

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0048223

Facility Name: Twin Lakes Rehab & Hlth Care

Address: 310 Eads Avenue Paris 61944
Number City Zip Code

County: Edgar

Telephone Number: (217) 465-5395 Fax # (217) 463-2242

HFS ID Number:

Date of Initial License for Current Owners: 6004188

Type of Ownership:

☐ VOLUNTARY,NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☒ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2016 to 12/31/2016 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or
Administrator
of Provider

(Signed)
(Type or Print Name) Mark B. Petersen
(Title) Chief Executive Officer

Paid
Preparer

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

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

Facility Name & ID Number Twin Lakes Rehab & Hlth Care

0048223 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

III. STATISTICAL DATA

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

N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>62</u>	Skilled (SNF)	<u>62</u>	<u>22,630</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>62</u>	TOTALS	<u>62</u>	<u>22,630</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>10,102</u>	<u>2,933</u>	<u>2,322</u>	<u>15,357</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>10,102</u>	<u>2,933</u>	<u>2,322</u>	<u>15,357</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.86%

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 ☐

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 4/22/2008

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

YES ☒ Date 4/22/2008 NO ☐

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

YES ☒ NO ☐ If YES, enter number of beds certified 18 and days of care provided 1,987

Medicare Intermediary Wisconsin Physicians Service

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number Twin Lakes Rehab & Hlth Care # 0048223 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	111,971	12,541		124,512		124,512	3,154	127,666			1
2	Food Purchase		101,342		101,342		101,342	(834)	100,508			2
3	Housekeeping	68,181	18,808		86,989		86,989	55	87,044			3
4	Laundry	59,365	11,960	72	71,397		71,397		71,397			4
5	Heat and Other Utilities			52,107	52,107		52,107	184	52,291			5
6	Maintenance	33,977	13,046	18,329	65,352		65,352	1,722	67,074			6
7	Other (specify):* Home Office Ben. Allocation											7
8	TOTAL General Services	273,494	157,697	70,508	501,699		501,699	4,281	505,980			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	828,265	95,867	7,965	932,097		932,097	(2,207)	929,890			10
10a	Therapy			344,239	344,239		344,239		344,239			10a
11	Activities	22,886	763	2,149	25,798		25,798	(5,761)	20,037			11
12	Social Services	31,984			31,984		31,984		31,984			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Office Ben. Allocation											15
16	TOTAL Health Care and Programs	883,135	96,630	366,353	1,346,118		1,346,118	(7,968)	1,338,150			16
	C. General Administration											
17	Administrative			245,300	245,300		245,300	(182,033)	63,267			17
18	Directors Fees											18
19	Professional Services			14,993	14,993		14,993	22,257	37,250			19
20	Dues, Fees, Subscriptions & Promotions			7,010	7,010		7,010	655	7,665			20
21	Clerical & General Office Expenses	33,565	2,769	15,766	52,100		52,100	36,774	88,874			21
22	Employee Benefits & Payroll Taxes			162,446	162,446		162,446	20,563	183,009			22
23	Inservice Training & Education							71	71			23
24	Travel and Seminar							34	34			24
25	Other Admin. Staff Transportation			3,180	3,180		3,180	2,893	6,073			25
26	Insurance-Prop.Liab.Malpractice			19,495	19,495		19,495	408	19,903			26
27	Other (specify):* Home Office Ben. Allocation											27
28	TOTAL General Administration	33,565	2,769	468,190	504,524		504,524	(98,378)	406,146			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,190,194	257,096	905,051	2,352,341		2,352,341	(102,065)	2,250,276			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			33,895	33,895		33,895	18,056	51,951			30
31	Amortization of Pre-Op. & Org.							15,964	15,964			31
32	Interest			37,144	37,144		37,144	22,398	59,542			32
33	Real Estate Taxes			31,164	31,164		31,164	187	31,351			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			34,757	34,757		34,757	662	35,419			35
36	Other (specify):*											36
37	TOTAL Ownership			136,960	136,960		136,960	57,267	194,227			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		55,235		55,235		55,235		55,235			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			113,111	113,111		113,111		113,111			42
43	Other (specify):*		1,050	87,360	88,410		88,410	(88,410)				43
44	TOTAL Special Cost Centers		56,285	200,471	256,756		256,756	(88,410)	168,346			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,190,194	313,381	1,242,482	2,746,057		2,746,057	(133,208)	2,612,849			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(891)	2		4
5	Telephone, TV & Radio in Resident Rooms	(1,066)	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	9,211	30		9
10	Interest and Other Investment Income	(50)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(70)	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	(12,552)	43		18
19	Entertainment				19
20	Contributions	(500)	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	(62,700)	43		24
25	Fund Raising, Advertising and Promotional	(2,530)	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 See Page 5A	(17,053)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (88,201)		\$	30

BHF USE ONLY							
48		49		50		51	
						52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(45,007)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (45,007)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (133,208)		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (5,006)	43	1
2	X-Rays-Part A	(3,108)	43	2
3	Pet Expense	(275)	43	3
4	Resident Flowers	(297)	43	4
5	Spccial Events	(306)	43	5
6	Offset Tranportation Revenue	(5,761)	11	6
7	Offset Miscellaneous Nursing Supplies Revenue	(2,300)	10	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(17,053)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Twin Lakes Rehab & Hlth Care# 0048223

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	3,154	0	0	0	0	0	0	0	0	0	3,154	1
2	Food Purchase	(891)	57	0	0	0	0	0	0	0	0	0	(834)	2
3	Housekeeping	0	55	0	0	0	0	0	0	0	0	0	55	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	184	0	0	0	0	0	0	0	0	0	184	5
6	Maintenance	0	1,722	0	0	0	0	0	0	0	0	0	1,722	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(891)	5,172	0	0	0	0	0	0	0	0	0	4,281	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(2,300)	93	0	0	0	0	0	0	0	0	0	(2,207)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(5,761)	0	0	0	0	0	0	0	0	0	0	(5,761)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(8,061)	93	0	0	0	0	0	0	0	0	0	(7,968)	16
	C. General Administration													
17	Administrative	0	(182,033)	0	0	0	0	0	0	0	0	0	(182,033)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	8,033	0	14,224	0	0	0	0	0	0	0	22,257	19
20	Fees, Subscriptions & Promotions	0	0	336	319	0	0	0	0	0	0	0	655	20
21	Clerical & General Office Expenses	0	0	36,774	0	0	0	0	0	0	0	0	36,774	21
22	Employee Benefits & Payroll Taxes	0	0	20,563	0	0	0	0	0	0	0	0	20,563	22
23	Inservice Training & Education	0	0	71	0	0	0	0	0	0	0	0	71	23
24	Travel and Seminar	0	0	34	0	0	0	0	0	0	0	0	34	24
25	Other Admin. Staff Transportation	0	0	2,893	0	0	0	0	0	0	0	0	2,893	25
26	Insurance-Prop.Liab.Malpractice	0	0	408	0	0	0	0	0	0	0	0	408	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	(174,000)	61,079	14,543	0	0	0	0	0	0	0	(98,378)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(8,952)	(168,735)	61,079	14,543	0	0	0	0	0	0	0	(102,065)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Twin Lakes Rehab & Hlth Care # 0048223 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	9,211	0	8,138	707	0	0	0	0	0	0	0	18,056	30
31	Amortization of Pre-Op. & Org.	0	0	0	15,964	0	0	0	0	0	0	0	15,964	31
32	Interest	(50)	0	239	22,209	0	0	0	0	0	0	0	22,398	32
33	Real Estate Taxes	0	0	187	0	0	0	0	0	0	0	0	187	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	662	0	0	0	0	0	0	0	0	662	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	9,161	0	9,226	38,880	0	0	0	0	0	0	0	57,267	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(88,410)	0	0	0	0	0	0	0	0	0	0	(88,410)	43
44	TOTAL Special Cost Centers	(88,410)	0	0	0	0	0	0	0	0	0	0	(88,410)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(88,201)	(168,735)	70,305	53,423	0	0	0	0	0	0	0	(133,208)	45

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	\$	Petersen Health Care Management, Inc.	100.00%	\$ 3,154	\$ 3,154	1
2	V	2	Food		Petersen Health Care Management, Inc.	100.00%	57	57	2
3	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	55	55	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	184	184	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	1,722	1,722	5
6	V	7	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		6
7	V	9	Medical Director		Petersen Health Care Management, Inc.	100.00%	0		7
8	V	10	Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	93	93	8
9	V	10A	Therapy		Petersen Health Care Management, Inc.	100.00%	0		9
10	V	15	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		10
11	V	17	Administrative	245,300	Petersen Health Care Management, Inc.	100.00%	63,267	(182,033)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	8,033	8,033	12
13	V								13
14	Total			\$ 245,300			\$ 76,565	\$ * (168,735)	14

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

VII. RELATED PARTIES (continued)

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

☒ X

 YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	Dues, Fees, Subs & Promotions	\$	Petersen Health Care Management, Inc.	100.00%	\$ 336	\$	336 15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	36,774		36,774 16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	20,563		20,563 17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	71		71 18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	34		34 19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	2,893		2,893 20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	408		408 21
22	V	27	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		0 22
23	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	8,138		8,138 23
24	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	239		239 24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	187		187 25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	662		662 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			\$			\$ 70,305	\$ *	70,305 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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	1 Dietary	\$	Petersen Health Care II, LLC	100.00%	\$ 0	\$	15
16	V	2 Food		Petersen Health Care II, LLC	100.00%	0		16
17	V	3 Housekeeping		Petersen Health Care II, LLC	100.00%	0		17
18	V	4 Laundry		Petersen Health Care II, LLC	100.00%	0		18
19	V	5 Utilities		Petersen Health Care II, LLC	100.00%	0		19
20	V	6 Maintenance		Petersen Health Care II, LLC	100.00%	0		20
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Care II, LLC	100.00%	0		21
22	V	10 Nursing and Medical Records		Petersen Health Care II, LLC	100.00%	0		22
23	V	15 Mgmt. Allocation of Benefits		Petersen Health Care II, LLC	100.00%	0		23
24	V	17 Administrative		Petersen Health Care II, LLC	100.00%	0		24
25	V	19 Professional Services		Petersen Health Care II, LLC	100.00%	14,224	14,224	25
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Care II, LLC	100.00%	319	319	26
27	V	21 Clerical and General Office		Petersen Health Care II, LLC	100.00%	0		27
28	V	22 Employee Benefits & Payroll		Petersen Health Care II, LLC	100.00%	0		28
29	V	23 Inservice Training & Education		Petersen Health Care II, LLC	100.00%	0		29
30	V	24 Travel and Seminar		Petersen Health Care II, LLC	100.00%	0		30
31	V	25 Other Admin. Staff Transport.		Petersen Health Care II, LLC	100.00%	0		31
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care II, LLC	100.00%	0		32
33	V	30 Depreciation		Petersen Health Care II, LLC	100.00%	707	707	33
34	V	31 Amortization		Petersen Health Care II, LLC	100.00%	15,964	15,964	34
35	V	32 Interest		Petersen Health Care II, LLC	100.00%	22,209	22,209	35
36	V	33 Real Estate Taxes		Petersen Health Care II, LLC	100.00%	0		36
37	V	34 Rent-Facility and Grounds		Petersen Health Care II, LLC	100.00%	0		37
38	V	35 Rent-Equipment & Vehicles		Petersen Health Care II, LLC	100.00%	0		38
39	Total		\$			\$ 53,423	\$ * 53,423	39

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

Facility Name & ID Number

Twin Lakes Rehab & Hlth Care

0048223

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Aledo Health Care Center	Aledo	Petersen Companies, I	Peoria	Mgmt/Bookkeeping	1
2			Arcola Health Care Center	Arcola	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	2
3			Aspen Rehab & Health Care	Silvis	Petersen Health Care,	Peoria	Mgmt/Bookkeeping	3
4			Batavia Rehab & Health Care Center	Batavia	Petersen Health Enter	Peoria	Mgmt/Bookkeeping	4
5			Bement Health Care Center	Bement	Petersen Health Opera	Peoria	Mgmt/Bookkeeping	5
6			Benton Rehab & Health Care Center	Benton	Petersen Health Syste	Peoria	Mgmt/Bookkeeping	6
7			Bloomington Rehab & Health Care Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality	7
8			Casey Health Care Center	Casey	Petersen Hospitality L	Peoria	Hospitality	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Management	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Busin	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care	Peoria	Lessor	13
14			Decatur Rehab & Health Care Center	Decatur	Midwest Health Opera	Peoria	Mgmt/Bookkeeping	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Health Prope	Peoria	Mgmt/Bookkeeping	15
16			Eastview Terrace	Sullivan	Petersen Roseville, LL	Roseville	Lessor	16
17			El Paso Health Care Center	El Paso	Petersen Health Juncti	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Petersen Health Qualit	Peoria	Mgmt/Bookkeeping	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Health and W	Peoria	Mgmt/Bookkeeping	19
20			Flanagan Rehab & Health Care Center	Flanagan	Petersen 24, LLC	Peoria	Hospitality	20
21			Flora Gardens Care Center	Flora				21
22			Flora Health Care Center	Flora				22
23			Fondulac Rehab & Health Care Center	East Peoria				23
24			Havana Health Care Center	Havana				24
25			Illini Heritage Rehab & Health Care	Champaign				25
26			Jonesboro Rehab & Health Care Center	Jonesboro				26
27			Kewanee Care Home	Kewanee				27
28			LaHarpe Davier Health Care Center	LaHarpe				28
29			Lebanon Care Center	Lebanon				29
30			Marigold Rehab & Health Care Center	Galesburg				30

Facility Name & ID Number

Twin Lakes Rehab & Hlth Care

0048223

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

VII. RELATED PARTIES

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

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

Facility Name & ID Number

Twin Lakes Rehab & Hlth Care

0048223

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Twin Lakes Rehab & Health Care Center	Paris				1
2			Vandalia Rehab & Health Care Center	Vandalia				2
3			Watseka Health Care Center	Watseka				3
4			Westside Rehab & Care Center	West Frankfort				4
5			Whispering Oaks	Rosiclare				5
6			White Oak Rehab & Health Care Center	Mt. Vernon				6
7			Willow Rose Rehab & Health Care Center	Jerseyville				7
8			Sheldon Health Care Center	Sheldon				8
9			Tuscola Health Care Center	Tuscola				9
10			Effingham Health Care Center	Effingham				10
11			Collinsville Health Care Center	Collinsville				11
12			Ozark Rehab & Health Care Center	Osage Beach, MO				12
13			Tarkio Rehab & Health Care Center	Tarkio, MO				13
14			Shangri-la Rehab & Living Center	Blue Springs, MO				14
15			Prairie Rose Care Center	Pana				15
16			Illini Heritage Rehab & Health Center	Champaign				16
17			Courtyard Estates of Kewanee	Kewanee				17
18			Courtyard Estates of Bradford	Bradford				18
19			Courtyard Estates of Galva	Galva				19
20			Courtyard Estates of Walcott	Walcott				20
21			Courtyard Village of Kewanee	Kewanee				21
22			Lakewood Village	Charleston				22
23			Courtyard Estates of Monmouth	Monmouth				23
24			Riverview Estates	Havana				24
25			Simple Blessings	Casey				25
26			Courtyard Estates of Bushnell	Bushnell				26
27			Courtyard Estates of Canton	Canton				27
28			Legacy Estates of Monmouth	Monmouth				28
29			Courtyard Estates of Sullivan	Sullivan				29
30			Courtyard Estates of Peoria	Peoria				30

Facility Name & ID Number

Twin Lakes Rehab & Hlth Care

0048223

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Cornerstone Health and Rehabilitation	Peoria				1
2			Rock River Gardens	Sterling				2
3			Sauk Valley Senior Living & Rehabilitation	Rock Falls				3
4			Courtyard Estates of Farmington	Farmington				4
5			Courtyard Estates of Knoxville	Knoxville				5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Twin Lakes Rehab & Hlth Care # 0048223 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Twin Lakes Rehab & Hlth Care# 0048223

Report Period Beginning:

1/1/2016Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Petersen Health Care Management, Inc.

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309) 691-8113

Fax Number

(309) 691-8622

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6			
1	1	Dietary	Resident Days	1,521,544	75	\$ 312,540	\$ 357,910	15,357	\$ 3,154	1
2	2	Food	Resident Days	1,521,544	75	5,673	0	15,357	57	2
3	3	Housekeeping	Resident Days	1,521,544	75	5,456	2,897	15,357	55	3
4	5	Utilities	Resident Days	1,521,544	75	18,209	0	15,357	184	4
5	6	Maintenance	Resident Days	1,521,544	75	170,632	137,057	15,357	1,722	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,521,544	75	0	0	15,357	0	6
7	9	Medical Director	Resident Days	1,521,544	75	0	0	15,357	0	7
8	10	Nursing and Medical Records	Resident Days	1,521,544	75	9,261	1,782,521	15,357	93	8
9	10A	Therapy	Resident Days	1,521,544	75	0	0	15,357	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,521,544	75	0	0	15,357	0	10
11	17	Administrative	Resident Days	1,521,544	75	4,899,467	5,473,961	15,357	63,267	11
12	19	Professional Services	Resident Days	1,521,544	75	795,918	0	15,357	8,033	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,521,544	75	33,278	0	15,357	336	13
14	21	Clerical and General Office	Resident Days	1,521,544	75	3,643,535	3,756,135	15,357	36,774	14
15	22	Employee Benefits and Payroll Tax	Resident Days	1,521,544	75	2,037,314	0	15,357	20,563	15
16	23	Inservice Training & Education	Resident Days	1,521,544	75	6,986	0	15,357	71	16
17	24	Travel and Seminar	Resident Days	1,521,544	75	3,389	0	15,357	34	17
18	25	Other Admin. Staff Transport.	Resident Days	1,521,544	75	286,637	0	15,357	2,893	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,521,544	75	40,378	0	15,357	408	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,521,544	75	0	0	15,357	0	20
21	30	Depreciation	Resident Days	1,521,544	75	806,271	0	15,357	8,138	21
22	32	Interest	Resident Days	1,521,544	75	23,686	0	15,357	239	22
23	33	Real Estate Taxes	Resident Days	1,521,544	75	18,560	0	15,357	187	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,521,544	75	65,550	0	15,357	662	24
25	TOTALS					\$ 13,182,740	\$ 11,510,481		\$ 146,870	25

Facility Name & ID Number Twin Lakes Rehab & Hlth Care# 0048223

Report Period Beginning:

1/1/2016Ending: 2/31/2016

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, LLC

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309)691-8113

Fax Number

(309)691-8622

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6			
1	1	Dietary	Resident Days	158,706	5	\$	\$	15,357	\$	1
2	2	Food	Resident Days	158,706	5			15,357		2
3	3	Housekeeping	Resident Days	158,706	5			15,357		3
4	4	Laundry	Resident Days	158,706	5			15,357		4
5	5	Utilities	Resident Days	158,706	5			15,357		5
6	6	Maintenance	Resident Days	158,706	5			15,357		6
7	7	Mgmt. Allocation of Benefits	Resident Days	158,706	5			15,357		7
8	10	Nursing and Medical Records	Resident Days	158,706	5			15,357		8
9	15	Mgmt. Allocation of Benefits	Resident Days	158,706	5			15,357		9
10	17	Administrative	Resident Days	158,706	5			15,357		10
11	19	Professional Services	Resident Days	158,706	5	146,994		15,357	14,224	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	158,706	5	3,300		15,357	319	12
13	21	Clerical and General Office	Resident Days	158,706	5			15,357		13
14	22	Employee Benefits & Payroll	Resident Days	158,706	5			15,357		14
15	23	Inservice Training & Education	Resident Days	158,706	5			15,357		15
16	24	Travel and Seminar	Resident Days	158,706	5			15,357		16
17	25	Other Admin. Staff Transport.	Resident Days	158,706	5			15,357		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	158,706	5			15,357		18
19	30	Depreciation	Resident Days	158,706	5	7,309		15,357	707	19
20	31	Amortization	Resident Days	158,706	5	164,981		15,357	15,964	20
21	32	Interest	Resident Days	158,706	5	229,513		15,357	22,209	21
22	33	Real Estate Taxes	Resident Days	158,706	5			15,357		22
23	34	Rent-Facility and Grounds	Resident Days	158,706	5			15,357		23
24	35	Rent-Equipment & Vehicles	Resident Days	158,706	5			15,357		24
25	TOTALS					\$ 552,097	\$		\$ 53,423	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	1st Merit		X	Mortgage	Varies	02/01/12	\$ 937,400	\$ 804,350	01/31/17	Varies	\$ 37,144	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 937,400	\$ 804,350			\$ 37,144	9	
	B. Non-Facility Related*												
10								Interest Income Offset			(50)	10	
11								Home Office Allocation-PHCM			239	11	
12								Home Office Allocation-PHC II			22,209	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ 22,398	14	
15	TOTALS (line 9+line14)						\$ 937,400	\$ 804,350			\$ 59,542	15	

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Twin Lakes Rehab & Hlth Care COUNTY Edgar

FACILITY IDPH LICENSE NUMBER 0048223

CONTACT PERSON REGARDING THIS REPORT MIKE KOCHER

TELEPHONE (309)689-5850 FAX #: (309)691-8622

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

(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. 09-19-06-300-018	Long-Term Care Facility	\$ 29,765.34	\$ 29,765.34
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 29,765.34	\$ 29,765.34

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

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:

799,059

2. Number of Years Over Which it is Being Amortized:

20

3. Current Period Amortization:

15,964

4. Dates Incurred:

2013-2014

Nature of Costs:

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

XI. OWNERSHIP COSTS:

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

HFS 3745 (N-4-99)

IL478-2471

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	62		2008	1977	\$ 519,985	\$	25	\$ 20,800	\$ 20,800	\$ 176,800
5										
6										
7										
8										
	Improvement Type**									
9	Parking Lot Sealcoat			2010	2,662		7	380	380	2,470
10	Roof Replacement			2010	15,225		25	610	610	3,965
11	Plumbing Repair			2012	3,186		7	456	456	2,052
12	Roof Replacement			2013	30,000		25	1,200	1,200	4,200
13	Fire Alarm Control Unit			2014	2,876		7	411	411	1,028
14	Nurse's Station			2014	13,750		15	917	917	2,459
15	Nurse Call System Replacement			2015	9,008		7	1,288	1,288	1,932
16	Air Conditioner-Rooftop			2015	13,988		15	934	934	1,401
17	Generator			2016	19,465		15	1,298	1,298	1,298
18	Remodel-Men's Bathroom & Shower			2016	2,700		7	193	193	193
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30	Land Improvements Booked					1,515			(1,515)	
31	Building Booked					20,799			(20,799)	
32	Building Improvement Booked					7,568			(7,568)	
33										
34	2016-Home Office Allocation-Building Improvements				6,780			163	163	
35	2016-Home Office Allocation-Land Improvements				624			40	40	
36										

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Twin Lakes Rehab & Hlth Care

0048223

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
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)		\$ 640,249	\$ 29,882		\$ 28,690	\$ (1,192)	\$ 197,798	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$161,640	\$4,013	\$15,326	\$11,313	5-10 yrs.	\$117,924	71
72	Current Year Purchases					7 yrs.		72
73	Fully Depreciated Assets							73
74	Home Office Allocation			7,935	7,935			74
75	TOTALS	\$161,640	\$4,013	\$23,261	\$19,248		\$117,924	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)	\$851,889	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$33,895	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$51,951	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$18,056	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$315,722	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			93
94	N/A		94
95		\$	95

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

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

Facility Name & ID Number	Twin Lakes Rehab & Hlth Care
--------------------------------------	---

0048223

Report Period Beginning: 1/1/2016

Ending: 12/31/2016

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: \$ 27,199 Description: See Attached Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1	2	3	4	
	Use	Model Year and Make	Monthly Lease Payment	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. /2017 \$

13. _____ /2018 \$ _____

14. _____/2019 \$ _____

*** 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 Rehab & Hlth Care
0048223

Period Beginning 1/1/2016
Period End 12/31/2016

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$	21,521
Dishwasher		645
Copier		4,371
Home Office Allocation		662
		<u>27,199</u>

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

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

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

	Service	Schedule V Line & Column Reference	2	3	4		6	7	8	
			Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	8,260	\$ 123,903	\$	8,260	\$	123,903
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		5,071	76,058		5,071		76,058
3	Licensed Recreational Therapist		hrs							
4	Licensed Physical Therapist	10A(3)	hrs		9,619	144,278		9,619		144,278
5	Physician Care		visits							
6	Dental Care		visits							
7	Work Related Program		hrs							
8	Habilitation		hrs							
9	Pharmacy	39(2)	# of prescrpts				55,235			55,235
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
11	Academic Education		hrs							
12	Other (specify):									
13	Other (specify):									
14	TOTAL			\$	22,950	\$ 344,239	\$ 55,235	22,950	\$	399,474

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.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,276,317	\$ 1,276,317	1
2	Cash-Patient Deposits	2,440	2,440	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 47,273)	1,321,486	1,321,486	3
4	Supply Inventory (priced at Cost)	6,756	6,756	4
5	Short-Term Investments			5
6	Prepaid Insurance	18,052	18,052	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Prepaid Expenses</u>	139,978	139,978	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,765,029	\$ 2,765,029	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	519,985	526,765	14
15	Leasehold Improvements, at Historical Cost	151,580	113,484	15
16	Equipment, at Historical Cost	161,640	161,640	16
17	Accumulated Depreciation (book methods)	(356,109)	(315,722)	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): <u>Intercompany Loans</u>	4,206	4,206	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 531,302	\$ 540,373	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,296,331	\$ 3,305,402	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 578,703	\$ 578,703	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	65,847	65,847	30
31	Accrued Taxes Payable (excluding real estate taxes)	44,502	44,502	31
32	Accrued Real Estate Taxes(Sch.IX-B)	33,067	33,067	32
33	Accrued Interest Payable	3,404	3,404	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	2,830	2,830	36
37	<u>Accrued Management Fees</u>	19,320	19,320	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 747,673	\$ 747,673	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	804,350	804,350	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)	\$ 804,350	\$ 804,350	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,552,023	\$ 1,552,023	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,744,308	\$ 1,753,379	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,296,331	\$ 3,305,402	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,103,055	1
2	Restatements (describe):		2
3	Prior Period Adjustments Made After Cost Reports Were Filed	(5,234)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,097,821	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	646,487	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)	\$ 646,487	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)	\$ 1,744,308	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Twin Lakes Rehab & Hlth Care

0048223

Report Period Beginning: 1/1/2016

Ending: 12/31/2016

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,849,919	1
2	Discounts and Allowances for all Levels	(312,406)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,537,513	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	694,226	6
7	Oxygen	9,301	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 703,527	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	891	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	104,758	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	6,195	20
21	Other Medical Services	31,549	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 143,393	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	50	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 50	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation Revenue</u>	5,761	28
28a	<u>Miscellaneous & Vending Revenue</u>	2,300	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 8,061	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,392,544	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	501,699	31
32	Health Care	1,346,118	32
33	General Administration	504,524	33
	B. Capital Expense		
34	Ownership	136,960	34
	C. Ancillary Expense		
35	Special Cost Centers	143,645	35
36	Provider Participation Fee	113,111	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,746,057	40
41	Income before Income Taxes (line 30 minus line 40)**	646,487	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 646,487	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,514,931	44
45	Private Pay - Net Inpatient Revenue	566,560	45
46	Medicare - Net Inpatient Revenue	383,974	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	72,048	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,537,513	49

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

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

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

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

Facility Name & ID Number Twin Lakes Rehab & Hlth Care# 0048223Report Period Beginning: 1/1/2016Ending: 12/31/2016

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	2,063	2,140	\$ 61,221	\$ 28.61	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,684	5,824	161,923	27.80	3
4	Licensed Practical Nurses	10,096	10,275	218,306	21.25	4
5	CNAs & Orderlies	32,630	33,235	343,191	10.33	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	2,025	2,025	31,984	15.79	11
12	Dietician					12
13	Food Service Supervisor	1,718	1,809	28,278	15.63	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,710	7,950	83,693	10.53	15
16	Dishwashers					16
17	Maintenance Workers	2,113	2,177	33,977	15.61	17
18	Housekeepers	5,821	6,105	68,181	11.17	18
19	Laundry	5,567	5,733	59,365	10.35	19
20	Administrator	2,080	2,080	63,267	30.42	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,006	2,073	33,565	16.19	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 <u>CPC</u>	1,919	1,959	43,624	22.27	32
33	Other(specify) <u>Transportation</u>	2,080	2,080	22,886	11.00	33
34	TOTAL (lines 1 - 33)	83,512	85,465	\$ 1,253,461 *	\$ 14.67	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		\$	L1, C3	35
36	Medical Director	Monthly	12,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,475	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	3	195	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)	3	\$ 15,670		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				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

STATE OF ILLINOIS

Facility Name & ID Number

Twin Lakes Rehab & Hlth Care

0048223

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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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	
Genettia Dean		Administrator	0	\$ 63,267	Workers' Compensation Insurance		\$ 21,055	IDPH License Fee		\$ 1,990	
					Unemployment Compensation Insurance		32,364	Advertising: Employee Recruitment		256	
					FICA Taxes		88,817	Health Care Worker Background Check			
					Employee Health Insurance		17,508	(Indicate # of checks performed 6)		180	
					Employee Meals			Patient Background Checks		56 1,622	
					Illinois Municipal Retirement Fund (IMRF)*			Miscellaneous Licenses & Permits		962	
					Employee Relations		2,373	Miscellaneous Dues & Subscriptions		2,000	
					Employee Retirement		329	Home Office Allocation		655	
					Home Office Allocation		20,563				
TOTAL (agree to Schedule V, line 17, col. 1)											
(List each licensed administrator separately.)				\$ 63,267							
B. Administrative - Other											
Description			Amount					Less: Public Relations Expense		()	
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 245,300					Non-allowable advertising		()	
								Yellow page advertising		()	
				TOTAL (agree to Schedule V, line 22, col.8)			\$ 183,009	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 7,665	
TOTAL (agree to Schedule V, line 17, col. 3)				\$ 245,300	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
(Attach a copy of any management service agreement)											
C. Professional Services											
Vendor/Payee		Type	Amount	Description		Line #	Amount	Description		Amount	
Frontier		Computer Services	\$ 2,058					Out-of-State Travel		\$	
Honkamp, Krueger & Co.		Accounting Fees	1,359								
E-Health Data Services		Computer Services	3,783	N/A							
Allscripts		Data Services	1,443					In-State Travel			
Clark Co Clerk		Legal Fees	46								
Roecker Consulting Engineers		Consulting Fees	6,304								
								Seminar Expense			
								Home Office Allocation		34	
								Entertainment Expense		()	
								(agree to Sch. V, line 24, col. 8)			
								TOTAL		\$ 34	
TOTAL (agree to Schedule V, line 19, column 3)				\$ 14,993	TOTAL						
(For legal fee disclosure, see page 39 of instructions)											

* Attach copy of IMRF notifications

**See instructions.

Twin Lakes Rehab & Hlth Care
0048223

Period Beginning
Period End

1/1/2016
12/31/2016

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		14,993
Home Office Allocation		
Lucie, Scalf, and Bougher	Legal	36
Miscellaneous	Legal	9
Miller Hall and Triggs	Legal	62
Healthcare Resources International	Legal	310
Hunziker Law	Legal	74
Lexis Nexis	Legal	6
GoffWilson	Legal	523
Daniel L. Freeland & Associates	Legal	628
Illinois Secretary of State	Legal	30
CliftonLarson Allen	Accountants	829
Ginoli & Co.	Accountants	2,710
First Merit	Accountants	1,686
Miscellaneous	Computer Services	41
Change Healthcare	Computer Services	6
PTC Select	Computer Services	4
Advanced Answers on Demand	Computer Services	2,828
Stratus Networks	Computer Services	288
Kemper Technology	Computer Services	190
AT&T	Computer Services	4
Ability Network	Computer Services	1,206
CIAN	Computer Services	144
Comcast	Computer Services	23
CCH	Computer Services	9
Charter Communications	Computer Services	28
Allscripts	Computer Services	420
ATS	Computer Services	190
Allpayer Exchange	Computer Services	10
Optimizer	Other Prof Fees	29
Ankura	Other Prof Fees	220
David Budde	Other Prof Fees	25
Bruner, Cooper, Zuck	Other Prof Fees	64
Marotta, Gund, Budd, Dzerda	Other Prof Fees	9,588
Professional Software and Services	Other Prof Fees	16
Hughes Valuation Services	Other Prof Fees	20
Alan Litwiller	Other Prof Fees	1

Total (agree to Schedule V, line 19, column 8)	<u><u>37,250</u></u>
--	----------------------

XX. GENERAL INFORMATION:

(1)

Are nursing employees (RN,LPN,NA) represented by a union?

No

(2)

Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount.

Yes
IHCA \$2000

(3)

Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report?

No
N/A

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No
N/A

(5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

Yes
7 yrs.

(6)

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

\$ 14,748 Line 10

(7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?
If NO, attach a complete explanation.

Yes

(8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No
N/A

(9)

Are you presently operating under a sublease agreement?

YES X NO

(10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
YES NO X
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.
This amount is to be recorded on line 42 of Schedule V.

\$ 113,111

(12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

No

(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?
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.

No

(15)

Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V.
Has any meal income been offset against related costs?

\$ 0
Yes
Indicate the amount. \$ 891

(16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

No

b.

Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

Yes
\$ 5,761

c.

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

100

d.

Have vehicle usage logs been maintained?

Adequate records have been maintained.

e.

Are all vehicles stored at the nursing home during the night and all other times when not in use?

Yes

f.

Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

Yes

g.

Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such transportation during this reporting period.

No
\$ N/A

(17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:

Yes
Ginoli and Company

(18)

Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

Yes

(19)

Has a schedule for the legal fees reported on the cost report been provided by the facility?
See page 39 of the instructions for details.
Attach invoices and a summary of services for all architect and appraisal fees

No

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB- SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB- SCHED.	LINE NO.	COL. NO.
Adjustment Detr	-133,208	equal to	-133,208	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expensi	59,542	equal to	59,542	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax	31,351	equal to	31,351	0	FAILED	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exj	15,964	equal to	15,964	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Cost	51,951	equal to	51,951	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	35,419	equal to	35,419	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Traini	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to	0	0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Service	344,239	equal to	344,239	0	O.K.	Pg16 Z12+Z14..	N/A,B	1-4,40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- S	55,235	equal to	55,235	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. Ge	501,699	equal to	501,699	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. He	1,346,118	equal to	1,346,118	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Ad	504,524	equal to	504,524	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ov	136,960	equal to	136,960	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Sp	143,645	equal to	143,645	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Pr	113,111	equal to	113,111	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	828,265	equal to	828,265	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aidi	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed T	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	22,886	equal to	22,886	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Sei	31,984	equal to	31,984	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	111,971	equal to	111,971	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenar	33,977	equal to	33,977	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekee	68,181	equal to	68,181	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	59,365	equal to	59,365	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administr	63,267	equal to	63,267	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	33,565	equal to	33,565	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical D	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries A	1,253,461	equal to	1,190,194	63,267	FAILED	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consult	0	< or = to		#VALUE!	#VALUE!	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	12,000	< or = to	12,000	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & c	3,670	< or = to	7,965	-4,295	O.K.	Pg20 X14..X16+	B. & C.	17to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consult	0	< or = to	2,149	-2,149	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service C	0	< or = to		0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- A	63,267	equal to	63,267	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- A	245,300	equal to	245,300	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- F	14,993	equal to	14,993	0	FAILED	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- E	183,009	equal to	183,009	0	FAILED	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- S	7,665	equal to	7,665	0	FAILED	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- S	34	equal to	34	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Parti	113,111	equal to	113,111	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Emp	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide train	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medical	1,987	equal to	2,322	-335	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for r	-45,007	equal to	-45,007	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4I	B.	14	8
Total loan balan	804,350	equal to	804,350	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27.	N/A	29+39-41	2
Real estate tax i	33,067	equal to	33,067	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	50,000	equal to	50,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	640,249	equal to	640,249	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and i	161,640	equal to	161,640	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated de	315,722	equal to	315,722	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equ	1,744,308	equal to	1,744,308	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (los	646,487	equal to	646,487	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized de	0	equal to		0	O.K.	Pg22 F31-J31..J	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	3,296,331	equal to	3,296,331	0	O.K.	Pg17:H41	N/A	25	1	Pg17 S41	N/A	48	1

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Total
1. Dietary	111,971	12,541	0	124,512	0	124,512	3,154	127,666
2. Food Purchase	0	101,342	0	101,342	0	101,342	-834	100,508
3. Housekeeping	68,181	18,808	0	86,989	0	86,989	55	87,044
4. Laundry	59,365	11,960	72	71,397	0	71,397	0	71,397
5. Heat and Other Utilities	0	0	52,107	52,107	0	52,107	184	52,291
6. Maintenance	33,977	13,046	18,329	65,352	0	65,352	1,722	67,074
7. Other (specify)*	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	0	0	<u>0</u>	0
8. Total General Services	<u>273,494</u>	<u>157,697</u>	<u>70,508</u>	<u>501,699</u>	0	501,699	<u>4,281</u>	505,980
9. Medical Director	0	0	12,000	12,000	0	12,000	0	12,000
10. Nursing & Medical Records	828,265	95,867	7,965	932,097	0	932,097	-2,207	929,890
10a. Therapy	0	0	344,239	344,239	0	344,239	0	344,239
11. Activities	22,886	763	2,149	25,798	0	25,798	-5,761	20,037
12. Social Services	31,984	0	0	31,984	0	31,984	0	31,984
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	0	0	<u>0</u>	0
16. Total Health Care & Programs	<u>883,135</u>	<u>96,630</u>	<u>366,353</u>	<u>1,346,118</u>	0	1,346,118	<u>-7,968</u>	#####
17. Administrative	0	0	245,300	245,300	0	245,300	-182,033	63,267
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	14,993	14,993	0	14,993	22,257	37,250
20. Fees, Subscriptions & Promotion	0	0	7,010	7,010	0	7,010	655	7,665
21. Clerical & General Office	33,565	2,769	15,766	52,100	0	52,100	36,774	88,874
22. Employee Benefits & Payroll	0	0	162,446	162,446	0	162,446	20,563	183,009
23. Inservice Training & Education	0	0	0	0	0	0	71	71
24. Travel and Seminar	0	0	0	0	0	0	34	34
25. Other Admin. Staff Trans	0	0	3,180	3,180	0	3,180	2,893	6,073
26. Insurance-Prop.Liab.Malpractice	0	0	19,495	19,495	0	19,495	408	19,903
27. Other (specify)*	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	0	0	<u>0</u>	0
28. Total General Adminis	<u>33,565</u>	<u>2,769</u>	<u>468,190</u>	<u>504,524</u>	0	504,524	<u>-98,378</u>	406,146
29. Total General Administrative	<u>1,190,194</u>	<u>257,096</u>	<u>905,051</u>	<u>2,352,341</u>	0	2,352,341	<u>-102,065</u>	#####
30. Depreciation	0	0	33,895	33,895	0	33,895	18,056	51,951
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	15,964	15,964
32. Interest	0	0	37,144	37,144	0	37,144	22,398	59,542
33. Real Estate	0	0	31,164	31,164	0	31,164	187	31,351
34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	34,757	34,757	0	34,757	662	35,419
36. Other (specify):*	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	0	0	<u>0</u>	0
37. Total Ownership	<u>0</u>	<u>0</u>	<u>136,960</u>	<u>136,960</u>	0	136,960	<u>57,267</u>	194,227
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	55,235	0	55,235	0	55,235	0	55,235
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	113,111	113,111	0	113,111	0	113,111
43. Other (specify):*	0	1,050	87,360	88,410	0	88,410	<u>-88,410</u>	0
44. Total Special Cost Ce	<u>0</u>	<u>56,285</u>	<u>200,471</u>	<u>256,756</u>	0	256,756	<u>-88,410</u>	168,346
45. Grand Total	<u>1,190,194</u>	<u>313,381</u>	<u>1,242,482</u>	<u>2,746,057</u>	0	2,746,057	<u>-133,208</u>	#####

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	1,276,317	1,276,317
2. Cash - Patient Deposits	2,440	2,440
3. Accounts & Notes Recievable	1,321,486	1,321,486
4. Supply Inventory	6,756	6,756
5. Short-Term Investments	0	0
6. Prepaid Insurance	18,052	18,052
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	<u>139,978</u>	139,978
10. Total current assets	<u>2,765,029</u>	2,765,029
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	50,000	50,000
14. Buildings, at Historical Cost	519,985	526,765
15. Leasehold Improvements, Historical Cost	151,580	113,484
16. Equipment, at Historical Cost	161,640	161,640
17. Accumulated Depreciation (book methods)	-356,109	-315,722
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	<u>4,206</u>	4,206
24. Total Long-Term Assets	<u>531,302</u>	540,373
25. Total Assets	<u>3,296,331</u>	3,305,402
CURRENT LIABILITIES		
26. Accounts Payable	578,703	578,703
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	65,847	65,847
31. Accrued Taxes Payable	44,502	44,502
32. Accrued Real Estate Taxes	33,067	33,067
33. Accrued Interest Payable	3,404	3,404
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	2,830	2,830
37. Other Current Liabilities (specify):	<u>19,320</u>	19,320
38. Total Current Liabilities	<u>747,673</u>	747,673
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	804,350	804,350
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	<u>0</u>	0
45.Total Long-Term Liabilities	<u>804,350</u>	804,350
46.Total Liabilities	<u>1,552,023</u>	1,552,023
47.Total Equity	<u>1,744,308</u>	1,753,379
48.Total Liabilities and Equity	<u>3,296,331</u>	3,305,402

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,849,919
2. Discounts and Allowances for all Levels	-312,406
Subtotal - Inpatient Care	2,537,513
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	694,226
7. Oxygen	9,301
Subtotal - Ancillary Revenue	703,527
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	891
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	104,758
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	6,195
21. Other Medical Services	31,549
22. Laundry	0
Subtotal - Other Operating Revenue	143,393
24. Contributions	0
25. Interest and Other Investments Income	50
Subtotal - Non-Operating Revenue	50
27. Other Revenue (specify):	5,761
28. Other Revenue (specify):	2,300
Subtotal - Other Revenue	8,061
30. Total Revenue	3,392,544
31. General Services	524,935
32. Health Care	1,324,870
33. General Administration	471,131
34. Ownership	135,243
35. Special Cost Centers	110,047
35. Provider Participation Fee	119,708
37. Other	0
40. Total Expenses	2,685,934
41. Income Before Income Taxes	706,610
42. Income Taxes	0
43. Net Income or Loss for the Year	706,610