

Facility Name & ID Number Timbercreek Rehabilitation & Health Care Center

0047522 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	202	Skilled (SNF)	202	73,730	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	202	TOTALS	202	73,730	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	33,133	10,478	4,806	48,417	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	33,133	10,478	4,806	48,417	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.67%

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 10/1/05

J. Was the facility purchased or leased after January 1, 1978?
YES Date 10/1/05 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 202 and days of care provided 4,806

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number Timbercreek Rehabilitation & Health Care C # 0047522 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	222,450	31,445		253,895		253,895	9,749	263,644		1
2	Food Purchase		280,299		280,299		280,299	(8,421)	271,878		2
3	Housekeeping	129,747	19,203		148,950		148,950	46	148,996		3
4	Laundry	57,358	22,276		79,634		79,634	3	79,637		4
5	Heat and Other Utilities			132,491	132,491		132,491	692	133,183		5
6	Maintenance	56,440	31,490	41,847	129,777		129,777	5,683	135,460		6
7	Other (specify):* Home Off. Ben. All.							6,601	6,601		7
8	TOTAL General Services	465,995	384,713	174,338	1,025,046		1,025,046	14,353	1,039,399		8
	B. Health Care and Programs										
9	Medical Director			9,000	9,000		9,000		9,000		9
10	Nursing and Medical Records	1,822,724	192,678	72,948	2,088,350		2,088,350	17,407	2,105,757		10
10a	Therapy		217	730,093	730,310		730,310		730,310		10a
11	Activities	73,337	2,337	6,374	82,048		82,048	(509)	81,539		11
12	Social Services	57,829	10		57,839		57,839		57,839		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.							7,952	7,952		15
16	TOTAL Health Care and Programs	1,953,890	195,242	818,415	2,967,547		2,967,547	24,850	2,992,397		16
	C. General Administration										
17	Administrative	72,205		259,000	331,205		331,205	(205,567)	125,638		17
18	Directors Fees										18
19	Professional Services			9,866	9,866		9,866	14,909	24,775		19
20	Dues, Fees, Subscriptions & Promotions			12,738	12,738		12,738	985	13,723		20
21	Clerical & General Office Expenses	46,232	9,168	13,434	68,834		68,834	74,126	142,960		21
22	Employee Benefits & Payroll Taxes			345,009	345,009		345,009		345,009		22
23	Inservice Training & Education			231	231		231	790	1,021		23
24	Travel and Seminar			655	655		655	1,258	1,913		24
25	Other Admin. Staff Transportation			15,350	15,350		15,350	8,193	23,543		25
26	Insurance-Prop.Liab.Malpractice			33,772	33,772		33,772	1,854	35,626		26
27	Other (specify):* Home Off. Ben. All.							39,050	39,050		27
28	TOTAL General Administration	118,437	9,168	690,055	817,660		817,660	(64,402)	753,258		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,538,322	589,123	1,682,808	4,810,253		4,810,253	(25,199)	4,785,054		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 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			282,151	282,151		282,151	6,205	288,356			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			501,264	501,264		501,264	110,865	612,129			32
33	Real Estate Taxes			88,790	88,790		88,790	1,585	90,375			33
34	Rent-Facility & Grounds							97	97			34
35	Rent-Equipment & Vehicles			28,433	28,433		28,433	1,276	29,709			35
36	Other (specify):*											36
37	TOTAL Ownership			900,638	900,638		900,638	120,028	1,020,666			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		113,898		113,898		113,898		113,898			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			110,595	110,595		110,595		110,595			42
43	Other (specify):* Non-allowable Cost	39,381	1,582	157,379	198,342		198,342	(198,342)				43
44	TOTAL Special Cost Centers	39,381	115,480	267,974	422,835		422,835	(198,342)	224,493			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,577,703	704,603	2,851,420	6,133,726		6,133,726	(103,513)	6,030,213			45

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

**See schedule of adjustments attached at end of cost report.

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	(8,561)	2		4
5	Telephone, TV & Radio in Resident Rooms	(831)	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	(1,351)	30		9
10	Interest and Other Investment Income	(130)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,746)	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	(5,915)	43		18
19	Entertainment				19
20	Contributions	(250)	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	(125,240)	43		24
25	Fund Raising, Advertising and Promotional	(54,325)	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 Pg. 5A</u>	(12,577)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (210,926)		\$	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	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)	107,413	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 107,413		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (103,513)		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	Exceptional Care Program		x		44
45	Other-Attach Schedule		x		45
46	Other-Attach Schedule		x		46
47	TOTAL (C): (sum of lines 38-46)			\$	47

Timbercreek Rehabilitation & Health Care Center

ID# 0047522

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (14,146)	43	1
2	X-Rays-Part A	4,111	43	2
3	Offset Transportation Revenue	(244)	11	3
4	Offset Miscellaneous office supplies	(1,093)	21	4
5	Nonallowable Dues	(940)	20	5
6	Pet Expense	(265)	11	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(12,577)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Timbercreek Rehabilitation & Health Care Center# 0047522

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	4,052	0	5,697	0	0	0	0	0	0	0	9,749	1
2	Food Purchase	(8,561)	140	0	0	0	0	0	0	0	0	0	(8,421)	2
3	Housekeeping	0	46	0	0	0	0	0	0	0	0	0	46	3
4	Laundry	0	3	0	0	0	0	0	0	0	0	0	3	4
5	Heat and Other Utilities	0	692	0	0	0	0	0	0	0	0	0	692	5
6	Maintenance	0	5,644	0	39	0	0	0	0	0	0	0	5,683	6
7	Other (specify):*	0	1,849	0	4,752	0	0	0	0	0	0	0	6,601	7
8	TOTAL General Services	(8,561)	12,426	0	10,488	0	14,353	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	0	10,713	0	6,694	0	0	0	0	0	0	0	17,407	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(509)	0	0	0	0	0	0	0	0	0	0	(509)	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	2,382	0	5,570	0	0	0	0	0	0	0	7,952	15
16	TOTAL Health Care and Programs	(509)	13,095	0	12,264	0	24,850	16						
	C. General Administration													
17	Administrative	0	(228,840)	0	23,273	0	0	0	0	0	0	0	(205,567)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	8,187	0	6,722	0	0	0	0	0	0	0	14,909	19
20	Fees, Subscriptions & Promotions	(940)	0	1,774	151	0	0	0	0	0	0	0	985	20
21	Clerical & General Office Expenses	(1,093)	0	68,676	6,543	0	0	0	0	0	0	0	74,126	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	790	0	0	0	0	0	0	0	0	790	23
24	Travel and Seminar	0	0	1,257	1	0	0	0	0	0	0	0	1,258	24
25	Other Admin. Staff Transportation	0	0	4,555	3,638	0	0	0	0	0	0	0	8,193	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,854	0	0	0	0	0	0	0	0	1,854	26
27	Other (specify):*	0	0	19,637	19,413	0	0	0	0	0	0	0	39,050	27
28	TOTAL General Administration	(2,033)	(220,653)	98,543	59,741	0	(64,402)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(11,103)	(195,132)	98,543	82,493	0	(25,199)	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Timbercreek Rehabilitation & Health Care Center # 0047522 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	(1,351)	0	4,809	2,747	0	0	0	0	0	0	0	6,205	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(130)	0	8,359	102,636	0	0	0	0	0	0	0	110,865	32
33	Real Estate Taxes	0	0	1,585	0	0	0	0	0	0	0	0	1,585	33
34	Rent-Facility & Grounds	0	0	97	0	0	0	0	0	0	0	0	97	34
35	Rent-Equipment & Vehicles	0	0	1,276	0	0	0	0	0	0	0	0	1,276	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,481)	0	16,126	105,383	0	120,028	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):*	(198,342)	0	0	0	0	0	0	0	0	0	0	(198,342)	43
44	TOTAL Special Cost Centers	(198,342)	0	0	0	0	0	0	0	0	0	0	(198,342)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(210,926)	(195,132)	114,669	187,876	0	(103,513)	45						

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 4,052	\$ 4,052	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	140	140	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	46	46	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	3	3	4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	692	692	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	5,644	5,644	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,849	1,849	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	10,713	10,713	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%	2,382	2,382	10
11	V	17 Administrative	259,000	Petersen Health Care, Inc.	100.00%	30,160	(228,840)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	8,187	8,187	12
13	V							13
14	Total		\$ 259,000			\$ 63,868	\$ * (195,132)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	20 Dues, Fees, Subs and Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 1,774	\$ 1,774
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	68,676	68,676
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	790	790
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	1,257	1,257
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	4,555	4,555
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	1,854	1,854
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	19,637	19,637
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	4,809	4,809
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	8,359	8,359
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	1,585	1,585
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	97	97
26	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	1,276	1,276
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 114,669	\$ * 114,669

* 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	1 Dietary	\$	Petersen Health Operations, LLC	100.00%	\$	\$	5,697	15	
16	V	2 Food		Petersen Health Operations, LLC	100.00%			0	16	
17	V	3 Housekeeping		Petersen Health Operations, LLC	100.00%			0	17	
18	V	4 Laundry		Petersen Health Operations, LLC	100.00%			0	18	
19	V	5 Utilities		Petersen Health Operations, LLC	100.00%			0	19	
20	V	6 Maintenance		Petersen Health Operations, LLC	100.00%			39	20	
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%			4,752	21	
22	V	10 Nursing and Medical Records		Petersen Health Operations, LLC	100.00%			6,694	22	
23	V	10A Therapy		Petersen Health Operations, LLC	100.00%			0	23	
24	V	15 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%			5,570	24	
25	V	17 Administrative		Petersen Health Operations, LLC	100.00%			23,273	25	
26	V	19 Professional Services		Petersen Health Operations, LLC	100.00%			6,722	26	
27	V	20 Dues, Fees, Subs and Promotions		Petersen Health Operations, LLC	100.00%			151	27	
28	V	21 Clerical and General Office		Petersen Health Operations, LLC	100.00%			6,543	28	
29	V	23 Inservice Training and Education		Petersen Health Operations, LLC	100.00%			0	29	
30	V	24 Travel and Seminar		Petersen Health Operations, LLC	100.00%			1	30	
31	V	25 Other Admin. Staff Transportation		Petersen Health Operations, LLC	100.00%			3,638	31	
32	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Operations, LLC	100.00%			0	32	
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%			19,413	33	
34	V	30 Depreciation		Petersen Health Operations, LLC	100.00%			2,747	34	
35	V	32 Interest		Petersen Health Operations, LLC	100.00%			102,636	35	
36	V	33 Real Estate Taxes		Petersen Health Operations, LLC	100.00%			0	36	
37	V	34 Rent-Facility and Grounds		Petersen Health Operations, LLC	100.00%			0	37	
38	V	35 Rent-Equipment and Vehicles		Petersen Health Operations, LLC	100.00%			0	38	
39	Total		\$			\$	0	\$ *	187,876	39

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

Facility Name & ID Number Timbercreek Rehabilitation & Health Care # 0047522 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Petersen	President	Administrative	100.00	See Schedule 7A	1.99	3.61	Salary	\$ 30,160	L17, C7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 30,160		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 Timbercreek Rehabilitation & Health Care Center # 0047522 Report Period Beginning: 01/01/2007 Ending: 2/31/2007

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,316,550	66	\$ 110,171	\$ 109,587	48,417	\$ 4,052	1
2	2	Food	Resident Days	1,316,550	66	3,806	0	48,417	140	2
3	3	Housekeeping	Resident Days	1,316,550	66	1,250	0	48,417	46	3
4	4	Laundry	Resident Days	1,316,550	66	73	0	48,417	3	4
5	5	Utilities	Resident Days	1,316,550	66	18,812	0	48,417	692	5
6	6	Maintenance	Resident Days	1,316,550	66	153,468	113,063	48,417	5,644	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	50,271	0	48,417	1,849	7
8	10	Nursing and Medical Records	Resident Days	1,316,550	66	291,305	286,855	48,417	10,713	8
9	10A	Therapy	Resident Days	1,316,550	66	0	0	48,417	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	64,765	0	48,417	2,382	10
11	17	Administrative	Resident Days	1,316,550	66	820,116	820,116	48,417	30,160	11
12	19	Professional Services	Resident Days	1,316,550	66	222,628	0	48,417	8,187	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,316,550	66	48,243	0	48,417	1,774	13
14	21	Clerical and General Office	Resident Days	1,316,550	66	1,867,440	1,544,801	48,417	68,676	14
15	23	Inservice Training & Education	Resident Days	1,316,550	66	21,481	0	48,417	790	15
16	24	Travel and Seminar	Resident Days	1,316,550	66	34,177	0	48,417	1,257	16
17	25	Other Admin. Staff Transport.	Resident Days	1,316,550	66	123,847	0	48,417	4,555	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,316,550	66	50,427	0	48,417	1,854	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	533,953	0	48,417	19,637	19
20	30	Depreciation	Resident Days	1,316,550	66	130,767	0	48,417	4,809	20
21	32	Interest	Resident Days	1,316,550	66	227,295	0	48,417	8,359	21
22	33	Real Estate Taxes	Resident Days	1,316,550	66	43,090	0	48,417	1,585	22
23	34	Rent-Facility and Grounds	Resident Days	1,316,550	66	2,648	0	48,417	97	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,316,550	66	34,690	0	48,417	1,276	24
25	TOTALS					\$ 4,854,723	\$ 2,874,422		\$ 178,537	25

Facility Name & ID Number Timbercreek Rehabilitation & Health Care Center # 0047522 Report Period Beginning: 01/01/2007 Ending: 2/31/2007

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	440,525	23	\$ 51,832	\$ 51,832	48,417	\$ 5,697	1
2	2	Food	Resident Days	440,525	23			48,417		2
3	3	Housekeeping	Resident Days	440,525	23			48,417		3
4	4	Laundry	Resident Days	440,525	23			48,417		4
5	5	Utilities	Resident Days	440,525	23			48,417		5
6	6	Maintenance	Resident Days	440,525	23	358		48,417	39	6
7	7	Mgmt. Allocation of Benefits	Resident Days	440,525	23	43,237		48,417	4,752	7
8	10	Nursing and Medical Records	Resident Days	440,525	23	60,910	60,761	48,417	6,694	8
9	10A	Therapy	Resident Days	440,525	23			48,417		9
10	15	Mgmt. Allocation of Benefits	Resident Days	440,525	23	50,681		48,417	5,570	10
11	17	Administrative	Resident Days	440,525	23	211,751	211,751	48,417	23,273	11
12	19	Professional Services	Resident Days	440,525	23	61,162		48,417	6,722	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	440,525	23	1,373		48,417	151	13
14	21	Clerical and General Office	Resident Days	440,525	23	59,529		48,417	6,543	14
15	23	Inservice Training & Education	Resident Days	440,525	23			48,417		15
16	24	Travel and Seminar	Resident Days	440,525	23	10		48,417	1	16
17	25	Other Admin. Staff Transport.	Resident Days	440,525	23	33,098		48,417	3,638	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	440,525	23			48,417		18
19	27	Mgmt. Allocation of Benefits	Resident Days	440,525	23	176,624		48,417	19,413	19
20	30	Depreciation	Resident Days	440,525	23	24,996		48,417	2,747	20
21	32	Interest	Resident Days	440,525	23	933,842		48,417	102,636	21
22	33	Real Estate Taxes	Resident Days	440,525	23			48,417		22
23	34	Rent-Facility and Grounds	Resident Days	440,525	23			48,417		23
24	35	Rent-Equipment & Vehicles	Resident Days	440,525	23			48,417		24
25	TOTALS					\$ 1,709,403	\$ 324,344		\$ 187,876	25

Facility Name & ID Number Timbercreek Rehabilitation & Health Care C

0047522

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					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	LaSalle Bank		X	Mortgage	Varies	1/19/07	\$ 6,100,000	\$ 6,057,418	12/31/13	Varies	\$ 501,264	1				
2												2				
3							Offset Interest Income				(130)	3				
4							Home Office Allocation				110,995	4				
5												5				
Working Capital																
6												6				
7												7				
8												8				
9	TOTAL Facility Related						\$ 6,100,000	\$ 6,057,418			\$ 612,129	9				
B. Non-Facility Related*																
10												10				
11												11				
12												12				
13												13				
14	TOTAL Non-Facility Related						\$	\$			\$	14				
15	TOTALS (line 9+line14)						\$ 6,100,000	\$ 6,057,418			\$ 612,129	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 2006 report.				\$	80,400	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.)		2006		\$	83,190	2																			
3. Under or (over) accrual (line 2 minus line 1).				\$	2,790	3																			
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	86,000	4																			
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$		5																			
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.																									
					Home Office Allocation																				
TOTAL REFUND	\$	For	Tax Year.																						
				\$	1,585	6																			
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	90,375	7																			
Real Estate Tax History:																									
Real Estate Tax Bill for Calendar Year:	2002		8	<table border="1"> <tr> <td colspan="3">FOR BHF USE ONLY</td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2006</td> <td>\$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td>\$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6</td> <td>\$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td>\$</td> <td>16</td> </tr> </table>			FOR BHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2006	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
FOR BHF USE ONLY																									
13	FROM R. E. TAX STATEMENT FOR 2006	\$	13																						
14	PLUS APPEAL COST FROM LINE 5	\$	14																						
15	LESS REFUND FROM LINE 6	\$	15																						
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																						
	2003		9																						
	2004		10																						
	2005	80,316	11																						
	2006	83,190	12																						
Accrual based on prior year tax bill.																									

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2007 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Timbercreek Rehabilitation & Health Care Center COUNTY Tazewell

FACILITY IDPH LICENSE NUMBER 0047522

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 2006 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 2006.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>04-04-36-412-004</u>	<u>Long-Term Care Facility</u>	\$ <u>83,190.02</u>	\$ <u>83,190.02</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>83,190.02</u>	\$ <u>83,190.02</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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: 58,020 B. General Construction Type: Exterior Brick Frame Metal 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>334,995</u>	<u>2005</u>	<u>\$ 220,500</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	334,995		\$ 220,500	3

Facility Name & ID Number **Timbercreek Rehabilitation & Health Care Center**# **0047522**

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	202	2005	1974	\$ 4,040,000	\$	25	\$ 161,600	\$ 161,600	\$ 404,000	4
5										5
6										6
7	Home Office Allocation			26,993			659	659		7
8										8
	Improvement Type**									
9										9
10	Original Land Improvements		2005	15,000		15	1,000	1,000	2,500	10
11	Nurses Station		2006	33,290		25	1,332	1,332	1,998	11
12	J.C. Painting		2006	10,951		5	2,190	2,190	3,285	12
13	G-M Mechanical of Canton, Inc		2006	4,998		15	333	333	500	13
14	Sidewalks		2007	12,569		15	419	419	419	14
15	Carpeting		2007	2,909		5	291	291	291	15
16	Roof Top Air Conditioner		2007	2,500		15	83	83	83	16
17	Kitchen Suppression System		2007	2,701		15	90	90	90	17
18	Wiring for Generator-Nurses Station		2007	2,910		15	97	97	97	18
19	Remodel Hallways		2007	9,177		15	306	306	306	19
20	Generator		2007	20,130		15	671	671	671	20
21	Air Conditioner		2007	4,578		15	153	153	153	21
22										22
23										23
24										24
25										25
26	Land Impovement Booked				1,489			(1,489)		26
27	Building Booked				161,699			(161,699)		27
28	Building Improvement Booked				2,779			(2,779)		28
29										29
30				1,806			107	107		30
31	2007-Home Office Allocation-Building Improvements									31
32										32
33										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 Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 4,190,512	\$ 165,967		\$ 169,331	\$ 3,364	\$ 414,393	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 784,022	\$ 115,023	\$ 111,821	\$ (3,202)	7-10	\$ 283,872	71
72	Current Year Purchases	8,277	1,161	414	(747)	10	414	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			6,790	6,790			74
75	TOTALS	\$ 792,299	\$ 116,184	\$ 119,025	\$ 2,841		\$ 284,286	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,203,311	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 282,151	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 288,356	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 6,205	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 698,679	85

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

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

G. Construction-in-Progress

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

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

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

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		<u>Home Office Allocation</u>			<u>97</u>			6
7	TOTAL				\$ <u>97</u>			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: \$ 29,709 Description: See Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2008 \$ _____

13. _____ /2009 \$ _____

14. _____ /2010 \$ _____

* 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.

Timbercreek Rehabilitation & Health Care Center
0047522

Period Beginning 01/01/2007

Period End 12/31/2007

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Copier	\$ 7,240
Dishwasher	440
Maintenance Equipment	1,217
Medical Equipment	19,536
Home Office Allocation	<u>1,276</u>
	<u><u>29,709</u></u>

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L. 10A, C. 3	hrs	\$	22,123	\$ 331,851	\$	22,123	\$ 331,851	1
2	Licensed Speech and Language Development Therapist	L. 10A ,C. 3	hrs		3,841	57,621		3,841	57,621	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L. 10A, C. 2, 3	hrs		22,657	339,855	217	22,657	340,072	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L. 39, C. 2	# of prescrpts				113,898		113,898	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <u>Respiratory Therapy</u>				51	766		51	766	13
14	TOTAL			\$	48,672	\$ 730,093	\$ 114,115	48,672	\$ 844,208	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 Timbercreek Rehabilitation & Health Care Center

0047522

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,791,322	\$ 2,791,322	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>N/A</u>)	1,104,629	1,104,629	3
4	Supply Inventory (priced at <u> </u>)			4
5	Short-Term Investments			5
6	Prepaid Insurance	28,117	28,117	6
7	Other Prepaid Expenses	11,691	11,691	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u> </u>			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,935,759	\$ 3,935,759	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		220,500	13
14	Buildings, at Historical Cost	4,288,069	4,068,799	14
15	Leasehold Improvements, at Historical Cost	58,065	121,713	15
16	Equipment, at Historical Cost	812,429	792,299	16
17	Accumulated Depreciation (book methods)	(620,389)	(698,679)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): <u> </u>			22
23	Other(specify): <u> </u>			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,538,174	\$ 4,504,632	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,473,933	\$ 8,440,391	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 760,176	\$ 760,176	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	47,286	47,286	30
31	Accrued Taxes Payable (excluding real estate taxes)	14,095	14,095	31
32	Accrued Real Estate Taxes(Sch.IX-B)	86,000	86,000	32
33	Accrued Interest Payable	37,870	37,870	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Expenses</u>	43,790	43,790	36
37	<u> </u>			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 989,217	\$ 989,217	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	6,057,418	6,057,418	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Due to Prior Owner</u>	51,154	51,154	43
44	<u> </u>			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 6,108,572	\$ 6,108,572	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,097,789	\$ 7,097,789	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,376,144	\$ 1,342,602	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 8,473,933	\$ 8,440,391	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 731,599	1
2	Restatements (describe):		2
3	Post Cost Report Audit Adjustments	(12,927)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 718,672	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	657,472	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)	\$ 657,472	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)	\$ 1,376,144	24 *

* This must agree with page 17, line 47.

