

Facility Name & ID Number Timbercreek Rehab & HCC

0047522 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	31,580	2,933	6,350	40,863	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,580	2,933	6,350	40,863	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 55.42%

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 10/1/05

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

YES Date 10/1/2005 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 5,039

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: 12/31/2013 Fiscal Year: 12/31/2013

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

Facility Name & ID Number

Timbercreek Rehab & HCC

0047522

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

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	207,181	26,925	1,578	235,684		235,684	8,052	243,736		1
2	Food Purchase		267,221		267,221		267,221	(3,911)	263,310		2
3	Housekeeping	185,717	44,032		229,749		229,749	80	229,829		3
4	Laundry	37,989	14,913		52,902		52,902		52,902		4
5	Heat and Other Utilities			127,041	127,041		127,041	611	127,652		5
6	Maintenance	59,416	16,036	31,553	107,005		107,005	3,944	110,949		6
7	Other (specify):* Home Off. Ben. All.							455	455		7
8	TOTAL General Services	490,303	369,127	160,172	1,019,602		1,019,602	9,231	1,028,833		8
	B. Health Care and Programs										
9	Medical Director			9,000	9,000		9,000		9,000		9
10	Nursing and Medical Records	1,886,067	225,753	11,343	2,123,163		2,123,163	(4,554)	2,118,609		10
10a	Therapy			792,776	792,776		792,776		792,776		10a
11	Activities	76,206	2	8,384	84,592		84,592	(6,881)	77,711		11
12	Social Services	30,188			30,188		30,188		30,188		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.										15
16	TOTAL Health Care and Programs	1,992,461	225,755	821,503	3,039,719		3,039,719	(11,435)	3,028,284		16
	C. General Administration										
17	Administrative			453,600	453,600		453,600	(380,492)	73,108		17
18	Directors Fees										18
19	Professional Services			15,216	15,216		15,216	213,684	228,900		19
20	Dues, Fees, Subscriptions & Promotions			6,438	6,438		6,438	2,276	8,714		20
21	Clerical & General Office Expenses	35,704	9,169	273,200	318,073		318,073	106,992	425,065		21
22	Employee Benefits & Payroll Taxes			391,079	391,079		391,079	(47)	391,032		22
23	Inservice Training & Education			350	350		350	161	511		23
24	Travel and Seminar							8	8		24
25	Other Admin. Staff Transportation			19,942	19,942		19,942	7,454	27,396		25
26	Insurance-Prop.Liab.Malpractice			74,193	74,193		74,193	1,440	75,633		26
27	Other (specify):* Home Off. Ben. All.							9,237	9,237		27
28	TOTAL General Administration	35,704	9,169	1,234,018	1,278,891		1,278,891	(39,287)	1,239,604		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,518,468	604,051	2,215,693	5,338,212		5,338,212	(41,491)	5,296,721		29

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

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

Facility Name & ID Number

Timbercreek Rehab & HCC

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Report Period Beginning:

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			214,157	214,157		214,157	1,853	216,010			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			164,291	164,291		164,291	32,763	197,054			32
33	Real Estate Taxes			113,499	113,499		113,499	648	114,147			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			87,696	87,696		87,696	1,192	88,888			35
36	Other (specify):*											36
37	TOTAL Ownership			579,643	579,643		579,643	36,456	616,099			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		319,577		319,577		319,577		319,577			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			323,106	323,106		323,106		323,106			42
43	Other (specify):* Non-allowable Costs		924	203,386	204,310		204,310	(204,310)				43
44	TOTAL Special Cost Centers		320,501	526,492	846,993		846,993	(204,310)	642,683			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,518,468	924,552	3,321,828	6,764,848		6,764,848	(209,345)	6,555,503			45

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

Timbercreek Rehab & HCC

ID# 0047522

Report Period Beginning: 1/1/2013

Ending: 12/31/2013

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (17,575)	43	1
2	X-Rays-Part A	(5,206)	43	2
3	Offset Transportation Revenue	(6,881)	11	3
4	Disallowed Special Events	130	43	4
5	Offset Miscellaneous Office Supplies Revenue	(452)	21	5
6	Disallowed Chamber of Commerce Dues	(500)	20	6
7	Disallowed Air Travel Expense	(959)	43	7
8	Offset Miscellaneous Nursing Supplies	(4,582)	10	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	(36,025)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Timbercreek Rehab & HCC# 0047522

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	8,052	0	0	0	0	0	0	0	0	0	8,052	1
2	Food Purchase	(4,083)	172	0	0	0	0	0	0	0	0	0	(3,911)	2
3	Housekeeping	0	80	0	0	0	0	0	0	0	0	0	80	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	611	0	0	0	0	0	0	0	0	0	611	5
6	Maintenance	0	3,944	0	0	0	0	0	0	0	0	0	3,944	6
7	Other (specify):*	0	455	0	0	0	0	0	0	0	0	0	455	7
8	TOTAL General Services	(4,083)	13,314	0	0	0	0	0	0	0	0	0	9,231	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	(4,582)	28	0	0	0	0	0	0	0	0	0	(4,554)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(6,881)	0	0	0	0	0	0	0	0	0	0	(6,881)	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	(11,463)	28	0	0	0	0	0	0	0	0	0	(11,435)	16
	C. General Administration													
17	Administrative	0	(380,492)	0	0	0	0	0	0	0	0	0	(380,492)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	16,976	0	196,708	0	0	0	0	0	0	0	213,684	19
20	Fees, Subscriptions & Promotions	(500)	0	1,079	1,697	0	0	0	0	0	0	0	2,276	20
21	Clerical & General Office Expenses	(452)	0	99,791	7,653	0	0	0	0	0	0	0	106,992	21
22	Employee Benefits & Payroll Taxes	0	0	0	(47)	0	0	0	0	0	0	0	(47)	22
23	Inservice Training & Education	0	0	161	0	0	0	0	0	0	0	0	161	23
24	Travel and Seminar	0	0	8	0	0	0	0	0	0	0	0	8	24
25	Other Admin. Staff Transportation	0	0	7,454	0	0	0	0	0	0	0	0	7,454	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,440	0	0	0	0	0	0	0	0	1,440	26
27	Other (specify):*	0	0	9,237	0	0	0	0	0	0	0	0	9,237	27
28	TOTAL General Administration	(952)	(363,516)	119,170	206,011	0	(39,287)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(16,498)	(350,174)	119,170	206,011	0	(41,491)	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Timbercreek Rehab & HCC# 0047522

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(5,212)	0	6,615	450	0	0	0	0	0	0	0	1,853	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(49,299)	0	11,004	71,058	0	0	0	0	0	0	0	32,763	32
33	Real Estate Taxes	0	0	648	0	0	0	0	0	0	0	0	648	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	1,192	0	0	0	0	0	0	0	0	1,192	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(54,511)	0	19,459	71,508	0	36,456	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):*	(204,310)	0	0	0	0	0	0	0	0	0	0	(204,310)	43
44	TOTAL Special Cost Centers	(204,310)	0	0	0	0	0	0	0	0	0	0	(204,310)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(275,319)	(350,174)	138,629	277,519	0	(209,345)	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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 8,052	\$ 8,052	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	172	172	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	80	80	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	611	611	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	3,944	3,944	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	455	455	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	28	28	8
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		10
11	V	17 Administrative	453,600	Petersen Health Care, Inc.	100.00%	73,108	(380,492)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	16,976	16,976	12
13	V							13
14	Total		\$ 453,600			\$ 103,426	\$ * (350,174)	14

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	20	Dues, Fees, Subs & Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 1,079	\$	1,079	15
16	V	21	Clerical and General Office		Petersen Health Care, Inc.	100.00%	99,791		99,791	16
17	V	23	Inservice Training & Education		Petersen Health Care, Inc.	100.00%	161		161	17
18	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	8		8	18
19	V	25	Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	7,454		7,454	19
20	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	1,440		1,440	20
21	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	9,237		9,237	21
22	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	6,615		6,615	22
23	V	32	Interest		Petersen Health Care, Inc.	100.00%	11,004		11,004	23
24	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	648		648	24
25	V	34	Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0		0	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	1,192		1,192	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			\$			\$ 138,629	\$ *	138,629	39

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

Facility Name & ID Number Timbercreek Rehab & HCC# 0047522Report Period Beginning: 1/1/2013Ending: 12/31/2013

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%	\$ 0	\$	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%	0		20	
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0		21	
22	V	10	Nursing and Medical Records		Petersen Health Operations, LLC	100.00%	0		22	
23	V	12	Social Services		Petersen Health Operations, LLC	100.00%	0		23	
24	V	17	Administrative		Petersen Health Operations, LLC	100.00%	0		24	
25	V	19	Professional Services		Petersen Health Operations, LLC	100.00%	196,708		196,708	25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Operations, LLC	100.00%	1,697		1,697	26
27	V	21	Clerical and General Office		Petersen Health Operations, LLC	100.00%	7,653		7,653	27
28	V	22	Employee Benefits & Payroll		Petersen Health Operations, LLC	100.00%	(47)		(47)	28
29	V	23	Inservice Training & Education		Petersen Health Operations, LLC	100.00%	0			29
30	V	24	Travel and Seminar		Petersen Health Operations, LLC	100.00%	0			30
31	V	25	Other Admin. Staff Transport.		Petersen Health Operations, LLC	100.00%	0			31
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Operations, LLC	100.00%	0			32
33	V	27	Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0			33
34	V	30	Depreciation		Petersen Health Operations, LLC	100.00%	450		450	34
35	V	32	Interest		Petersen Health Operations, LLC	100.00%	71,058		71,058	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 & Vehicles		Petersen Health Operations, LLC	100.00%	0			38
39	Total			\$			\$ 277,519	\$ *	277,519	39

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

Facility Name & ID Number

Timbercreek Rehab & HCC

0047522

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

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, L	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 System	Peoria	Mgmt/Bookkeeping	6
7			Bloomington Rehab & Health Care Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality	7
8			Casey Health Care Center	Casey	Petersen Restaurants,	Peoria	Restaurant	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Health Care V	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Care V	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care V	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care V	Peoria	Mgmt/Bookkeeping	13
14			Decatur Rehab & Health Care Center	Decatur	Petersen Health Care V	Peoria	Lessor	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Osage Beach,	Osage Beach, MO	Lessor	15
16			Eastview Terrace	Sullivan	Petersen West Frankfo	West Frankfort	Lessor	16
17			El Paso Health Care Center	El Paso	Midwest Health Care,	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Poplar Bluff Health Ca	Poplar Bluff, MO	Lessor	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Roseville, LL	Roseville	Lessor	19
20			Flanagan Rehab & Health Care Center	Flanagan				20
21			Flora Gardens Care Center	Flora				21
22			Flora Health Care Center	Flora				22
23			Fondulac Rehab & Health Care Center	East Peoria				23
24			Havana Health Care Center	Havana				24
25			Illini Heritage Rehab & Health Care	Champaign				25
26			Jonesboro Rehab & Health Care Center	Jonesboro				26
27			Kewanee Care Home	Kewanee				27
28			LaHarpe Davier Health Care Center	LaHarpe				28
29			Lebanon Care Center	Lebanon				29
30			Marigold Rehab & Health Care Center	Galesburg				30

Facility Name & ID Number

Timbercreek Rehab & HCC

0047522

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

VII. RELATED PARTIES

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

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

Facility Name & ID Number

Timbercreek Rehab & HCC

0047522

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

VII. RELATED PARTIES

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

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

Facility Name & ID Number

Timbercreek Rehab & HCC

#

0047522

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Timbercreek Rehab & HCC

0047522

Report Period Beginning:

1/1/2013

Ending: 2/31/2013

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,560,986	75	\$ 307,592	\$ 295,212	40,863	\$ 8,052	1
2	2	Food	Resident Days	1,560,986	75	6,577	0	40,863	172	2
3	3	Housekeeping	Resident Days	1,560,986	75	3,057	0	40,863	80	3
4	4	Laundry	Resident Days	1,560,986	75	0	0	40,863	0	4
5	5	Utilities	Resident Days	1,560,986	75	23,338	0	40,863	611	5
6	6	Maintenance	Resident Days	1,560,986	75	150,672	97,358	40,863	3,944	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,560,986	75	17,394	0	40,863	455	7
8	10	Nursing and Medical Records	Resident Days	1,560,986	75	1,082	0	40,863	28	8
9	10A	Therapy	Resident Days	1,560,986	75	0	0	40,863	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,560,986	75	0	0	40,863	0	10
11	17	Administrative	Resident Days	1,560,986	75	4,578,456	4,578,456	40,863	73,108	11
12	19	Professional Services	Resident Days	1,560,986	75	648,504	0	40,863	16,976	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,560,986	75	41,231	0	40,863	1,079	13
14	21	Clerical and General Office	Resident Days	1,560,986	75	3,812,055	3,383,297	40,863	99,791	14
15	23	Inservice Training & Education	Resident Days	1,560,986	75	6,148	0	40,863	161	15
16	24	Travel and Seminar	Resident Days	1,560,986	75	313	0	40,863	8	16
17	25	Other Admin. Staff Transport.	Resident Days	1,560,986	75	284,745	0	40,863	7,454	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,560,986	75	54,993	0	40,863	1,440	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,560,986	75	352,851	0	40,863	9,237	19
20	30	Depreciation	Resident Days	1,560,986	75	252,711	0	40,863	6,615	20
21	32	Interest	Resident Days	1,560,986	75	420,365	0	40,863	11,004	21
22	33	Real Estate Taxes	Resident Days	1,560,986	75	24,742	0	40,863	648	22
23	34	Rent-Facility and Grounds	Resident Days	1,560,986	75	0	0	40,863	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,560,986	75	45,546	0	40,863	1,192	24
25	TOTALS					\$ 11,032,372	\$ 8,354,323		\$ 242,055	25

Facility Name & ID Number Timbercreek Rehab & HCC

0047522

Report Period Beginning:

1/1/2013

Ending: 2/31/2013

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 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

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	408,598	21	\$	\$	40,863	\$	1
2	2	Food	Resident Days	408,598	21			40,863		2
3	3	Housekeeping	Resident Days	408,598	21			40,863		3
4	4	Laundry	Resident Days	408,598	21			40,863		4
5	5	Utilities	Resident Days	408,598	21			40,863		5
6	6	Maintenance	Resident Days	408,598	21			40,863		6
7	7	Mgmt. Allocation of Benefits	Resident Days	408,598	21			40,863		7
8	10	Nursing and Medical Records	Resident Days	408,598	21			40,863		8
9	12	Social Services	Resident Days	408,598	21			40,863		9
10	17	Administrative	Resident Days	408,598	21			40,863		10
11	19	Professional Services	Resident Days	408,598	21	1,966,927		40,863	196,708	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	408,598	21	16,972		40,863	1,697	12
13	21	Clerical and General Office	Resident Days	408,598	21	76,520		40,863	7,653	13
14	22	Employee Benefits & Payroll	Resident Days	408,598	21	(465)		40,863	(47)	14
15	23	Inservice Training & Education	Resident Days	408,598	21			40,863		15
16	24	Travel and Seminar	Resident Days	408,598	21			40,863		16
17	25	Other Admin. Staff Transport.	Resident Days	408,598	21			40,863		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	408,598	21			40,863		18
19	27	Mgmt. Allocation of Benefits	Resident Days	408,598	21			40,863		19
20	30	Depreciation	Resident Days	408,598	21	4,500		40,863	450	20
21	32	Interest	Resident Days	408,598	21	710,525		40,863	71,058	21
22	33	Real Estate Taxes	Resident Days	408,598	21			40,863		22
23	34	Rent-Facility and Grounds	Resident Days	408,598	21			40,863		23
24	35	Rent-Equipment & Vehicles	Resident Days	408,598	21			40,863		24
25	TOTALS					\$ 2,774,979	\$		\$ 277,519	25

Facility Name & ID Number

Timbercreek Rehab & HCC

0047522

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

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 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Bank of America		X	Mortgage	Varies	1/19/07	\$ 6,100,000	\$ 4,553,908	12/31/14	Varies	\$ 164,291	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$ 6,100,000	\$ 4,553,908			\$ 164,291	9
	B. Non-Facility Related*											
10												10
11											(49,299)	11
12											11,004	12
13											71,058	13
14	TOTAL Non-Facility Related						\$	\$			\$ 32,763	14
15	TOTALS (line 9+line14)						\$ 6,100,000	\$ 4,553,908			\$ 197,054	15

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

* 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 2012 report.			\$	100,020	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.)	2012		\$	105,183	2
3.	Under or (over) accrual (line 2 minus line 1).			\$	5,163	3
4.	Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	108,336	4
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		Home Office Allocation		648	6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	114,147	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2008	88,738	8		
		2009	91,195	9		
		2010	96,343	10		
		2011	97,105	11		
		2012	105,183	12		
Accrual based on prior year tax bill.						
		FOR BHF USE ONLY				
		13	FROM R. E. TAX STATEMENT FOR 2012	\$		13
		14	PLUS APPEAL COST FROM LINE 5	\$		14
		15	LESS REFUND FROM LINE 6	\$		15
		16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

NOTES:

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

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Timbercreek Rehab & HCC 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 2012 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 2012.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>04-04-36-412-004</u>	<u>Long-Term Care Facility</u>	\$ <u>105,182.96</u>	\$ <u>105,182.96</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>105,182.96</u></u>	\$ <u><u>105,182.96</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES 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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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.

Facility Name & ID Number Timbercreek Rehab & HCC

0047522

Report Period Beginning:

1/1/2013 Ending:

12/31/2013

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

N/A

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>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 Rehab & HCC# 0047522

Report Period Beginning:

1/1/2013

Ending:

12/31/2013**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	202		2005	1974	\$ 4,040,000	\$	25	\$ 161,600	\$ 161,600	\$ 1,373,600	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Original Land Improvements		2005		15,000		15	1,000	1,000	8,500	9
10	Nurses Station		2006		33,290		25	1,332	1,332	9,990	10
11	J.C. Painting		2006		10,951		5			10,951	11
12	G-M Mechanical of Canton, Inc		2006		4,998		15	333	333	2,498	12
13	Sidewalks		2007		12,569		15	838	838	5,447	13
14	Carpeting		2007		2,909		5			2,909	14
15	Roof Top Air Conditioner		2007		2,500		15	167	167	1,085	15
16	Kitchen Suppression System		2007		2,701		15	180	180	1,170	16
17	Wiring for Generator-Nurses Station		2007		2,910		15	194	194	1,261	17
18	Remodel Hallways		2007		9,177		15	612	612	3,978	18
19	Generator		2007		20,130		15	1,342	1,342	8,723	19
20	Air Conditioner		2007		4,578		15	305	305	3,020	20
21	Roof Repairs		2008		7,086		25	284	284	1,562	21
22	Rooftop Unit		2008		5,600		15	374	374	2,057	22
23	Painting of B & C Wings		2008		9,337		39	240	240	1,320	23
24	Grease Seperator		2008		6,127		7	876	876	4,818	24
25	Roof Repairs		2008		3,953		39	102	102	561	25
26	Water Heater		2008		9,500		5	950	950	9,500	26
27	Plumbing Repair		2008		6,013		20	300	300	1,650	27
28	Water & Drain Line		2008		6,200		39	158	158	869	28
29	Compressor Install (2)		2008		9,484		15	632	632	3,485	29
30	Roof Repairs		2008		2,607		15	174	174	957	30
31	Sprinkler System Installment		2009		130,800		25	5,232	5,232	23,544	31
32	Removal and Cap of Water Line		2009		5,692		7	814	814	3,663	32
33	Roof Installation		2009		78,359		20	3,918	3,918	17,631	33
34	Parking Lot Resurfacing		2009		52,100		15	3,474	3,474	15,633	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.

Facility Name & ID Number Timbercreek Rehab & HCC# 0047522

Report Period Beginning:

1/1/2013

Ending:

12/31/2013**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	3	4	5	6	7	8	9		
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Water Heater	2010	\$ 5,385	\$	10	\$ 538	\$ 538	\$ 1,883	37
38	Roof Replacement	2010	89,845		20	4,492	4,492	15,722	38
39	Water Filtration System	2011	3,636		7	520	520	1,300	39
40	Completion of 2010 Roof	2011	13,568		25	542	542	1,355	40
41	Nurses Station Remodel	2011	16,804		20	840	840	2,100	41
42	Air Conditioning Unit	2012	22,800		15	1,520	1,520	2,280	42
43	Call Station Repairs	2013	8,360		7	597	597	597	43
44	Water Heater	2013	5,782		7	413	413	413	44
45	Nurses Station Remodel Completion	2013	4,518		15	151	151	151	45
46	Patio and Sidewalk Replacement	2013	15,489		15	516	516	516	46
47	Roof Replacement	2013	160,330		25	3,207	3,207	3,207	47
48	Retaining Wall	2013	7,319		15	244	244	244	48
49	Alarm System Panel Replacement	2013	2,582		7	184	184	184	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	Land Improvements Booked						(5,311)		63
64	Building Booked						(161,699)		64
65	Building Improvement Booked						(35,623)		65
66									66
67	2013-Home Office Allocation-Building Improvements		19,214			461	461		67
68	2013-Home Office Allocation-Land Improvements		1,794			115	115		68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,871,997	\$ 202,633		\$ 199,771	\$ (2,862)	\$ 1,550,334	70

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

Facility Name & ID Number Timbercreek Rehab & HCC

0047522

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

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	\$ 67,614	\$ 8,264	\$ 6,761	\$ (1,503)	5-10 yrs.	\$ 29,639	71
72	Current Year Purchases	59,785	3,260	2,989	(271)	10 yrs.	2,989	72
73	Fully Depreciated Assets	779,782					779,782	73
74	Home Office Allocation			6,489	6,489			74
75	TOTALS	\$ 907,181	\$ 11,524	\$ 16,239	\$ 4,715		\$ 812,410	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	N/A									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)		\$ 5,999,678	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 214,157	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 216,010	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 1,853	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 2,362,744	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								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: \$ 72,286

Description: See Attached Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2006 Ford E250	\$ 578.17	\$ 6,936	17
18	Facility	2012 Ford E250	689.74	9,666	18
19					19
20					20
21	TOTAL		\$ #####	\$ 16,602	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. _____ /2014 \$ _____

13. _____ /2015 \$ _____

14. _____ /2016 \$ _____

* 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 Rehab & HCC

0047522

Period Beginning 1/1/2013

Period End 12/31/2013

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$ 58,390
Dishwasher	1,389
Natural Gas Tank	80
Copier	11,235
Home Office Allocation	1,192
	<u>72,286</u>

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs		\$	21,687	\$ 325,310	\$	21,687	\$ 325,310	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs			2,657	39,849		2,657	39,849	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	10A(3)	hrs			28,508	427,617		28,508	427,617	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39(2)	# of prescripts					319,577		319,577	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Other (specify):										12
13	Other (specify):										13
14	TOTAL				\$	52,852	\$ 792,776	\$ 319,577	52,852	\$ 1,112,353	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 Rehab & HCC

0047522

Report Period Beginning: 1/1/2013

Ending:

12/31/2013

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2013

(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	\$ 5,370,852	\$ 5,370,852	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>260,069</u>)	1,279,040	1,279,040	3
4	Supply Inventory (priced at _____)	23,194	23,194	4
5	Short-Term Investments			5
6	Prepaid Insurance	70,762	70,762	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Employee Loans, Sec Dep, PPD I</u>	10,533	10,533	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,754,381	\$ 6,754,381	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	300,169	220,500	13
14	Buildings, at Historical Cost	4,040,000	4,059,214	14
15	Leasehold Improvements, at Historical Cost	760,292	812,783	15
16	Equipment, at Historical Cost	907,181	907,181	16
17	Accumulated Depreciation (book methods)	(2,341,078)	(2,362,744)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,666,564	\$ 3,636,934	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 10,420,945	\$ 10,391,315	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,910,567	\$ 1,910,567	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	60,366	60,366	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,655	11,655	31
32	Accrued Real Estate Taxes(Sch.IX-B)	108,336	108,336	32
33	Accrued Interest Payable	12,425	12,425	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Payroll Withholdings</u>	92,119	92,119	36
37	<u>Accrued Management Fees</u>	242,654	242,654	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,438,122	\$ 2,438,122	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	4,553,908	4,553,908	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Intercompany Loans</u>	3,010,735	3,010,735	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 7,564,643	\$ 7,564,643	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 10,002,765	\$ 10,002,765	46
47	TOTAL EQUITY(page 18, line 24)	\$ 418,180	\$ 388,550	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 10,420,945	\$ 10,391,315	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 668,057	1
2	Restatements (describe):		2
3	Rounding	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 668,056	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(249,876)	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)	\$ (249,876)	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)	\$ 418,180	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Timbercreek Rehab & HCC

0047522

Report Period Beginning: 1/1/2013

Ending: 12/31/2013

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

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,703,688	1
2	Discounts and Allowances for all Levels	(962,429)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,741,259	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,230,077	6
7	Oxygen	952	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,231,029	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	4,083	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	435,866	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	22,100	20
21	Other Medical Services	19,421	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 481,470	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	49,299	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 49,299	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Revenue</u>	5,034	28
28a	<u>Transportation Revenue</u>	6,881	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 11,915	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,514,972	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,019,602	31
32	Health Care	3,039,719	32
33	General Administration	1,278,891	33
B. Capital Expense			
34	Ownership	579,643	34
C. Ancillary Expense			
35	Special Cost Centers	523,887	35
36	Provider Participation Fee	323,106	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,764,848	40
41	Income before Income Taxes (line 30 minus line 40)**	(249,876)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (249,876)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 3,393,348	44
45	Private Pay - Net Inpatient Revenue	430,948	45
46	Medicare - Net Inpatient Revenue	839,928	46
47	Other-(specify) <u>Veterans -Net Patient Revenue</u>	84,967	47
48	Other-(specify) <u>Charity Contractual Allowance</u>	(7,932)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,741,259	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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 **Timbercreek Rehab & HCC**

0047522

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

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	65,406	\$ 31.45	1
2	Assistant Director of Nursing	3,317	3,381	86,081	25.46	2
3	Registered Nurses	2,966	3,068	87,962	28.67	3
4	Licensed Practical Nurses	27,188	28,072	596,817	21.26	4
5	CNAs & Orderlies	72,702	75,340	961,252	12.76	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,730	2,023	34,048	16.83	9
10	Activity Assistants	1,268	1,376	19,720	14.33	10
11	Social Service Workers	1,987	2,059	30,188	14.66	11
12	Dietician					12
13	Food Service Supervisor	1,993	1,993	35,843	17.98	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,365	17,849	171,338	9.60	15
16	Dishwashers					16
17	Maintenance Workers	3,601	3,624	59,416	16.40	17
18	Housekeepers	16,583	18,992	185,717	9.78	18
19	Laundry	3,832	4,064	37,989	9.35	19
20	Administrator	2,080	2,080	73,108	35.15	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,089	2,318	35,704	15.40	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 C: CPC	3,987	3,987	88,549	22.21	32
33	Other(specify) <u>Transportation</u>	1,800	1,800	22,438	12.47	33
34	TOTAL (lines 1 - 33)	166,568	174,106	\$ 2,591,576 *	\$ 14.89	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	32	\$ 1,578	L1, C3	35
36	Medical Director	Monthly	9,000	L9, C3	36
37	Medical Records Consultant	2	100	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	8,137	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	2	110	L10, 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)	36	\$ 18,925		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	58	1,290	L10, C3	51
52	Certified Nurse Assistants/Aides			52	
53	TOTAL (lines 50 - 52)	58	\$ 1,290		53

Timbercreek Rehab & HCC**0047522****Period Beginning****1/1/2013****Period End****12/31/2013****Schedule 21A****XIX. SUPPORT SCHEDULE****C. Professional Services**

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		15,216
Home Office Allocation		
SmithAmundsen	Legal	1009
Cole, Schotz, Meisel	Legal	556
Black, Hedin, Ballard	Legal	50
Elias, Meginnes, Riffle & Seghetti	Legal	101
Miller, Hall, and Triggs	Legal	2124
Evapar	Legal	409
Ginoli & Company	Accountants	5842
E-Health Data Solutions	Computer Services	7266
Miscellaneous	Computer Services	157
Odessian LLC	Computer Services	79
CCH	Computer Services	23
Lexis-Nexis	Computer Services	9
Ipanema Solutions	Computer Services	21
Macquarie Technology Services	Computer Services	144
Advanced Answers on Demand	Computer Services	7472
TeamViewer	Computer Services	24
Stratus Networks	Computer Services	603
Kemper Technology	Computer Services	466
AT&T	Computer Services	8
Medifax	Computer Services	67
Vision Share/Ability Network	Computer Services	1023
Barracuda	Computer Services	184
CIAN	Computer Services	246
Comcast	Computer Services	55
Emdeon	Computer Services	82
Marotta Gund Budd & Dzera	Other Prof Fees	182401
David Budde	Other Prof Fees	48
Pharmacy Price Mangement	Other Prof Fees	941
All Scripts	Other Prof Fees	1675
Registered Agent Solutions	Other Prof Fees	79
Healthink	Other Prof Fees	520

Total (agree to Schedule V, line 19, column 8)

228,900

Facility Name & ID Number Timbercreek Rehab & HCC# 0047522

Report Period Beginning:

1/1/2013

Ending:

12/31/2013**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 34,345 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. \$ 323,106
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 benefit on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 4,083
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 6,881
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Company
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? No
Attach invoices and a summary of services for all architect and appraisal fees