

Facility Name & ID Number Westside Rehabilitation & Care Center

0050344 Report Period Beginning: 3/1/09 Ending: 12/31/2009

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>96</u>	Skilled (SNF)	<u>96</u>	<u>29,376</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>96</u>	TOTALS	<u>96</u>	<u>29,376</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	Private Pay	4 Other	Total	
8	SNF	<u>11,500</u>	<u>2,326</u>	<u>2,249</u>	<u>16,075</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>11,500</u>	<u>2,326</u>	<u>2,249</u>	<u>16,075</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 54.72%

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 3/1/2009

J. Was the facility purchased or leased after January 1, 1978?
YES Date 3/1/2009 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 40 and days of care provided 2,131

Medicare Intermediary Wisconsin Physicians Service

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/2009

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

Facility Name & ID Number Westside Rehabilitation & Care Center # 0050344 Report Period Beginning: 3/1/09 Ending: 12/31/2009

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	84,040	4,849		88,889		88,889	2,811	91,700		1
2	Food Purchase		70,410		70,410		70,410	63	70,473		2
3	Housekeeping	66,970	8,253		75,223		75,223	26	75,249		3
4	Laundry	58,737	7,495		66,232		66,232		66,232		4
5	Heat and Other Utilities			47,983	47,983		47,983	278	48,261		5
6	Maintenance	25,194	9,065	10,387	44,646		44,646	1,362	46,008		6
7	Other (specify):* <u>Home Off. Ben. All.</u>							508	508		7
8	TOTAL General Services	234,941	100,072	58,370	393,383		393,383	5,048	398,431		8
	B. Health Care and Programs										
9	Medical Director			10,000	10,000		10,000		10,000		9
10	Nursing and Medical Records	555,688	33,831	2,285	591,804		591,804	1,701	593,505		10
10a	Therapy		92	211,747	211,839		211,839		211,839		10a
11	Activities	28,983	1,677	163	30,823		30,823		30,823		11
12	Social Services	25,133	29		25,162		25,162		25,162		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Off. Ben. All.</u>							210	210		15
16	TOTAL Health Care and Programs	609,804	35,629	224,195	869,628		869,628	1,911	871,539		16
	C. General Administration										
17	Administrative	5,000		132,000	137,000		137,000	(85,172)	51,828		17
18	Directors Fees										18
19	Professional Services			5,925	5,925		5,925	3,942	9,867		19
20	Dues, Fees, Subscriptions & Promotions			2,447	2,447		2,447	1,098	3,545		20
21	Clerical & General Office Expenses	35,044	7,007	12,995	55,046		55,046	28,602	83,648		21
22	Employee Benefits & Payroll Taxes			122,603	122,603		122,603		122,603		22
23	Inservice Training & Education			1,100	1,100		1,100	293	1,393		23
24	Travel and Seminar							90	90		24
25	Other Admin. Staff Transportation			3,001	3,001		3,001	1,413	4,414		25
26	Insurance-Prop.Liab.Malpractice			34,396	34,396		34,396	586	34,982		26
27	Other (specify):* <u>Home Off. Ben. All.</u>							7,694	7,694		27
28	TOTAL General Administration	40,044	7,007	314,467	361,518		361,518	(41,454)	320,064		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	884,789	142,708	597,032	1,624,529		1,624,529	(34,495)	1,590,034		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 Westside Rehabilitation & Care Center

#0050344

Report Period Beginning:

3/1/09

Ending:

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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			143	143		143	43,165	43,308			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							49,353	49,353			32
33	Real Estate Taxes							23,744	23,744			33
34	Rent-Facility & Grounds			110,423	110,423		110,423	(110,423)				34
35	Rent-Equipment & Vehicles			17,179	17,179		17,179	341	17,520			35
36	Other (specify):*											36
37	TOTAL Ownership			127,745	127,745		127,745	6,180	133,925			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		56,636		56,636		56,636		56,636			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			44,064	44,064		44,064		44,064			42
43	Other (specify):* Non-allowable Cost		517	48,656	49,173		49,173	(49,173)				43
44	TOTAL Special Cost Centers		57,153	92,720	149,873		149,873	(49,173)	100,700			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	884,789	199,861	817,497	1,902,147		1,902,147	(77,488)	1,824,659			45

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

Westside Rehabilitation & Care Center

ID# 0050344

Report Period Beginning: 3/1/09

Ending: 12/31/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (4,748)	43	1
2	X-Rays-Part A	(4,517)	43	2
3	Disallowed Special Events	(14)	43	3
4	Offset Miscellaneous Office Supplies Revenue	(63)	21	4
5	Pet Expense	(1,397)	43	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
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19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
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31				31
32				32
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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	(10,739)		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%	\$ 2,811	\$ 2,811	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	63	63	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	26	26	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	278	278	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,362	1,362	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	508	508	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	1,701	1,701	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%	210	210	10
11	V	17 Administrative	132,000	Petersen Health Care, Inc.	100.00%	46,828	(85,172)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	3,942	3,942	12
13	V							13
14	Total		\$ 132,000			\$ 57,729	\$ * (74,271)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	20 Dues, Fees, Subs and Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 1,098	\$	1,098	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	28,665		28,665	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	293		293	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	90		90	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	1,413		1,413	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	586		586	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	7,694		7,694	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	2,317		2,317	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	3,564		3,564	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	356		356	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0			25
26	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	341		341	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 46,417	\$ *	46,417	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	30 Depreciation	\$	Petersen West Frankfort, LLC	100.00%	\$ 77,143	\$	77,143	15
16	V	32 Interest		Petersen West Frankfort, LLC	100.00%	46,979		46,979	16
17	V	33 Real Estate Taxes		Petersen West Frankfort, LLC	100.00%	23,388		23,388	17
18	V	34 Rent-Facility and Grounds	110,423	Petersen West Frankfort, LLC	100.00%			(110,423)	18
19	V								19
20	V								20
21	V								21
22	V								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		\$ 110,423			\$ 147,510	\$ *	37,087	39

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

Facility Name & ID Number Westside Rehabilitation & Care Center # 0050344 Report Period Beginning: 3/1/09 Ending: 12/31/2009

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	157,285	0.62	1.04	Salary	\$ 1,828	L17, C7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 1,828		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 Westside Rehabilitation & Care Center

0050344

Report Period Beginning:

3/1/09

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V 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	1,493,044	75	\$ 261,102	\$ 259,584	16,075	\$ 2,811	1
2	2	Food	Resident Days	1,493,044	75	5,864	0	16,075	63	2
3	3	Housekeeping	Resident Days	1,493,044	75	2,458	0	16,075	26	3
4	4	Laundry	Resident Days	1,493,044	75	0	0	16,075	0	4
5	5	Utilities	Resident Days	1,493,044	75	25,776	0	16,075	278	5
6	6	Maintenance	Resident Days	1,493,044	75	126,463	107,810	16,075	1,362	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	47,148	0	16,075	508	7
8	10	Nursing and Medical Records	Resident Days	1,493,044	75	158,020	151,697	16,075	1,701	8
9	10A	Therapy	Resident Days	1,493,044	75	0	0	16,075	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	19,462	0	16,075	210	10
11	17	Administrative	Resident Days	1,493,044	75	3,315,953	3,315,953	16,075	46,828	11
12	19	Professional Services	Resident Days	1,493,044	75	366,089	0	16,075	3,942	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,493,044	75	102,022	0	16,075	1,098	13
14	21	Clerical and General Office	Resident Days	1,493,044	75	2,662,394	2,253,243	16,075	28,665	14
15	23	Inservice Training & Education	Resident Days	1,493,044	75	27,176	0	16,075	293	15
16	24	Travel and Seminar	Resident Days	1,493,044	75	8,381	0	16,075	90	16
17	25	Other Admin. Staff Transport.	Resident Days	1,493,044	75	131,200	0	16,075	1,413	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,493,044	75	54,425	0	16,075	586	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	714,650	0	16,075	7,694	19
20	30	Depreciation	Resident Days	1,493,044	75	215,197	0	16,075	2,317	20
21	32	Interest	Resident Days	1,493,044	75	330,981	0	16,075	3,564	21
22	33	Real Estate Taxes	Resident Days	1,493,044	75	33,065	0	16,075	356	22
23	34	Rent-Facility and Grounds	Resident Days	1,493,044	75	0	0	16,075	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,493,044	75	31,635	0	16,075	341	24
25	TOTALS					\$ 8,639,461	\$ 6,088,287		\$ 104,146	25

Facility Name & ID Number Westside Rehabilitation & Care Center

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Report Period Beginning:

3/1/09

Ending:

12/31/2009

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										
										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	Bank of America		X	Mortgage	Varies	3/1/09	\$ 1,312,500	\$ 1,279,257	12/31/13	Varies	\$	1							
2												2							
3							Interest Income Offset					(1,190)	3						
4							Home Office Allocation-PHC					3,564	4						
5							Home Office Allocation-Petersen West Frankfort					28,861	5						
Working Capital																			
6													6						
7													7						
8													8						
9	TOTAL Facility Related						\$ 1,312,500	\$ 1,279,257			\$	31,235	9						
B. Non-Facility Related*																			
10							Amortization Expense					18,118	10						
11													11						
12													12						
13													13						
14	TOTAL Non-Facility Related						\$	\$			\$	18,118	14						
15	TOTALS (line 9+line14)						\$ 1,312,500	\$ 1,279,257			\$	49,353	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.)

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 23,727 B. General Construction Type: Exterior Brick Frame _____ 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>17,241</u>	<u>2009</u>	<u>\$ 180,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	17,241		\$ 180,000	3

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	96		2009	1979	\$ 1,350,000	\$	25	\$ 27,000	\$ 27,000	\$ 27,000
5										
6										
7										
8										
	Improvement Type**									
9										
10										
11										
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30										
31										
32		2009-Home Office Allocation-Land Improvements			529			33	33	
33		2009-Home Office Allocation-Building Improvements			7,902			190	190	
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)	\$	1,358,431	\$		\$ 27,223	\$ 27,223	\$ 27,000	70

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

Facility Name & ID Number Westside Rehabilitation & Care Center

0050344

Report Period Beginning:

3/1/09

Ending:

12/31/2009

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>275,367</u>	<u>143</u>	<u>13,768</u>	<u>13,625</u>	<u>10 yrs.</u>	<u>13,768</u>	72
73	Fully Depreciated Assets							73
74	<u>Home Office Allocation</u>			<u>2,317</u>	<u>2,317</u>			74
75	TOTALS	\$ <u>275,367</u>	\$ <u>143</u>	\$ <u>16,085</u>	\$ <u>15,942</u>		\$ <u>13,768</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)	\$ 1,813,798	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 143	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 43,308	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 43,165	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 40,768	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	<u>N/A</u>				88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	<u>N/A</u>		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: \$ 17,520 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.	<u>/2010</u>	\$ _____
13.	<u>/2011</u>	\$ _____
14.	<u>/2012</u>	\$ _____

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

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

Westside Rehabilitation & Care Center

0050344

Period Beginning 3/1/2009

Period End 12/31/2009

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$	12,329
Dishwasher		649
Maintenance Equipment		175
Copier		4,026
Home Office Allocation		341
		<u>17,520</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?</p> <p><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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	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	\$	6,221	\$ 93,309	\$	6,221	\$ 93,309	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,140	17,105		1,140	17,105	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		6,756	101,333	92	6,756	101,425	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				56,636		56,636	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	14,117	\$ 211,747	\$ 56,728	14,117	\$ 268,475	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2009** (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	\$ 20,098	\$ 20,098	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>N/A</u>)	465,065	471,767	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	47,856	47,856	6
7	Other Prepaid Expenses	7,308	7,308	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Security Deposit</u>	3,086	3,086	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 543,413	\$ 550,115	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		180,000	13
14	Buildings, at Historical Cost		1,357,902	14
15	Leasehold Improvements, at Historical Cost		529	15
16	Equipment, at Historical Cost	5,367	275,367	16
17	Accumulated Depreciation (book methods)	(143)	(40,768)	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):		86,966	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 5,224	\$ 1,859,996	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 548,637	\$ 2,410,111	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 327,416	\$ 327,416	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	61,715	61,715	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,501	7,501	31
32	Accrued Real Estate Taxes(Sch.IX-B)		27,600	32
33	Accrued Interest Payable		3,092	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Payroll Withholdings</u>	50,031	50,031	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 446,663	\$ 477,355	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,279,257	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Due To Related Parties</u>	(64,963)	478,701	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ (64,963)	\$ 1,757,958	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 381,700	\$ 2,235,313	46
47	TOTAL EQUITY(page 18, line 24)	\$ 166,937	\$ 174,798	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 548,637	\$ 2,410,111	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			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	166,937	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)	\$ 166,937	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)	\$ 166,937	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Westside Rehabilitation & Care Center

0050344

Report Period Beginning: 3/1/09

Ending: 12/31/2009

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	\$ 1,621,918	1
2	Discounts and Allowances for all Levels	16,748	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,638,666	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	322,745	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 322,745	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		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	93,321	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	10,681	20
21	Other Medical Services	2,418	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 106,420	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,190	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,190	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Revenue</u>	63	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 63	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,069,084	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	393,383	31
32	Health Care	869,628	32
33	General Administration	361,518	33
B. Capital Expense			
34	Ownership	127,745	34
C. Ancillary Expense			
35	Special Cost Centers	105,809	35
36	Provider Participation Fee	44,064	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,902,147	40
41	Income before Income Taxes (line 30 minus line 40)**	166,937	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 166,937	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 reported on owner's 1040 Schedule C

*** 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 Westside Rehabilitation & Care Center

0050344

Report Period Beginning:

3/1/09

Ending:

12/31/2009

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	1,733	1,733	\$ 41,167	\$ 23.75	1
2	Assistant Director of Nursing	1,733	1,733	28,600	16.50	2
3	Registered Nurses	4,785	4,850	89,566	18.47	3
4	Licensed Practical Nurses	8,219	8,346	130,477	15.63	4
5	CNAs & Orderlies	28,635	28,979	265,878	9.17	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,328	1,342	16,366	12.20	9
10	Activity Assistants	1,448	1,448	12,617	8.71	10
11	Social Service Workers	1,733	1,733	25,133	14.50	11
12	Dietician					12
13	Food Service Supervisor	1,733	1,733	21,233	12.25	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,281	7,408	62,807	8.48	15
16	Dishwashers					16
17	Maintenance Workers	1,733	1,733	25,194	14.54	17
18	Housekeepers	7,860	7,941	66,970	8.43	18
19	Laundry	6,392	6,484	58,737	9.06	19
20	Administrator	1,733	1,733	50,000	28.85	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	3,269	3,299	35,044	10.62	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)					33
34	TOTAL (lines 1 - 33)	79,615	80,495	\$ 929,789 *	\$ 11.55	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 10,000	9(3)	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 540	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)	\$ 10,540		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

Westside Rehabilitation & Care Center

0050344

Period Beginning 3/1/2009

Period End 12/31/2009

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		5,925

Home Office Allocation

Heyl, Royster, Voelker & Allen	Legal	25
GoffWilson, P.A.	Legal	36
Jackson Lewis	Legal	282
Peter Gartelos	Legal	27
Misc.	Legal	24
Ginoli & Company	Accountants	627
Miscellaneous Vendors	Computer Services	26
Emdeon Business Services	Computer Services	12
Advanced Answers on Demand	Computer Services	1,514
Access 2 Go	Computer Services	146
Ivans	Computer Services	17
Kemper Technology	Computer Services	412
VisionShare	Computer Services	128
MediFax	Computer Services	52
LogmeIn	Computer Services	23
Charter Communications	Computer Services	1
Simple LTC	Computer Services	349
Miscellaneous Vendors	Miscellaneous	241
Total (agree to Schedule V, line 19, column 8)		<u>9,867</u>

Facility Name & ID Number Westside Rehabilitation & Care Center# 0050344Report Period Beginning: 3/1/09Ending: 12/31/2009**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (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. \$ 1,039 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. \$ 44,064
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? No Indicate the amount. \$ N/A
- (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. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (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.