126	7,638	23,764			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							8,563	8,563			32
33	Real Estate Taxes			44,014	44,014		44,014	191	44,205			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			3,919	3,919		3,919	203	4,122			35
36	Other (specify):*											36
37	TOTAL Ownership			64,059	64,059		64,059	16,595	80,654			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		46,185		46,185		46,185		46,185			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			22,785	22,785		22,785		22,785			42
43	Other (specify):* Non-allowable Cost	16,855	1,766	262,216	280,837		280,837	(280,837)				43
44	TOTAL Special Cost Centers	16,855	47,951	285,001	349,807		349,807	(280,837)	68,970			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	576,938	145,543	640,378	1,362,859		1,362,859	(276,318)	1,086,541			45

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

Twin Lakes Rehabilitation & Health Care

ID# 0048223

Report Period Beginning: 4/22/08

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (2,369)	43	1
2	X-Rays-Part A	(363)	43	2
3	Disallowed Dues	(124)	20	3
4	Offset Miscellaneous Office Supplies Revenue	(147)	21	4
5	Resident Flowers	(1,366)	43	5
6	Spccial Events	(185)	43	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
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(4,554)		49

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark Petersen	100	See Attached Schedule 6E		See Attached Sch 6E		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 1,336	\$ 1,336	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	22	22	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	10	10	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	1	1	4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	138	138	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	817	817	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	329	329	7
8	V	10A Therapy		Petersen Health Care, Inc.	100.00%	2,319	2,319	8
9	V	11 Activities		Petersen Health Care, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	405	405	10
11	V	17 Administrative	52,000	Petersen Health Care, Inc.	100.00%	10,403	(41,597)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	1,174	1,174	12
13	V							13
14	Total		\$ 52,000			\$ 16,954	\$ * (35,046)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	20 <u>Dues, Fees, Subs and Promotions</u>	\$	<u>Petersen Health Care, Inc.</u>	100.00%	\$ 362	\$	362	15
16	V	21 <u>Clerical and General Office</u>		<u>Petersen Health Care, Inc.</u>	100.00%	13,054		13,054	16
17	V	23 <u>Inservice Training and Education</u>		<u>Petersen Health Care, Inc.</u>	100.00%	79		79	17
18	V	24 <u>Travel and Seminar</u>		<u>Petersen Health Care, Inc.</u>	100.00%	79		79	18
19	V	25 <u>Other Admin. Staff Transportation</u>		<u>Petersen Health Care, Inc.</u>	100.00%	1,028		1,028	19
20	V	26 <u>Insurance-Prop./Liab/Malpractice</u>		<u>Petersen Health Care, Inc.</u>	100.00%	63		63	20
21	V	27 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Care, Inc.</u>	100.00%	3,717		3,717	21
22	V	30 <u>Depreciation</u>		<u>Petersen Health Care, Inc.</u>	100.00%	1,422		1,422	22
23	V	32 <u>Interest</u>		<u>Petersen Health Care, Inc.</u>	100.00%	1,000		1,000	23
24	V	33 <u>Real Estate Taxes</u>		<u>Petersen Health Care, Inc.</u>	100.00%	191		191	24
25	V	34 <u>Rent-Facility and Grounds</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			25
26	V	35 <u>Rent-Equipment and Vehicles</u>		<u>Petersen Health Care, Inc.</u>	100.00%	163		163	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		\$			\$ 21,158	\$ *	21,158	39

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

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VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 <u>Dietary</u>	\$	<u>Petersen Health Care II, Inc.</u>	100.00%	\$ 0	\$	15	
16	V	2 <u>Food</u>		<u>Petersen Health Care II, Inc.</u>	100.00%	0		16	
17	V	3 <u>Housekeeping</u>		<u>Petersen Health Care II, Inc.</u>	100.00%	0		17	
18	V	4 <u>Laundry</u>		<u>Petersen Health Care II, Inc.</u>	100.00%	0		18	
19	V	5 <u>Utilities</u>		<u>Petersen Health Care II, Inc.</u>	100.00%	0		19	
20	V	6 <u>Maintenance</u>		<u>Petersen Health Care II, Inc.</u>	100.00%	344	344	20	
21	V	7 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Care II, Inc.</u>	100.00%	0		21	
22	V	10 <u>Nursing and Medical Records</u>		<u>Petersen Health Care II, Inc.</u>	100.00%	0		22	
23	V	10A <u>Therapy</u>		<u>Petersen Health Care II, Inc.</u>	100.00%	0		23	
24	V	15 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Care II, Inc.</u>	100.00%	0		24	
25	V	17 <u>Administrative</u>		<u>Petersen Health Care II, Inc.</u>	100.00%	0		25	
26	V	19 <u>Professional Services</u>		<u>Petersen Health Care II, Inc.</u>	100.00%	1,564	1,564	26	
27	V	20 <u>Dues, Fees, Subs and Promotions</u>		<u>Petersen Health Care II, Inc.</u>	100.00%	555	555	27	
28	V	21 <u>Clerical and General Office</u>		<u>Petersen Health Care II, Inc.</u>	100.00%	2,019	2,019	28	
29	V	22 <u>Employee Benefits & Payroll</u>		<u>Petersen Health Care II, Inc.</u>	100.00%	261	261	29	
30	V	24 <u>Travel and Seminar</u>		<u>Petersen Health Care II, Inc.</u>	100.00%	29	29	30	
31	V	25 <u>Other Admin. Staff Transportation</u>		<u>Petersen Health Care II, Inc.</u>	100.00%	672	672	31	
32	V	26 <u>Insurance-Prop./Liab/Malpractice</u>		<u>Petersen Health Care II, Inc.</u>	100.00%	408	408	32	
33	V	27 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Care II, Inc.</u>	100.00%	0		33	
34	V	30 <u>Depreciation</u>		<u>Petersen Health Care II, Inc.</u>	100.00%	5,369	5,369	34	
35	V	32 <u>Interest</u>		<u>Petersen Health Care II, Inc.</u>	100.00%	7,563	7,563	35	
36	V	33 <u>Real Estate Taxes</u>		<u>Petersen Health Care II, Inc.</u>	100.00%	0		36	
37	V	34 <u>Rent-Facility and Grounds</u>		<u>Petersen Health Care II, Inc.</u>	100.00%	0		37	
38	V	35 <u>Rent-Equipment and Vehicles</u>		<u>Petersen Health Care II, Inc.</u>	100.00%	40	40	38	
39	Total		\$			\$ 18,824	\$ *	18,824	39

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

Facility Name & ID Number Twin Lakes Rehabilitation & Health Care # 0048223 Report Period Beginning: 4/22/08 Ending: 12/31/2008

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Petersen	President	Administrative	100.00	1,818,271	0.48	0.80	Salary	\$ 10,403	L17, C7	1
2											2
3											3
4											4
5		See Attached Schedule 7A									5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 10,403		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 Twin Lakes Rehabilitation & Health Care# 0048223

Report Period Beginning:

4/22/08Ending: 2/31/2008

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization

Petersen Health Care, Inc.

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309) 691-8113

Fax Number

(309) 691-8622

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,413,604	69	\$ 251,260	\$ 250,687	7,518	\$ 1,336	1
2	2	Food	Resident Days	1,413,604	69	4,125	0	7,518	22	2
3	3	Housekeeping	Resident Days	1,413,604	69	1,859	0	7,518	10	3
4	4	Laundry	Resident Days	1,413,604	69	110	0	7,518	1	4
5	5	Utilities	Resident Days	1,413,604	69	26,036	0	7,518	138	5
6	6	Maintenance	Resident Days	1,413,604	69	153,551	100,245	7,518	817	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	61,774	0	7,518	329	7
8	10	Nursing and Medical Records	Resident Days	1,413,604	69	436,084	432,530	7,518	2,319	8
9	10A	Therapy	Resident Days	1,413,604	69	0	0	7,518	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	76,136	0	7,518	405	10
11	17	Administrative	Resident Days	1,413,604	69	1,955,999	1,956,000	7,518	10,403	11
12	19	Professional Services	Resident Days	1,413,604	69	220,762	0	7,518	1,174	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,413,604	69	68,094	0	7,518	362	13
14	21	Clerical and General Office	Resident Days	1,413,604	69	2,454,596	2,013,896	7,518	13,054	14
15	23	Inservice Training & Education	Resident Days	1,413,604	69	14,912	0	7,518	79	15
16	24	Travel and Seminar	Resident Days	1,413,604	69	14,938	0	7,518	79	16
17	25	Other Admin. Staff Transport.	Resident Days	1,413,604	69	193,264	0	7,518	1,028	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,413,604	69	11,767	0	7,518	63	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	698,810	0	7,518	3,717	19
20	30	Depreciation	Resident Days	1,413,604	69	267,426	0	7,518	1,422	20
21	32	Interest	Resident Days	1,413,604	69	188,107	0	7,518	1,000	21
22	33	Real Estate Taxes	Resident Days	1,413,604	69	35,872	0	7,518	191	22
23	34	Rent-Facility and Grounds	Resident Days	1,413,604	69	0	0	7,518	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,413,604	69	30,580	0	7,518	163	24
25	TOTALS					\$ 7,166,062	\$ 4,753,358		\$ 38,112	25

Facility Name & ID Number Twin Lakes Rehabilitation & Health Care

0048223

Report Period Beginning:

4/22/08

Ending: 2/31/2008

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization Petersen Health Care II, Inc.
 Street Address 830 W. Trailcreek Drive
 City / State / Zip Code Peoria, IL 61614
 Phone Number (309) 691-8113
 Fax Number (309) 691-8622

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	331,413	13	\$	7,518	\$	1
2	2	Food	Resident Days	331,413	13		7,518		2
3	3	Housekeeping	Resident Days	331,413	13		7,518		3
4	4	Laundry	Resident Days	331,413	13		7,518		4
5	5	Utilities	Resident Days	331,413	13		7,518		5
6	6	Maintenance	Resident Days	331,413	13	15,163	7,518	344	6
7	7	Mgmt. Allocation of Benefits	Resident Days	331,413	13		7,518		7
8	10	Nursing and Medical Records	Resident Days	331,413	13		7,518		8
9	10A	Therapy	Resident Days	331,413	13		7,518		9
10	15	Mgmt. Allocation of Benefits	Resident Days	331,413	13		7,518		10
11	17	Administrative	Resident Days	331,413	13		7,518		11
12	19	Professional Services	Resident Days	331,413	13	68,939	7,518	1,564	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	331,413	13	24,482	7,518	555	13
14	21	Clerical and General Office	Resident Days	331,413	13	88,982	7,518	2,019	14
15	22	Employee Benefits & Payroll	Resident Days	331,413	13	11,527	7,518	261	15
16	24	Travel and Seminar	Resident Days	331,413	13	1,299	7,518	29	16
17	25	Other Admin. Staff Transport.	Resident Days	331,413	13	29,621	7,518	672	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	331,413	13	18,001	7,518	408	18
19	27	Mgmt. Allocation of Benefits	Resident Days	331,413	13		7,518		19
20	30	Depreciation	Resident Days	331,413	13	236,686	7,518	5,369	20
21	32	Interest	Resident Days	331,413	13	333,393	7,518	7,563	21
22	33	Real Estate Taxes	Resident Days	331,413	13		7,518		22
23	34	Rent-Facility and Grounds	Resident Days	331,413	13		7,518		23
24	35	Rent-Equipment & Vehicles	Resident Days	331,413	13	1,756	7,518	40	24
25	TOTALS				\$ 829,849	\$		\$ 18,824	25

Facility Name & ID Number

Twin Lakes Rehabilitation & Health Care

0048223

Report Period Beginning:

4/22/08

Ending:

12/31/2008

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	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
	A. Directly Facility Related																	
	Long-Term																	
1												\$	1					
2													2					
3													3					
4								Home Office Allocation-PHC				1,000	4					
5								Home Office Allocation-PHC II				7,563	5					
	Working Capital																	
6													6					
7													7					
8													8					
9	TOTAL Facility Related						\$	\$				\$ 8,563	9					
	B. Non-Facility Related*																	
10													10					
11													11					
12													12					
13													13					
14	TOTAL Non-Facility Related						\$	\$				\$	14					
15	TOTALS (line 9+line14)						\$	\$				\$ 8,563	15					

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

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

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2008 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Twin Lakes Rehabilitation & Health Care COUNTY Edgar

FACILITY IDPH LICENSE NUMBER 0048223

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE (309) 691-8113 FAX #: (309) 691-8622

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2007 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 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>09-19-06-300-018</u>	<u>Long-Term Care Facility</u>	\$ <u>33,153.72</u>	\$ <u>33,153.72</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>33,153.72</u>	\$ <u>33,153.72</u>

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & 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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 14,020 B. General Construction Type: Exterior Concrete Frame Steel Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

N/A

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>128,700</u>	<u>2008</u>	<u>\$ 50,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	128,700		\$ 50,000	3

Facility Name & ID Number Twin Lakes Rehabilitation & Health Care

0048223

Report Period Beginning:

4/22/08

Ending:

12/31/2008

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	62	2008	1977	\$ 519,985	\$	25	\$ 10,400	\$ 10,400	\$ 10,400
5									
6									
7	Home Office Allocation								
8									
Improvement Type**									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25	Building Booked				6,933			(6,933)	
26	Building Improvement Booked				1,789			(1,789)	
27									
28									
29	2008-Home Office Allocation-Land Improvements			400			26	26	
30	2008-Home Office Allocation-Building Improvements			5,974			143	143	
31									
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 526,359	\$ 8,722		\$ 10,569	\$ 1,847	\$ 10,400	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$	\$	\$	\$		\$	71
72	Current Year Purchases	<u>128,880</u>	<u>7,404</u>	<u>6,573</u>	(831)	10 yrs.	<u>8,412</u>	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			<u>6,622</u>	6,622			74
75	TOTALS	\$ <u>128,880</u>	\$ <u>7,404</u>	\$ <u>13,195</u>	\$ <u>5,791</u>		\$ <u>8,412</u>	75

D. Vehicle Depreciation (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										76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 705,239	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 16,126	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 23,764	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 7,638	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 18,812	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 4,122 Description: See Attached Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18			N/A		18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____ /2009 \$ _____

13. _____ /2010 \$ _____

14. _____ /2011 \$ _____

* 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.

Twin Lakes Rehabilitation & Health Care

0048223

Period Beginning 4/22/2008

Period End 12/31/2008

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$ 735
Laundry Equipment	1,862
Copier	1,322
Home Office Allocation	203
	<u>4,122</u>

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		Contract	Total
		1 Drop-outs	2 Completed		
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$		\$ 45,086	\$		\$ 45,086	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs			3,498			3,498	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(1,2,3)	1336 hrs	12,943		45,507	52	1,336	58,502	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 prescripts				46,185		46,185	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	TOTAL			\$ 12,943		\$ 94,091	\$ 46,237	1,336	\$ 153,271	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 Twin Lakes Rehabilitation & Health Care

0048223

Report Period Beginning: 4/22/08

Ending:

12/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (2,291,506)	\$ (2,291,506)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>N/A</u>)	1,785,689	1,785,689	3
4	Supply Inventory (priced at <u> </u>)			4
5	Short-Term Investments			5
6	Prepaid Insurance	15,354	15,354	6
7	Other Prepaid Expenses	6,896	6,896	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u> </u>			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (483,567)	\$ (483,567)	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	50,000	50,000	13
14	Buildings, at Historical Cost	536,994	525,959	14
15	Leasehold Improvements, at Historical Cost	8,636	400	15
16	Equipment, at Historical Cost	128,880	128,880	16
17	Accumulated Depreciation (book methods)	(22,504)	(18,812)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): <u> </u>			22
23	Other(specify): <u> </u>			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 702,006	\$ 686,427	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 218,439	\$ 202,860	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 467,104	\$ 467,104	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	57,110	57,110	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,341	2,341	31
32	Accrued Real Estate Taxes(Sch.IX-B)	34,500	34,500	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Expenses</u>	14,801	14,801	36
37	<u> </u>			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 575,856	\$ 575,856	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u> </u>			43
44	<u> </u>			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 575,856	\$ 575,856	46
47	TOTAL EQUITY (page 18, line 24)	\$ (357,417)	\$ (372,996)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 218,439	\$ 202,860	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3	Equity Prior to 4/21-Prior Owner	(76,910)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (76,910)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(280,507)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (280,507)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (357,417)	24 *

* This must agree with page 17, line 47.

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

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 768,001	1
2	Discounts and Allowances for all Levels	69,403	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 837,404	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	152,262	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 152,262	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	993	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	74,984	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	15,112	20
21	Other Medical Services	1,450	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 92,539	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Revenue</u>	147	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 147	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,082,352	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	268,113	31
32	Health Care	499,276	32
33	General Administration	181,604	33
	B. Capital Expense		
34	Ownership	64,059	34
	C. Ancillary Expense		
35	Special Cost Centers	327,022	35
36	Provider Participation Fee	22,785	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,362,859	40
41	Income before Income Taxes (line 30 minus line 40)**	(280,507)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (280,507)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. Facility is part of larger entity.

*** 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 Twin Lakes Rehabilitation & Health Care

0048223

Report Period Beginning:

4/22/08

Ending:

12/31/2008

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	542	\$ 12,397	\$ 22.87	1
2	Assistant Director of Nursing				2
3	Registered Nurses	3,161	73,343	22.18	3
4	Licensed Practical Nurses	5,218	96,727	17.91	4
5	CNAs & Orderlies	17,328	156,188	8.71	5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director				9
10	Activity Assistants				10
11	Social Service Workers				11
12	Dietician				12
13	Food Service Supervisor	2,604	24,741	9.39	13
14	Head Cook				14
15	Cook Helpers/Assistants	6,024	48,163	7.77	15
16	Dishwashers				16
17	Maintenance Workers	1,245	12,747	10.24	17
18	Housekeepers	5,050	43,549	8.16	18
19	Laundry	1,986	16,209	7.95	19
20	Administrator	1,387	38,930	28.07	20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical				24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)				28
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)				30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify) <u>See Sch 20a</u>	3,932	53,944	13.17	33
34	TOTAL (lines 1 - 33)	48,477	\$ 576,938 *	\$ 11.51	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$		35
36	Medical Director	Monthly 6,000	9(3)	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 400	10(3)	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)	\$ 6,400		49

C. CONTRACT NURSES

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

Twin Lakes Rehabilitation & Health Care Center

0041442

Period Beginning 4/22/2008

Period End 12/31/2008

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Director of Nursing				
Assistant Director of Nsg.				
Registered Nurses				
Licensed Practical Nurses				
Nurse Aides & Orderlies				
Nurse Aide Trainees				
Licensed Therapist				
Activity Director				
Activity Assistants				
Social Service Workers				
Dietician				
Food Service Supervisor				
Head Cook				
Cook Helpers/Assistants				
Dishwashers				
Maintenance Workers				
Housekeepers				
Laundry				
Administrator				
Assistant Administrator				
Other Administrative				
Office Manager				
Clerical				
Vocational Instruction				
Academic Instruction				
Medical Director				
Qualified Mental Retard.Prof.				
Resident Services Coordinator				
Habilitation Aides				
Medical Records				
Care Plan Coordinator	1,316	1,372	24,146	17.60
Marketing	1,387	1,387	16,855	12.15
Transportation				
Unit Aide				
Physical Therapy Aides	1,229	1,336	12,943	9.69
Marketing				
TOTAL (lines 1 - 35)	3,932	4,095	53,944	

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Karen Dowell	Administrator	0	\$ 38,930	Workers' Compensation Insurance	\$ 15,502	IDPH License Fee	\$ 990	
				Unemployment Compensation Insurance	10,107	Advertising: Employee Recruitment	2,735	
				FICA Taxes	44,117	Health Care Worker Background Check (Indicate # of checks performed)		
				Employee Health Insurance	5,124	Patient Background Checks	44	
				Employee Meals		Miscellaneous Licenses & Permits	130	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Subscriptions	449	
				Employee Relations	1,001	IHCA Dues	980	
				Employee Retirement	210	Home Office Allocation	917	
				Employee Life Insurance	265			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 38,930			Less: Public Relations Expense	(124)	
						Non-allowable advertising	()	
						Yellow page advertising	()	
						TOTAL (agree to Sch. V, line 20, col. 8)	\$ 6,517	
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)				
Description			Amount					
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 52,000					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 52,000	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description			Description	
Vendor/Payee	Type		Amount		Line #	Amount	Amount	
AT&T	Computer Services		\$ 483				Out-of-State Travel	
E-Health Data Solutions	Computer Services		2,025					
LTC Solutions	Computer Services		1,600				In-State Travel	
Asher, Smith & Isaf	Legal Services		477					
							Seminar Expense	
							Home Office Allocation	
							108	
							Entertainment Expense	
							()	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 4,585	TOTAL			\$	
							TOTAL (agree to Sch. V, line 24, col. 8)	
							\$ 108	

* Attach copy of IMRF notifications

**See instructions.

Period Beginning 4/22/2008
Period End 12/31/2008

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount	
Total (agree to Schedule V, line 19, column 3)		4,585	
Home Office Allocation			
Heyl, Royster, Voelker & Allen	Legal	42	
U.S. Bank	Legal	249	381
GoffWilson, P.A.	Legal	142	218
Ginoli & Company	Accountants	1,257	1,923
U.S. Bank	Accountants	153	234
RSM McGladrey	Accountants	3	5
Emdeon Business Services	Computer Services	16	25
Advanced Answers on Demand	Computer Services	23	35
Access 2 Go	Computer Services	271	413
Ivans	Computer Services	260	398
Kemper Technology	Computer Services	41	63
VisionShare	Computer Services	146	224
Logmein	Computer Services	16	24
Comm Net Communiations	Computer Services	11	17
Charter Communications	Computer Services	4	6
Advanced System Designs	Computer Services	3	5
CDW	Computer Services	76	116
Consolidated Communications	Computer Services	5	8
Miscellaneous Vendors	Miscellaneous	20	30
Total (agree to Schedule V, line 19, column 8)		<u>7,323</u>	

Facility Name & ID Number Twin Lakes Rehabilitation & Health Care# 0048223

Report Period Beginning:

4/22/08

Ending:

12/31/2008**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. 980 -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? No
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,231 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? N/A
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 22,785
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. \$ 993
- (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? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ No
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. \$ No
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Company The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit currently in progress
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees