

Facility Name & ID Number Twin Lakes Rehabilitation & Health Care Center

0048223 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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	62	Skilled (SNF)	62	22,630	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	62	TOTALS	62	22,630	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	3 Private Pay	4 Other	4 Total	
8	SNF	8,870	1,515	2,634	13,019	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,870	1,515	2,634	13,019	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 57.53%

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 62 and days of care provided 2,522

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: 12/31/11 Fiscal Year: 12/31/11

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

Facility Name & ID Number Twin Lakes Rehabilitation & Health Care Ce # 0048223 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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	109,814	9,710		119,524		119,524	2,626	122,150		1
2	Food Purchase		73,767		73,767		73,767	(1,685)	72,082		2
3	Housekeeping	57,067	12,951		70,018		70,018	17	70,035		3
4	Laundry	39,138	8,366		47,504		47,504		47,504		4
5	Heat and Other Utilities			49,594	49,594		49,594	172	49,766		5
6	Maintenance	23,671	10,086	16,283	50,040		50,040	1,967	52,007		6
7	Other (specify):* Home Off. Ben. All.							599	599		7
8	TOTAL General Services	229,690	114,880	65,877	410,447		410,447	3,696	414,143		8
	B. Health Care and Programs										
9	Medical Director			9,000	9,000		9,000		9,000		9
10	Nursing and Medical Records	569,438	70,309	9,483	649,230		649,230	26	649,256		10
10a	Therapy	21,647	166	357,560	379,373		379,373		379,373		10a
11	Activities	11,919	204	999	13,122		13,122	(712)	12,410		11
12	Social Services										12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.										15
16	TOTAL Health Care and Programs	603,004	70,679	377,042	1,050,725		1,050,725	(686)	1,050,039		16
	C. General Administration										
17	Administrative			98,000	98,000		98,000	(32,000)	66,000		17
18	Directors Fees										18
19	Professional Services			4,767	4,767		4,767	4,925	9,692		19
20	Dues, Fees, Subscriptions & Promotions			4,904	4,904		4,904	(39)	4,865		20
21	Clerical & General Office Expenses		4,406	5,186	9,592		9,592	28,325	37,917		21
22	Employee Benefits & Payroll Taxes			99,758	99,758		99,758		99,758		22
23	Inservice Training & Education							88	88		23
24	Travel and Seminar			100	100		100	26	126		24
25	Other Admin. Staff Transportation			5,445	5,445		5,445	4,650	10,095		25
26	Insurance-Prop.Liab.Malpractice			20,816	20,816		20,816	609	21,425		26
27	Other (specify):* Home Off. Ben. All.							9,952	9,952		27
28	TOTAL General Administration		4,406	238,976	243,382		243,382	16,536	259,918		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	832,694	189,965	681,895	1,704,554		1,704,554	19,546	1,724,100		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 Center

#0048223

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

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			43,251	43,251		43,251	4,371	47,622			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							25,657	25,657			32
33	Real Estate Taxes			35,595	35,595		35,595	216	35,811			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			32,005	32,005		32,005	385	32,390			35
36	Other (specify):*											36
37	TOTAL Ownership			110,851	110,851		110,851	30,629	141,480			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		80,251		80,251		80,251		80,251			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			33,945	33,945		33,945		33,945			42
43	Other (specify):* Non-allowable Costs	27,926	1,838	357,482	387,246		387,246	(387,246)				43
44	TOTAL Special Cost Centers	27,926	82,089	391,427	501,442		501,442	(387,246)	114,196			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	860,620	272,054	1,184,173	2,316,847		2,316,847	(337,071)	1,979,776			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,697)	2		4
5	Telephone, TV & Radio in Resident Rooms	(681)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(8,461)	30		9
10	Interest and Other Investment Income	(433)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(115)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(522)	43		18
19	Entertainment				19
20	Contributions	(50)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(328,210)	43		24
25	Fund Raising, Advertising and Promotional	(7,445)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>See Page 5A</u>	(51,410)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (399,024)		\$	30

BHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	61,953	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 61,953		36
	(sum of SUBTOTALS)			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (337,071)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.		X	\$	38
39					39
40	Gift and Coffee Shops		X		40
41	Barber and Beauty Shops		X		41
42	Laboratory and Radiology		X		42
43	Prescription Drugs		X		43
44					44
45	Other-Attach Schedule		X		45
46	Other-Attach Schedule		X		46
47	TOTAL (C): (sum of lines 38-46)			\$	47

Twin Lakes Rehabilitation & Health Care Center

ID# 0048223

Report Period Beginning: 1/1/2011

Ending: 12/31/2011

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (15,921)	43	1
2	X-Rays-Part A	(4,881)	43	2
3	Disallowed Chamber of Commerce Dues	(390)	20	3
4	Offset Miscellaneous Office Supplies Revenue	(85)	21	4
5	Resident Flowers	(1,574)	43	5
6	Spccial Events	79	43	6
7	Offset Tranportation Revenue	(712)	11	7
8	Disallowed Marketing Salaries	(27,926)	43	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	(51,410)		49

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 2,626	\$ 2,626	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	12	12	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	17	17	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	172	172	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,071	1,071	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	599	599	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	26	26	8
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		10
11	V	17 Administrative	98,000	Petersen Health Care, Inc.	100.00%	66,000	(32,000)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	3,005	3,005	12
13	V							13
14	Total		\$ 98,000			\$ 73,528	\$ * (24,472)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	20 Dues, Fees, Subs & Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 211	\$ 211	15	
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	24,484	24,484	16	
17	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	88	88	17	
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	26	26	18	
19	V	25 Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	2,250	2,250	19	
20	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	609	609	20	
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	9,952	9,952	21	
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	3,518	3,518	22	
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	4,234	4,234	23	
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	216	216	24	
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0		25	
26	V	35 Rent-Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	384	384	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		\$			\$ 45,972	\$ *	45,972	39

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

Facility Name & ID Number Twin Lakes Rehabilitation & Health Care Center# 0048223Report Period Beginning: 1/1/2011Ending: 12/31/2011

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary	\$	Petersen Health Care II, Inc.	100.00%	\$ 0	\$	15
16	V	2 Food		Petersen Health Care II, Inc.	100.00%	0		16
17	V	3 Housekeeping		Petersen Health Care II, Inc.	100.00%	0		17
18	V	4 Laundry		Petersen Health Care II, Inc.	100.00%	0		18
19	V	5 Utilities		Petersen Health Care II, Inc.	100.00%	0		19
20	V	6 Maintenance		Petersen Health Care II, Inc.	100.00%	896		896 20
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0		21
22	V	10 Nursing and Medical Records		Petersen Health Care II, Inc.	100.00%	0		22
23	V	12 Social Services		Petersen Health Care II, Inc.	100.00%	0		23
24	V	17 Administrative		Petersen Health Care II, Inc.	100.00%	0		24
25	V	19 Professional Services		Petersen Health Care II, Inc.	100.00%	1,920		1,920 25
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Care II, Inc.	100.00%	140		140 26
27	V	21 Clerical and General Office		Petersen Health Care II, Inc.	100.00%	3,926		3,926 27
28	V	22 Employee Benefits & Payroll		Petersen Health Care II, Inc.	100.00%	0		28
29	V	23 Inservice Training & Education		Petersen Health Care II, Inc.	100.00%	0		29
30	V	24 Travel and Seminar		Petersen Health Care II, Inc.	100.00%	0		30
31	V	25 Other Admin. Staff Transport.		Petersen Health Care II, Inc.	100.00%	2,400		2,400 31
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care II, Inc.	100.00%	0		32
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0		33
34	V	30 Depreciation		Petersen Health Care II, Inc.	100.00%	9,314		9,314 34
35	V	32 Interest		Petersen Health Care II, Inc.	100.00%	21,856		21,856 35
36	V	33 Real Estate Taxes		Petersen Health Care II, Inc.	100.00%	0		36
37	V	34 Rent-Facility and Grounds		Petersen Health Care II, Inc.	100.00%	0		37
38	V	35 Rent-Equipment & Vehicles		Petersen Health Care II, Inc.	100.00%	1		1 38
39	Total		\$			\$ 40,453	\$ *	40,453 39

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

Facility Name & ID Number

Twin Lakes Rehabilitation & Health Care Center

0048223

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Aledo Health Care Center	Aledo				1
2			Arcola Health Care Center	Arcola				2
3			Aspen Rehab & Health Care	Silvis				3
4			Batavia Rehab & Health Care Center	Batavia				4
5			Bement Health Care Center	Bement				5
6			Benton Rehab & Health Care Center	Benton				6
7			Bloomington Rehab & Health Care Center	Bloomington				7
8			Casey Health Care Center	Casey				8
9			Charleston Rehab & Health Care Center	Charleston				9
10			Cisne Rehab & Health Care Center	Cisne				10
11			Countryview Care Center of Macomb	Macomb				11
12			Countryview Terrace	Louisville				12
13			Cumberland Rehab & Health Care Center	Greenup				13
14			Decatur Rehab & Health Care Center	Decatur				14
15			Eastside Health & Rehabilitation Center	Pittsfield				15
16			Eastview Terrace	Sullivan				16
17			El Paso Health Care Center	El Paso				17
18			Enfield Rehab & Health Care Center	Enfield				18
19			Farmer City Rehab & Health Care Center	Farmer City				19
20			Flanagan Rehab & Health Care Center	Flanagan				20
21			Flora Gardens Care Center	Flora				21
22			Flora Health Care Center	Flora				22
23			Fondulac Rehab & Health Care Center	East Peoria				23
24			Havana Health Care Center	Havana				24
25			Illini Heritage Rehab & Health Care	Champaign				25
26			Jonesboro Rehab & Health Care Center	Jonesboro				26
27			Kewanee Care Home	Kewanee				27
28			LaHarpe Davier Health Care Center	LaHarpe				28
29			Lebanon Care Center	Lebanon				29
30			Marigold Rehab & Health Care Center	Galesburg				30

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

Report Period Beginning:

1/1/2011Ending: 12/31/2011

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Mason Point	Sullivan				1
2			McLeansboro Rehab & Health Care Center	McLeansboro				2
3			Mt. Vernon Health Care Center	Mt. Vernon				3
4			Newman Rehab & Health Care Center	Newman				4
5			Nokomis Rehab & Health Care Center	Nokomis				5
6			North Aurora Care Center	North Aurora				6
7			Orchard View Rehab & Health Care Center	Princeton				7
8			Palm Terrace of Mattoon	Mattoon				8
9			Piper City Rehab & Living Center	Piper City				9
10			Pleasant View Rehab & Health Care Center	Morrison				10
11			Polo Rehabilitation & Health Care Center	Polo				11
12			Prairie City Rehab & Health Care Center	Prairie City				12
13			Robings Manor Nursing Home	Brighton				13
14			Rochelle Gardens	Rochelle				14
15			Rochelle Rehab & Health Care Center	Rochelle				15
16			Rock Falls Rehab & Health Care Center	Rock Falls				16
17			Arrow Wood Independent Living	Rock Falls				17
18			Roseville Rehab and Health Care Center	Roseville				18
19			Rosiclare Rehab & Health Care Center	Rosiclare				19
20			Royal Oaks Care Center	Kewanee				20
21			Sandwich Rehab & Health Care Center	Sandwich				21
22			Iron Wood Independent Living	Sandwich				22
23			Shawnee Rose Care Center	Harrisburg				23
24			Shelbyville Rehab & Health Care Center	Shelbyville				24
25			South Elgin Rehab & Health Care Center	South Elgin				25
26			Sugar Creek Care Center	Watseka				26
27			Sullivan Health Care Center	Sullivan				27
28			Sunset Manor Nursing Home	Canton				28
29			Swansea Rehab & Health Care	Swansea				29
30			Timbercreek Rehab & Health Center	Pekin				30

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VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Toulon Health Care Center	Toulon				1
2			Tuscola Health Care Center	Tuscola				2
3			Twin Lakes Rehab & Health Care Center	Paris				3
4			Vandalia Rehab & Health Care Center	Vandalia				4
5			Watseka Health Care Center	Watseka				5
6			Westside Rehab & Care Center	West Frankfort				6
7			Whispering Oaks	Rosiclare				7
8			White Oak Rehab & Health Care Center	Mt. Vernon				8
9			Willow Rose Rehab & Health Care Center	Jerseyville				9
10			Sheldon Health Care Center	Sheldon				10
11			Tuscola Health Care Center	Tuscola				11
12			Effingham Health Care Center	Effingham				12
13			Collinsville Health Care Center	Collinsville				13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number

Twin Lakes Rehabilitation & Health Care Center

0048223

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Ozark Rehab & Health Care Center	Osage Beach, MO	Petersen Companies, LLC	Peoria	Mgmt/Bookkeeping	1
2			South Shore Health Care, LLC	Gary, IN	Petersen Health Care II, Inc.	Peoria	Mgmt/Bookkeeping	2
3			Cedargate Skilled Nursing Facility	Poplar Bluff, MO	Petersen Health Care, Inc.	Peoria	Mgmt/Bookkeeping	3
4			Tarkio Rehab & Health Care Center	Tarkio, MO	Petersen Health Enterprises, LLC	Peoria	Mgmt/Bookkeeping	4
5			Shangri-la Rehab & Living Center	Blue Springs, MO	Petersen Health Operations LLC	Peoria	Mgmt/Bookkeeping	5
6			Prairie Rose Care Center	Pana	Petersen Health Systems, Inc.	Peoria	Mgmt/Bookkeeping	6
7			Illini Heritage Rehab & Health Center	Champaign	Petersen Hotels LLC	Peoria	Hospitality	7
8			Courtyard Estates of Kewanee	Kewanee	Petersen Restaurants, LLC	Peoria	Restaurant	8
9			Courtyard Estates of Bradford	Bradford	Petersen Health Care IV, LLC	Peoria	Mgmt/Bookkeeping	9
10			Courtyard Estates of Galva	Galva	Petersen Health Care V, LLC	Peoria	Mgmt/Bookkeeping	10
11			Courtyard Estates of Walcott	Walcott	Petersen Health Care VI, LLC	Peoria	Mgmt/Bookkeeping	11
12			Courtyard Village of Kewanee	Kewanee	Petersen Health Care VII, LLC	Sullivan	Lessor	12
13			Lakewood Village	Charleston	Petersen Health Care VIII, LLC	Peoria	Mgmt/Bookkeeping	13
14			Courtyard Estates of Monmouth	Monmouth	Petersen Health Care X, LLC	Peoria	Lessor	14
15			Riverview Estates	Havana	Petersen Osage Beach, LLC	Osage Beach, MO	Lessor	15
16			Simple Blessings	Casey	Petersen West Frankfort, LLC	West Frankfort	Lessor	16
17			Courtyard Estates of Bushnell	Bushnell	Midwest Health Care, LLC	Peoria	Mgmt/Bookkeeping	17
18			Courtyard Estates of Canton	Canton	Poplar Bluff Health Care, LLC	Poplar Bluff, MO	Lessor	18
19			Legacy Estates of Monmouth	Monmouth	Petersen Roseville, LLC	Roseville	Lessor	19
20			Courtyard Estates of Sullivan	Sullivan				20
21			Courtyard Estates of Peoria	Peoria				21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Twin Lakes Rehabilitation & Health Care C # 0048223 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Twin Lakes Rehabilitation & Health Care Center # 0048223 Report Period Beginning: 1/1/2011 Ending: 2/31/2011

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	1,542,131	77	\$ 311,109	\$ 308,619	13,019	\$ 2,626	1
2	2	Food	Resident Days	1,542,131	77	1,436	0	13,019	12	2
3	3	Housekeeping	Resident Days	1,542,131	77	2,014	0	13,019	17	3
4	4	Laundry	Resident Days	1,542,131	77	0	0	13,019	0	4
5	5	Utilities	Resident Days	1,542,131	77	20,347	0	13,019	172	5
6	6	Maintenance	Resident Days	1,542,131	77	126,852	100,385	13,019	1,071	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,542,131	77	70,933	0	13,019	599	7
8	10	Nursing and Medical Records	Resident Days	1,542,131	77	3,130	0	13,019	26	8
9	10A	Therapy	Resident Days	1,542,131	77	0	0	13,019	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,542,131	77	0	0	13,019	0	10
11	17	Administrative	Resident Days	1,542,131	77	4,905,497	4,905,497	13,019	66,000	11
12	19	Professional Services	Resident Days	1,542,131	77	355,921	0	13,019	3,005	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,542,131	77	25,013	0	13,019	211	13
14	21	Clerical and General Office	Resident Days	1,542,131	77	2,900,214	2,467,442	13,019	24,484	14
15	23	Inservice Training & Education	Resident Days	1,542,131	77	10,374	0	13,019	88	15
16	24	Travel and Seminar	Resident Days	1,542,131	77	3,057	0	13,019	26	16
17	25	Other Admin. Staff Transport.	Resident Days	1,542,131	77	266,518	0	13,019	2,250	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,542,131	77	72,152	0	13,019	609	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,542,131	77	1,178,815	0	13,019	9,952	19
20	30	Depreciation	Resident Days	1,542,131	77	416,712	0	13,019	3,518	20
21	32	Interest	Resident Days	1,542,131	77	501,565	0	13,019	4,234	21
22	33	Real Estate Taxes	Resident Days	1,542,131	77	25,635	0	13,019	216	22
23	34	Rent-Facility and Grounds	Resident Days	1,542,131	77	0	0	13,019	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,542,131	77	45,440	0	13,019	384	24
25	TOTALS					\$ 11,242,734	\$ 7,781,943		\$ 119,500	25

Facility Name & ID Number Twin Lakes Rehabilitation & Health Care Center

0048223

Report Period Beginning:

1/1/2011

Ending: 2/31/2011

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 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

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	325,902	13	\$	\$	13,019	\$	1
2	2	Food	Resident Days	325,902	13			13,019		2
3	3	Housekeeping	Resident Days	325,902	13			13,019		3
4	4	Laundry	Resident Days	325,902	13			13,019		4
5	5	Utilities	Resident Days	325,902	13			13,019		5
6	6	Maintenance	Resident Days	325,902	13	22,420		13,019	896	6
7	7	Mgmt. Allocation of Benefits	Resident Days	325,902	13			13,019		7
8	10	Nursing and Medical Records	Resident Days	325,902	13			13,019		8
9	15	Mgmt. Allocation of Benefits	Resident Days	325,902	13			13,019		9
10	17	Administrative	Resident Days	325,902	13			13,019		10
11	19	Professional Services	Resident Days	325,902	13	48,058		13,019	1,920	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	325,902	13	3,502		13,019	140	12
13	21	Clerical and General Office	Resident Days	325,902	13	98,273		13,019	3,926	13
14	22	Employee Benefits & Payroll	Resident Days	325,902	13			13,019		14
15	23	Inservice Training & Education	Resident Days	325,902	13			13,019		15
16	24	Travel and Seminar	Resident Days	325,902	13			13,019		16
17	25	Other Admin. Staff Transport.	Resident Days	325,902	13	60,087		13,019	2,400	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	325,902	13			13,019		18
19	27	Mgmt. Allocation of Benefits	Resident Days	325,902	13			13,019		19
20	30	Depreciation	Resident Days	325,902	13	233,155		13,019	9,314	20
21	32	Interest	Resident Days	325,902	13	547,113		13,019	21,856	21
22	33	Real Estate Taxes	Resident Days	325,902	13			13,019		22
23	34	Rent-Facility and Grounds	Resident Days	325,902	13			13,019		23
24	35	Rent-Equipment & Vehicles	Resident Days	325,902	13	36		13,019	1	24
25	TOTALS					\$ 1,012,644	\$		\$ 40,453	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1										1										
2	N/A									2										
3								Interest Income Offset	(433)	3										
4								Home Office Allocation-PHC	4,234	4										
5								Home Office Allocation-PHC II	21,856	5										
Working Capital																				
6										6										
7										7										
8										8										
9	TOTAL Facility Related					\$	\$		\$ 25,657	9										
B. Non-Facility Related*																				
10										10										
11										11										
12										12										
13										13										
14	TOTAL Non-Facility Related					\$	\$		\$	14										
15	TOTALS (line 9+line14)					\$	\$		\$ 25,657	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.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1.	Real Estate Tax accrual used on 2010 report.			\$	36,300	1
2.	Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2010		\$	35,415	2
3.	Under or (over) accrual (line 2 minus line 1).			\$	(885)	3
4.	Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	36,480	4
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		Home Office Allocation		216	6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	35,811	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2006	33,145	8		
		2007	33,154	9		
		2008	35,254	10		
		2009	35,220	11		
		2010	35,415	12		
<u>Accrual based on prior year tax bill.</u>						
		FOR BHF USE ONLY				
		13	FROM R. E. TAX STATEMENT FOR 2010	\$		13
		14	PLUS APPEAL COST FROM LINE 5	\$		14
		15	LESS REFUND FROM LINE 6	\$		15
		16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

NOTES:

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

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Twin Lakes Rehabilitation & Health Care Center 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 2010 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 2010.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>09-19-06-300-018</u>	<u>Long-Term Care Facility</u>	\$ <u>35,414.58</u>	\$ <u>35,414.58</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>35,414.58</u></u>	\$ <u><u>35,414.58</u></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 and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	62		2008	1977	\$ 519,985	\$	25	\$ 20,800	\$ 20,800	\$ 72,800	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Parking Lot Sealcoat			2010	2,662		7	380	380	570	9
10	Roof Replacement			2010	15,225		25	610	610	915	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	Land Improvements Booked					1,514			(1,514)		28
29	Building Booked					20,799			(20,799)		29
30	Building Improvement Booked					2,158			(2,158)		30
31											31
32	2011-Home Office Allocation-Building Improvements				6,196			149	149		32
33	2011-Home Office Allocation-Land Improvements				578			37	37		33
34											34
35											35
36											36

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

See Page 12A, Line 70 for total

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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)	\$	\$		\$	\$	\$	70
			544,646	24,471	21,976	(2,495)	74,285	

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 131,366	\$ 18,780	\$ 12,814	\$ (5,966)	7-10 yrs.	\$ 47,062	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Home Office Allocation			12,832	12,832			74
75	TOTALS	\$ 131,366	\$ 18,780	\$ 25,646	\$ 6,866		\$ 47,062	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	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)	\$ 726,012	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 43,251	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 47,622	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 4,371	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 121,347	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: \$ 24,170 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	Facility	2010 Ford Van	\$ 685.00	\$ 8,220	17
18					18
19					19
20					20
21	TOTAL		\$ 685.00	\$ 8,220	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. _____ /2012 \$ _____

13. _____ /2013 \$ _____

14. _____ /2014 \$ _____

* 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 Center

0048223

Period Beginning

1/1/2011

Period End

12/31/2011

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$	17,572
Dishwasher		-
Laundry Equipment		2,792
Copier		3,421
Home Office Allocation		385
		<u>24,170</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		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	1 Schedule V Line & Column Reference	2		3		4		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5 Outside Practitioner (other than consultant)							
					Units	Cost						
1	Licensed Occupational Therapist	10A(3)	hrs	\$	10,652	\$	159,778	\$	10,652	\$	159,778	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		670		10,043		670		10,043	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		12,516		187,739	166	12,516		187,905	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					80,251			80,251	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			\$	23,838	\$	357,560	\$	80,417	\$	437,977	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 Center

0048223

Report Period Beginning: 1/1/2011

Ending:

12/31/2011

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2011

(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	\$ 425	\$ 425	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 60,000)	804,005	804,005	3
4	Supply Inventory (priced at Cost)			4
5	Short-Term Investments			5
6	Prepaid Insurance	17,474	17,474	6
7	Other Prepaid Expenses	6,756	6,756	7
8	Accounts Receivable (owners or related parties)	8,803	8,803	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 837,463	\$ 837,463	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	539,656	526,181	14
15	Leasehold Improvements, at Historical Cost	23,861	18,465	15
16	Equipment, at Historical Cost	131,366	131,366	16
17	Accumulated Depreciation (book methods)	(151,349)	(121,347)	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):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 593,534	\$ 604,665	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,430,997	\$ 1,442,128	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,607,195	\$ 1,607,195	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	55,525	55,525	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,114	3,114	31
32	Accrued Real Estate Taxes(Sch.IX-B)	36,480	36,480	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	46,525	46,525	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,748,839	\$ 1,748,839	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				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,748,839	\$ 1,748,839	46
47	TOTAL EQUITY(page 18, line 24)	\$ (317,842)	\$ (306,711)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,430,997	\$ 1,442,128	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (505,228)	1
2	Restatements (describe):		2
3	Rounding	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (505,229)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	187,387	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)	\$ 187,387	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)	\$ (317,842)	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	\$ 1,932,833	1
2	Discounts and Allowances for all Levels	(216,883)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,715,950	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	601,073	6
7	Oxygen	4,426	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 605,499	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	1,697	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	135,339	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	23,085	20
21	Other Medical Services	21,434	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 181,555	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	433	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 433	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	85	28
28a	Transportation Revenue	712	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 797	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,504,234	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	410,447	31
32	Health Care	1,050,725	32
33	General Administration	243,382	33
B. Capital Expense			
34	Ownership	110,851	34
C. Ancillary Expense			
35	Special Cost Centers	467,497	35
36	Provider Participation Fee	33,945	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,316,847	40
41	Income before Income Taxes (line 30 minus line 40)**	187,387	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 187,387	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 Center**

0048223

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,080	2,080	\$ 45,840	\$ 22.04	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,039	6,223	140,012	22.50	3
4	Licensed Practical Nurses	3,714	3,883	68,246	17.58	4
5	CNAs & Orderlies	26,193	26,924	271,252	10.07	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,855	2,015	21,647	10.74	8
9	Activity Director	777	777	7,404	9.53	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	3,120	3,120	30,568	9.80	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,299	9,600	79,246	8.25	15
16	Dishwashers					16
17	Maintenance Workers	1,841	1,908	23,671	12.41	17
18	Housekeepers	6,444	6,699	57,067	8.52	18
19	Laundry	4,474	4,680	39,138	8.36	19
20	Administrator	2,080	2,080	66,000	31.73	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) See Sch 20A	4,728	4,927	76,529	15.53	33
34	TOTAL (lines 1 - 33)	72,644	74,916	\$ 926,620 *	\$ 12.37	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	9,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,393	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	6	251	L10a, C3	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	\$ 11,644		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

Period Beginning 1/1/2011

Period End 12/31/2011

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	2,315	2,404	44,088	18.34
Transportation	333	443	4,515	10.19
Marketing	2,080	2,080	27,926	13.43
TOTAL	<u>4,728</u>	<u>4,927</u>	<u>76,529</u>	

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	\$ 66,000	Workers' Compensation Insurance	\$ 18,678	IDPH License Fee	\$	
				Unemployment Compensation Insurance	12,551	Advertising: Employee Recruitment	275	
				FICA Taxes	64,891	Health Care Worker Background Check (Indicate # of checks performed)		
				Employee Health Insurance	2,770	Patient Background Checks	403 4,034	
				Employee Meals		Miscellaneous Licenses & Permits	205	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Subscriptions	390	
				Employee Relations	240	Home Office Allocation	351	
				Employee Retirement	628			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						Less: Public Relations Expense	(390)	
						Non-allowable advertising	()	
						Yellow page advertising	()	
						TOTAL (agree to Sch. V, line 20, col. 8)	\$ 4,865	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL (agree to Schedule V, line 22, col.8)				
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description				Description			Description	
Amount				Line #			Amount	
Management Fees-See Page 6, Eliminated on P 3, C 7				N/A			Out-of-State Travel	
\$ 98,000							\$	
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			Seminar Expense	
\$ 98,000				\$			100	
							Home Office Allocation	
							26	
							Entertainment Expense	
							()	
							TOTAL (agree to Sch. V, line 24, col. 8)	
							\$ 126	
C. Professional Services								
Vendor/Payee								
Type								
Amount								
Allscripts								
Computer Services								
638								
E-Health Data Solutions								
Computer Services								
3,485								
Frontier								
Computer Services								
504								
Honkamp, Krueger & Co.								
Accounting Fees								
140								
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				TOTAL				
\$ 4,767				\$				

* Attach copy of IMRF notifications

**See instructions.

Twin Lakes Rehabilitation & Health Care Center

0048223

Period Beginning 1/1/2011**Period End** 12/31/2011**Schedule 21A****XIX. SUPPORT SCHEDULE****C. Professional Services**

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		4,767
Home Office Allocation		
Heyl, Royster, Voelker & Allen	Legal	3
Henry County Recorder	Legal	-
Ginoli & Company	Accountants	417
Miscellaneous Vendors	Computer Services	37
Advanced Answers on Demand	Computer Services	1,743
Access 2 Go	Computer Services	171
Kemper Technology	Computer Services	80
MediFax	Computer Services	27
VisionShare/Ability Network	Computer Services	123
Advanced System Design	Computer Services	160
Simple LTC	Computer Services	201
Optimizer Systems	Other Prof Fees	20
Clifton Gunderson	Other Prof Fees	7
Mike Miller	Other Prof Fees	10
OIC Group	Other Prof Fees	2
AllScripts	Other Prof Fees	5
Miscellaneous Vendors	Legal	1
Ginoli & Company	Accountants	690
U.S. Bank	Accountants	397
CDW	Computer Services	424
Polaris Group	Professional Fees	<u>407</u>
Total (agree to Schedule V, line 19, column 8)		<u><u>9,692</u></u>

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3	N/A											
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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

Report Period Beginning:

1/1/2011

Ending:

12/31/2011**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 8,980 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 33,945
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? N/A 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. \$ 1,697
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 413
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? Yes
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? No
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? Yes
Firm Name: Ginoli & Company
- (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