Timbercreek Rehabilitation & Health Care Center

0047522

Period Beginning 01/01/2007

Period End 12/31/2007

Schedule 18A

XVI. Statement of Changes in Equity

Beginning Equity Restatements:

Post Cost Report Audit Adjustments

After filing the previous year's State of Illinois Financial and Statistical Report for Long-Term Care Facilities, an adjustment was made to the facility's financial records to properly state bad debt expense. Therefore, an adjustment to the current year's beginning equity is necessary to reconcile the previous year's cost report equity to the current year's equity per books. After this adjustment, cost report equity agrees to book equity on Schedule XVI.

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	\$ 5,271,564	1
2	Discounts and Allowances for all Levels	49,529	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,321,093	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,127,009	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,127,009	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	5,313	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	282,381	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	32,715	20
21	Other Medical Services	17,972	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 338,381	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	130	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 130	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	<u>See Attached Schedule 19A</u>	4,585	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,585	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,791,198	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,025,046	31
32	Health Care	2,967,547	32
33	General Administration	817,660	33
	B. Capital Expense		
34	Ownership	900,638	34
	C. Ancillary Expense		
35	Special Cost Centers	312,240	35
36	Provider Participation Fee	110,595	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,133,726	40
41	Income before Income Taxes (line 30 minus line 40)**	657,472	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 657,472	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 a division of a 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.

Timbercreek Rehabilitation & Health Care Center
0047522

Period Beginning 01/01/2007

Period End 12/31/2007

Schedule 19A

XVII. INCOME STATEMENT

Line 28a - Other revenue

Vending	3,248
Transportation	244
Office Supplies	<u>1,093</u>
	<u><u>4,585</u></u>

Facility Name & ID Number Timbercreek Rehabilitation & Health Care Center

0047522

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

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	\$ 63,318	\$ 30.44	1
2	Assistant Director of Nursing	1,979	1,979	50,656	25.60	2
3	Registered Nurses	6,505	6,529	134,344	20.58	3
4	Licensed Practical Nurses	29,095	29,633	581,695	19.63	4
5	CNAs & Orderlies	82,960	84,554	879,467	10.40	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,218	2,370	35,178	14.84	9
10	Activity Assistants	2,651	2,814	27,245	9.68	10
11	Social Service Workers	4,023	4,191	57,829	13.80	11
12	Dietician					12
13	Food Service Supervisor	2,009	2,129	39,538	18.57	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,448	23,124	182,912	7.91	15
16	Dishwashers					16
17	Maintenance Workers	5,779	5,876	56,440	9.61	17
18	Housekeepers	15,625	16,015	129,747	8.10	18
19	Laundry	6,824	7,068	57,358	8.12	19
20	Administrator	2,057	2,057	72,205	35.10	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,788	3,905	46,232	11.84	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	2,297	2,297	29,150	12.69	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Sch 20A</u>	7,291	7,315	134,389	18.37	33
34	TOTAL (lines 1 - 33)	199,629	203,936	\$ 2,577,703 *	\$ 12.64	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	L. 9, C. 3	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 782	L. 10, C. 3	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 9,782		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	3,351 67,027	L. 10, C. 3	52
53	TOTAL (lines 50 - 52)	3,351 \$ 67,027		53

Timbercreek Rehabilitation & Health Care Center
 0047522
 Period Beginning 01/01/2007
 Period End 12/31/2007

Schedule 20A

XVIII. Staffing and Salary Costs
Line 32-Other

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	4,160	4,184	84,094	20.10
Marketing	2,167	2,167	39,381	18.17
Transportation	964	964	10,914	11.32
Total Line 32-Other	7,291	7,315	134,389	18.37

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	
Rebecca Maddalozzo	Adminstrator	0	\$ 40,981	Workers' Compensation Insurance	\$ 28,168	IDPH License Fee	\$ 995	
Tony Twardowski	Adminstrator	0	9,750	Unemployment Compensation Insurance	112,971	Advertising: Employee Recruitment	2,205	
Scott Bowles	Asst. Administrator	0	7,128	FICA Taxes	194,628	Health Care Worker Background Check	2,570	
Sally Strode	Adminstrator	0	14,346	Employee Health Insurance	3,060	(Indicate # of checks performed <u>257</u>)		
				Employee Meals		IHCA	2,043	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Subscriptions	2,688	
						Miscellaneous Licenses	637	
TOTAL (agree to Schedule V, line 17, col. 1)				Employee Retirement	663	LTC Solutions	1,600	
(List each licensed administrator separately.)			\$ 72,205	Employee Relations	5,519	Home Office Allocation	1,925	
B. Administrative - Other								
Description			Amount			Less: Public Relations Expense	(940)	
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 259,000			Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 259,000	TOTAL (agree to Schedule V, line 22, col.8)	\$ 345,009	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 13,723	
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount					
McGladrey & Pullen, LLP	Accounting		\$ 6,080				Out-of-State Travel	\$
E-Health Data Solutions	Computer Services		3,175					
Gallatin River Communications	Computer Services		611	N/A			In-State Travel	
							Seminar Expense	655
							Home Office Allocation	1,258
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 9,866				TOTAL	\$ 1,913

* Attach copy of IMRF notifications

**See instructions.

Timbercreek Rehabilitation & Health Care Center
0047522
Period Beginning 01/01/2007
Period End 12/31/2007

Schedule 21A

**XIX. SUPPORT SCHEDULE
C. Professional Services**

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		9,866

Non-allowable legal expense

**Home Office Allocation
Petersen Health Care, Inc**

Pearl & Associates	Legal	53
Addy Bush & Assoc	Legal	27
Registered Agent Solutions	Legal	5
Heyl, Royster, Voelker & Allen	Legal	119
Duane Morris	Legal	184
Ginoli & Co.	Accountants	1,872
RSM McGladrey	Accountants	324
McGladrey & Pullen	Accountants	494
Emdeon Business Services	Computer Services	129
Advanced Answers on Demand	Computer Services	3,472
Access 2 Go	Computer Services	262
Ivans	Computer Services	230
Kemper Technology	Computer Services	544
Adminastar Federal	Computer Services	68
Logmein	Computer Services	43
E-Health Data Solutions	Computer Services	340
Miscellaneous Vendors	Miscellaneous	21

Petersen Health Operations, LLC

Ginoli & Co.	Accountants	4,157
Julie Breedlove	Computer Services	40
Ivans	Computer Services	933
Miscellaneous Vendors	Computer Services	17
Amerisearch	Employment fees	1,575

Non-allowable Legal

Total (agree to Schedule V, line 19, column 8)	<u>24,775</u>
--	---------------

Timbercreek Rehabilitation & Health Care Center

0047522

Period Beginning 01/01/2007

Period End 12/31/2007

Schedule 21B

Travel and Seminar Detail

Month	Description	Amount	Location	Employee	Seminar Title
Aug-07	WCIAA Seminar	125.00	Rock Island, IL	Nathaniel Smith	Pioneer Program Conf.
September-07	IHCA Convention	745.00	Springfield, IL	Nathaniel Smith, Sandra Milnes, Julie Martin	Annual Conf.
October-07	Illinois Activity Professionals Conf.	260.00	Peoria, IL	Jeralynn Krause	Annual Conf.
October-07	Illinois Activity Professionals Conf.	<u>260.00</u>	Peoria, IL	Lucy Appenheimer	Annual Conf.
	Total - allowable travel & seminar	1,390.00			
	Allocation from Mgmt. Company-PHC	968.00			
	Allocation from Mgmt. Company-PHC II	<u>49.00</u>			
	Total Travel & Seminar (Sch. V., Line 24, Col.8)	<u><u>2,407.00</u></u>			

Facility Name & ID Number Timbercreek Rehabilitation & Health Care Center# 0047522Report Period Beginning: 01/01/2007Ending: 12/31/2007**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA \$2043
- (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. \$ 55,587 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. \$ 110,595
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 8,561
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? 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 & Co. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit currently in progress
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees