

Facility Name & ID Number Timbercreek Rehab Hlth C Ctr

0047522 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	20,167	1,900	3,596	25,663	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,167	1,900	3,596	25,663	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 34.81%

D. How many bed reserve days during this year were paid by the Department? None (Do not include bed reserve 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 10/1/2005

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 3,045

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: 12/31/2020 Fiscal Year: 12/31/2020

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

Facility Name & ID Number Timbercreek Rehab Hlth C Ctr # 0047522 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	205,821	43,570	623	250,014		250,014	6,833	256,847		1
2	Food Purchase		196,037		196,037		196,037	(9,283)	186,754		2
3	Housekeeping	186,299	35,169		221,468		221,468	132	221,600		3
4	Laundry	38,714	9,741		48,455		48,455		48,455		4
5	Heat and Other Utilities			136,093	136,093		136,093	467	136,560		5
6	Maintenance	44,844	10,123	45,081	100,048		100,048	10,798	110,846		6
7	Other (specify):*										7
8	TOTAL General Services	475,678	294,640	181,797	952,115		952,115	8,947	961,062		8
	B. Health Care and Programs										
9	Medical Director			9,000	9,000		9,000		9,000		9
10	Nursing and Medical Records	1,500,246	132,638	844,907	2,477,791		2,477,791	3,325	2,481,116		10
10a	Therapy			343,610	343,610		343,610		343,610		10a
11	Activities	111,117	447	(1,600)	109,964		109,964	(1,652)	108,312		11
12	Social Services	20,636			20,636		20,636		20,636		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,631,999	133,085	1,195,917	2,961,001		2,961,001	1,673	2,962,674		16
	C. General Administration										
17	Administrative	80,004		283,700	363,704		363,704	(245,698)	118,006		17
18	Directors Fees										18
19	Professional Services			157,994	157,994		157,994	26,989	184,983		19
20	Dues, Fees, Subscriptions & Promotions			4,679	4,679		4,679	3,498	8,177		20
21	Clerical & General Office Expenses	48,550	4,347	24,246	77,143		77,143	45,026	122,169		21
22	Employee Benefits & Payroll Taxes			252,624	252,624		252,624	27,656	280,280		22
23	Inservice Training & Education							70	70		23
24	Travel and Seminar							22	22		24
25	Other Admin. Staff Transportation			10,582	10,582		10,582	4,895	15,477		25
26	Insurance-Prop.Liab.Malpractice			78,214	78,214		78,214	41,722	119,936		26
27	Other (specify):*										27
28	TOTAL General Administration	128,554	4,347	812,039	944,940		944,940	(95,820)	849,120		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,236,231	432,072	2,189,753	4,858,056		4,858,056	(85,200)	4,772,856		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 Hlth C Ctr

#0047522

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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			9,546	9,546		9,546	257,290	266,836			30
31	Amortization of Pre-Op. & Org.							8,361	8,361			31
32	Interest							150,162	150,162			32
33	Real Estate Taxes							93,407	93,407			33
34	Rent-Facility & Grounds			405,843	405,843		405,843	(405,843)				34
35	Rent-Equipment & Vehicles			23,830	23,830		23,830	13,739	37,569			35
36	Other (specify):*											36
37	TOTAL Ownership			439,219	439,219		439,219	117,116	556,335			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		80,925		80,925		80,925		80,925			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			234,659	234,659		234,659		234,659			42
43	Other (specify):*		102	146,196	146,298		146,298	(146,298)				43
44	TOTAL Special Cost Centers		81,027	380,855	461,882		461,882	(146,298)	315,584			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,236,231	513,099	3,009,827	5,759,157		5,759,157	(114,382)	5,644,775			45

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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(9,283)	2		4
5	Telephone, TV & Radio in Resident Rooms	(17,449)	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	14,638	30		9
10	Interest and Other Investment Income	(26)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(834)	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	(64,693)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(47,000)	43		24
25	Fund Raising, Advertising and Promotional	(1,235)	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	(173,377)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (299,259)		\$	30

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)	184,877	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 184,877		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (114,382)		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.			\$	38
39					39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY							
48		49		50		51	

Timbercreek Rehab Hlth C Ctr

ID# 0047522

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (10,325)	43	1
2	X-Rays-Part A	(5,025)	43	2
3	Offset Transportation Revenue	(1,652)	11	3
4	Offset Miscellaneous Office Supplies Revenue	(170)	21	4
5	Special Events	263	43	5
6	Offset Miscellaneous Nursing Supplies	(6,468)	10	6
7	Non-Allowable Legal Settlement	(150,000)	19	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
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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	(173,377)		49

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	1 Dietary	\$	Petersen Health Care Management, Inc.	100.00%	\$ 6,833	\$ 6,833	1
2	V	2 Food		Petersen Health Care Management, Inc.	100.00%	0		2
3	V	3 Housekeeping		Petersen Health Care Management, Inc.	100.00%	132	132	3
4	V	5 Utilities		Petersen Health Care Management, Inc.	100.00%	467	467	4
5	V	6 Maintenance		Petersen Health Care Management, Inc.	100.00%	4,104	4,104	5
6	V	7 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		6
7	V	9 Medical Director		Petersen Health Care Management, Inc.	100.00%	0		7
8	V	10 Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	6,403	6,403	8
9	V	10A Therapy		Petersen Health Care Management, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		10
11	V	17 Administrative	283,700	Petersen Health Care Management, Inc.	100.00%	38,002	(245,698)	11
12	V	19 Professional Services		Petersen Health Care Management, Inc.	100.00%	22,447	22,447	12
13	V							13
14	Total		\$ 283,700			\$ 78,388	\$ * (205,312)	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 Management, Inc.	100.00%	\$ 3,498	\$	3,498	15
16	V	21 Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	42,369		42,369	16
17	V	22 Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	11,631		11,631	17
18	V	23 Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	70		70	18
19	V	24 Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	22		22	19
20	V	25 Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	4,895		4,895	20
21	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	746		746	21
22	V	30 Depreciation		Petersen Health Care Management, Inc.	100.00%	6,917		6,917	22
23	V	31 Amortization		Petersen Health Care Management, Inc.	100.00%	0		0	23
24	V	32 Interest		Petersen Health Care Management, Inc.	100.00%	337		337	24
25	V	33 Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	269		269	25
26	V	35 Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	2,481		2,481	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		\$			\$ 73,235	\$ *	73,235	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	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%	3,390	3,390	22
23	V	15 Mgmt. Allocation of Benefits		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%	147,837	147,837	25
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Operations, LLC	100.00%	0		26
27	V	21 Clerical and General Office		Petersen Health Operations, LLC	100.00%	0		27
28	V	22 Employee Benefits & Payroll		Petersen Health Operations, LLC	100.00%	16,025	16,025	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	30 Depreciation		Petersen Health Operations, LLC	100.00%	0		33
34	V	31 Amortization		Petersen Health Operations, LLC	100.00%	0		34
35	V	32 Interest		Petersen Health Operations, LLC	100.00%	11,417	11,417	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%	11,258	11,258	38
39	Total		\$			\$ 189,927	\$ *	189,927 39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	6 Maintenance	\$	Timbercreek Land, LLC	100.00%	\$ 6,694	\$ 6,694
16	V	19 Professional Services	\$	Timbercreek Land, LLC	100.00%	6,705	6,705
17	V	21 Equipment		Timbercreek Land, LLC	100.00%	2,827	2,827
18	V	26 Insurance-Property		Timbercreek Land, LLC	100.00%	16,639	16,639
19	V	26 Insurance-Mortgage Insurance		Timbercreek Land, LLC	100.00%	24,337	24,337
20	V	30 Depreciation		Timbercreek Land, LLC	100.00%	235,735	235,735
21	V	31 Amortization		Timbercreek Land, LLC	100.00%	8,361	8,361
22	V	32 Interest	544	Timbercreek Land, LLC	100.00%	138,978	138,434
23	V	33 Real Estate Taxes		Timbercreek Land, LLC	100.00%	93,138	93,138
24	V	34 Rent-Income and Grounds	405,843	Timbercreek Land, LLC	100.00%		(405,843)
25	V						
26	V						
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		\$ 406,387			\$ 533,414	\$ * 127,027

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

Facility Name & ID Number

Timbercreek Rehab Hlth C Ctr

0047522

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

VII. RELATED PARTIES

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

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

Facility Name & ID Number

Timbercreek Rehab Hlth C Ctr

0047522

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

VII. RELATED PARTIES

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

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

Facility Name & ID Number

Timbercreek Rehab Hlth C Ctr

0047522

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

VII. RELATED PARTIES

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

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

Facility Name & ID Number

Timbercreek Rehab Hlth C Ctr

0047522

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

VII. RELATED PARTIES

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

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

Facility Name & ID Number Timbercreek Rehab Hlth C Ctr # 0047522 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Timbercreek Rehab Hlth C Ctr

0047522

Report Period Beginning:

1/1/2020

Ending: 2/31/2020

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 Management, Inc.
 Street Address 830 W. Trailcreek Drive
 City / State / Zip Code Peoria, IL 61614
 Phone Number (309) 691-8113
 Fax Number (309) 691-8622

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	1,282,791	75	\$ 341,562	\$ 398,718	25,663	\$ 6,833	1
2	2	Food	Resident Days	1,282,791	75	0	0	25,663	0	2
3	3	Housekeeping	Resident Days	1,282,791	75	6,607	3,056	25,663	132	3
4	5	Utilities	Resident Days	1,282,791	75	23,320	0	25,663	467	4
5	6	Maintenance	Resident Days	1,282,791	75	205,132	187,746	25,663	4,104	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,282,791	75	0	0	25,663	0	6
7	9	Medical Director	Resident Days	1,282,791	75	0	0	25,663	0	7
8	10	Nursing and Medical Records	Resident Days	1,282,791	75	320,057	736,064	25,663	6,403	8
9	10A	Therapy	Resident Days	1,282,791	75	0	0	25,663	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,282,791	75	0	0	25,663	0	10
11	17	Administrative	Resident Days	1,282,791	75	1,899,565	7,673,667	25,663	38,002	11
12	19	Professional Services	Resident Days	1,282,791	75	1,122,028	0	25,663	22,447	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,282,791	75	174,863	0	25,663	3,498	13
14	21	Clerical and General Office	Resident Days	1,282,791	75	2,117,880	2,195,755	25,663	42,369	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,282,791	75	581,393	0	25,663	11,631	15
16	23	Inservice Training & Education	Resident Days	1,282,791	75	3,513	0	25,663	70	16
17	24	Travel and Seminar	Resident Days	1,282,791	75	1,094	0	25,663	22	17
18	25	Other Admin. Staff Transport.	Resident Days	1,282,791	75	244,700	0	25,663	4,895	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,282,791	75	37,297	0	25,663	746	19
20	30	Depreciation	Resident Days	1,282,791	75	345,756	0	25,663	6,917	20
21	31	Amortization	Resident Days	1,282,791	75	0	0	25,663	0	21
22	32	Interest	Resident Days	1,282,791	75	16,842	0	25,663	337	22
23	33	Real Estate Taxes	Resident Days	1,282,791	75	13,451	0	25,663	269	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,282,791	75	124,017	0	25,663	2,481	24
25	TOTALS					\$ 7,579,077	\$ 11,195,006		\$ 151,623	25

Facility Name & ID Number Timbercreek Rehab Hlth C Ctr

0047522

Report Period Beginning:

1/1/2020

Ending: 2/31/2020

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	163,986	9	\$	\$	25,663	\$	1
2	2	Food	Resident Days	163,986	9			25,663		2
3	3	Housekeeping	Resident Days	163,986	9			25,663		3
4	4	Laundry	Resident Days	163,986	9			25,663		4
5	5	Utilities	Resident Days	163,986	9			25,663		5
6	6	Maintenance	Resident Days	163,986	9			25,663		6
7	7	Mgmt. Allocation of Benefits	Resident Days	163,986	9			25,663		7
8	10	Nursing and Medical Records	Resident Days	163,986	9	21,660		25,663	3,390	8
9	15	Mgmt. Allocation of Benefits	Resident Days	163,986	9			25,663		9
10	17	Administrative	Resident Days	163,986	9			25,663		10
11	19	Professional Services	Resident Days	163,986	9	944,677		25,663	147,837	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	163,986	9			25,663		12
13	21	Clerical and General Office	Resident Days	163,986	9			25,663		13
14	22	Employee Benefits & Payroll	Resident Days	163,986	9	102,400		25,663	16,025	14
15	23	Inservice Training & Education	Resident Days	163,986	9			25,663		15
16	24	Travel and Seminar	Resident Days	163,986	9			25,663		16
17	25	Other Admin. Staff Transport.	Resident Days	163,986	9			25,663		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	163,986	9			25,663		18
19	30	Depreciation	Resident Days	163,986	9			25,663		19
20	31	Amortization	Resident Days	163,986	9			25,663		20
21	32	Interest	Resident Days	163,986	9	72,956		25,663	11,417	21
22	33	Real Estate Taxes	Resident Days	163,986	9			25,663		22
23	34	Rent-Facility and Grounds	Resident Days	163,986	9			25,663		23
24	35	Rent-Equipment & Vehicles	Resident Days	163,986	9	71,940		25,663	11,258	24
25	TOTALS					\$ 1,213,633	\$		\$ 189,927	25

Facility Name & ID Number

Timbercreek Rehab Hlth C Ctr

0047522

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	Capital Finance		X	Mortgage	Varies	9/15/14	\$ 4,222,400	\$ 3,701,479	12/31/34	Varies	\$ 138,978	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6												6						
7												7						
8												8						
9	TOTAL Facility Related						\$ 4,222,400	\$ 3,701,479			\$ 138,978	9						
B. Non-Facility Related*																		
10									Interest Income Offset		(570)	10						
11									Home Office Allocation-PHCM		337	11						
12									Home Office Allocation-PHO		11,417	12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ 11,184	14						
15	TOTALS (line 9+line14)						\$ 4,222,400	\$ 3,701,479			\$ 150,162	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 24,337 Line # 26

* 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.)

2019 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 MIKE KOCHER

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2019 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 2019.

(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>90,750.06</u>	\$ <u>90,750.06</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>90,750.06</u></u>	\$ <u><u>90,750.06</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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 Hlth C Ctr

0047522 Report Period Beginning:

1/1/2020 Ending:

12/31/2020

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: 250,839 2. Number of Years Over Which it is Being Amortized: 30
3. Current Period Amortization: 8,361 4. Dates Incurred: 2013-2014

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

XI. OWNERSHIP COSTS:

	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

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	\$ 4,349,448	\$	25	\$ 173,978	\$ 173,978	\$ 2,541,934	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Nurses Station		2006	33,290		25	1,332	1,332	19,314	9
10	J.C. Painting		2006	10,951		5			10,951	10
11	G-M Mechanical of Canton, Inc		2006	4,998		15	333	333	4,829	11
12	Sidewalks		2007	12,569		15	838	838	11,313	12
13	Carpeting		2007	2,909		5			2,909	13
14	Roof Top Air Conditioner		2007	2,500		15	167	167	2,254	14
15	Kitchen Suppression System		2007	2,701		15	180	180	2,430	15
16	Wiring for Generator-Nurses Station		2007	2,910		15	194	194	2,619	16
17	Remodel Hallways		2007	9,177		15	612	612	8,262	17
18	Generator		2007	20,130		15	1,342	1,342	18,117	18
19	Air Conditioner		2007	4,578		15			4,578	19
20	Roof Repairs		2008	7,086		25	284	284	3,550	20
21	Rooftop Unit		2008	5,600		15	374	374	4,675	21
22	Painting of B & C Wings		2008	9,337		39	240	240	3,000	22
23	Grease Seperator		2008	6,127		7			6,127	23
24	Roof Repairs		2008	3,953		39	102	102	1,275	24
25	Water Heater		2008	9,500		5			9,500	25
26	Plumbing Repair		2008	6,013		20	300	300	3,750	26
27	Water & Drain Line		2008	6,200		39	158	158	1,975	27
28	Compressor Install (2)		2008	9,484		15	632	632	7,909	28
29	Roof Repairs		2008	2,607		15	174	174	2,175	29
30	Sprinkler System Installment		2009	130,800		25	5,232	5,232	60,168	30
31	Removal and Cap of Water Line		2009	5,692		7			5,692	31
32	Roof Installation		2009	78,359		20	3,918	3,918	45,057	32
33	Parking Lot Resurfacing		2009	52,100		15	3,474	3,474	39,951	33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Timbercreek Rehab Hlth C Ctr

0047522

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Water Heater	2010	\$ 5,385	\$	10	\$ 274	\$ 274	\$ 5,385	37
38	Roof Replacement	2010	89,845		20	4,492	4,492	47,166	38
39	Water Filtration System	2011	3,636		7			3,636	39
40	Completion of 2010 Roof	2011	13,568		25	542	542	5,149	40
41	Nurses Station Remodel	2011	16,804		20	840	840	7,980	41
42	Air Conditioning Unit	2012	22,800		15	1,520	1,520	12,920	42
43	Call Station Repairs	2013	8,360		7	599	599	8,360	43
44	Water Heater	2013	5,782		7	413	413	5,782	44
45	Nurses Station Remodel Completion	2013	4,518		15	302	302	2,265	45
46	Patio and Sidewalk Replacement	2013	15,489		15	1,032	1,032	7,740	46
47	Roof Replacement	2013	160,330		25	6,414	6,414	48,105	47
48	Retaining Wall	2013	7,319		15	488	488	3,660	48
49	Alarm System Panel Replacement	2013	2,582		7	190	190	2,582	49
50	A/C Unit Rooftop	2014	7,690		15	513	513	3,335	50
51	Nurse Station Replacement	2014	15,741		15	1,049	1,049	6,819	51
52	A/C Unit	2014	6,550		15	437	437	2,841	52
53	Water Heater	2015	6,520		7	932	932	5,126	53
54	Water Heater-100 Gallon	2017	4,653		7	664	664	2,324	54
55	Door Alarm Repair	2017	3,060		7	438	438	1,533	55
56	Rewiring for Bathroom Remodel	2017	29,135		7	4,162	4,162	14,567	56
57	Concrete Replacement-North & South Side	2017	13,461		15	898	898	3,143	57
58	Tiling-Utility Room, Bathroom, Shower Room, Nurses Station	2017	116,094		15	7,740	7,740	27,090	58
59	Plumbing Pipe and Toilet Replacements-6 Bathrooms	2017	16,960		15	1,131	1,131	4,077	59
60	Front Entry Door	2018	4,699		7	672	672	1,680	60
61	Plumbing Repair in Bathroom	2019	4,756		7	680	680	1,020	61
62	Water Softener System	2019	16,804		7	2,402	2,402	3,603	62
63	Asphalt Resurfacing	2019	24,865		15	1,658	1,658	2,487	63
64	Heat Exchanger	2019	4,525		15	302	302	453	64
65	Water Pipe Replacement	2019	4,468		7	638	638	957	65
66	Water Heater	2019	13,929		7	1,990	1,990	2,985	66
67	Water Line Repair	2019	3,480		7	498	498	747	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,442,827	\$		\$ 237,774	\$ 237,774	\$ 3,069,831	70

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,442,827	\$		\$ 237,774	\$ 237,774	\$ 3,069,831	1
2	Boiler Repair	2020	5,312		7	379	379	379	2
3	Generators Repair	2020	4,790		7	342	342	342	3
4	Flooring Installation	2020	13,000		10	650	650	650	4
5	Tiling in Bathrooms	2020	3,250		10	163	163	163	5
6	Boiler Repair	2020	3,473		7	496	496	496	6
7	Door Alarm Repair	2020	3,571		7	255	255	255	7
8	Plumbing Repair	2020	4,348		7	311	311	311	8
9	HVAC Repair	2020	3,148		7	225	225	225	9
10	HVAC In Front Of	2020	17,983		15	599	599	599	10
11	Water Heater	2020	9,255		7	661	661	661	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21	Land Improvements Booked			5,583			(5,583)		21
22	Building Booked			161,699			(161,699)		22
23	Building Improvement Booked			63,570			(63,570)		23
24									24
25	2020-Home Office Allocation-Building Improvements		12,976			311	311		25
26	2020-Home Office Allocation-Land Improvements		1,302			82	82		26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,525,235	\$ 230,852		\$ 242,248	\$ 11,396	\$ 3,073,912	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 143,831	\$ 13,112	\$ 16,581	\$ 3,469	5-10 yrs.	\$ 97,213	71
72	Current Year Purchases	20,761	1,317	1,483	166	7 yrs.	1,483	72
73	Fully Depreciated Assets	818,170					818,170	73
74	Home Office Allocation			6,524	6,524			74
75	TOTALS	\$ 982,762	\$ 14,429	\$ 24,588	\$ 10,159		\$ 916,866	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,728,497	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 245,281	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 266,836	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 21,555	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,990,778	85

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

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

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

Facility Name & ID Number Timbercreek Rehab Hlth C Ctr

0047522

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

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

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.	_____ /2021	\$ _____
13.	_____ /2022	\$ _____
14.	_____ /2023	\$ _____

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: \$ 37,569 Description: See Attached Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* 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 Hlth C Ctr
0047522**

Period Beginning 1/1/2020
Period End 12/31/2020

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$	17,857
Dishwasher		701
Copier		5,272
Home Office Allocation		13,739
		<u>37,569</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>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			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	9,706	\$ 145,592	\$	9,706	\$ 145,592	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		3,002	45,036		3,002	45,036	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		10,199	152,982		10,199	152,982	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				80,925		80,925	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			\$	22,907	\$ 343,610	\$ 80,925	22,907	\$ 424,535	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 Hlth C Ctr**

0047522

Report Period Beginning: **1/1/2020**

Ending:

12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2020**

(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	\$ 688,996	\$ 688,996	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>94,932</u>)	4,048,853	4,048,853	3
4	Supply Inventory (priced at <u>Cost</u>)	23,194	23,194	4
5	Short-Term Investments			5
6	Prepaid Insurance	39,737	67,408	6
7	Other Prepaid Expenses		37,141	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Employee Education Loans</u>	2,745	2,745	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,803,525	\$ 4,868,337	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		4,362,424	14
15	Leasehold Improvements, at Historical Cost	112,912	1,162,811	15
16	Equipment, at Historical Cost	28,462	982,762	16
17	Accumulated Depreciation (book methods)	(19,806)	(3,990,778)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		250,839	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(52,258)	20
21	Restricted Funds		244,507	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Intercompany Loans</u>	71,864	121,789	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 193,432	\$ 3,302,596	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,996,957	\$ 8,170,933	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,102,917	\$ 1,110,751	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	100,541	100,541	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		93,468	32
33	Accrued Interest Payable		11,876	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	122,675	122,675	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,326,133	\$ 1,439,311	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,701,479	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	<u>Loan Payable-MCAD Adv. Payment</u>	300,000	300,000	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 300,000	\$ 4,001,479	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,626,133	\$ 5,440,790	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,370,824	\$ 2,730,143	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,996,957	\$ 8,170,933	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,474,823	1
2	Restatements (describe):		2
3	Post-Filing Adjustments Made Due To Refinancing	314,466	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,789,289	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,581,535	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)	\$ 1,581,535	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)	\$ 3,370,824	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Timbercreek Rehab Hlth C Ctr

0047522

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

1

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,368,171	1
2	Discounts and Allowances for all Levels	(452,908)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,915,263	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	529,224	6
7	Oxygen	9,595	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 538,819	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	9,283	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	129,580	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	24,444	20
21	Other Medical Services	42,114	21
22	Laundry	224	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 205,645	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	26	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 26	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation Revenue</u>	1,652	28
28a	<u>Miscellaneous and Illinois Cares Revenue</u>	1,679,287	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,680,939	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,340,692	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	952,115	31
32	Health Care	2,961,001	32
33	General Administration	944,940	33
B. Capital Expense			
34	Ownership	439,219	34
C. Ancillary Expense			
35	Special Cost Centers	227,223	35
36	Provider Participation Fee	234,659	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,759,157	40
41	Income before Income Taxes (line 30 minus line 40)**	1,581,535	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,581,535	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 3,026,157	44
45	Private Pay - Net Inpatient Revenue	358,209	45
46	Medicare - Net Inpatient Revenue	1,344,127	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	186,770	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,915,263	49

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

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

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

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

Facility Name & ID Number Timbercreek Rehab Hlth C Ctr

0047522

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,621	1,633	\$ 62,332	\$ 38.17	1
2	Assistant Director of Nursing	717	719	26,125	36.34	2
3	Registered Nurses	1,082	1,083	54,701	50.51	3
4	Licensed Practical Nurses	13,591	13,963	433,939	31.08	4
5	CNAs & Orderlies	43,309	45,031	792,487	17.60	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,080	2,080	41,102	19.76	9
10	Activity Assistants	1,040	1,040	16,061	15.44	10
11	Social Service Workers	869	870	20,636	23.72	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	46,590	22.40	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,741	16,440	159,231	9.69	15
16	Dishwashers					16
17	Maintenance Workers	2,442	2,495	44,844	17.97	17
18	Housekeepers	14,671	15,362	186,299	12.13	18
19	Laundry	3,498	3,618	38,714	10.70	19
20	Administrator	2,104	2,168	80,004	36.90	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	3,156	3,304	48,550	14.69	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	320	320	12,134	37.92	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,515	1,543	42,841	27.76	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Page 20A</u>	4,933	5,084	129,641	25.50	33
34	TOTAL (lines 1 - 33)	114,769	118,833	\$ 2,236,231 *	\$ 18.82	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	12	\$ 623	L1, C3	35
36	Medical Director	Monthly	9,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,626	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	32	1,761	L10, C3	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Telehealth</u>	2	130	L10, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	46	\$ 19,140		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	2,080	\$ 89,550	L10,C3	50
51	Licensed Practical Nurses	3,989	104,974	L10,C3	51
52	Certified Nurse Assistants/Aides	29,831	640,866	L10,C3	52
53	TOTAL (lines 50 - 52)	35,900	\$ 835,390		53

Timbercreek Rehab Hlth C Ctr
0047522

Period Beginning 1/1/2020

Period End 12/31/2020

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	2,167	2,286	75,687	33.11
Transportation	2,766	2,798	53,954	19.28
TOTAL	4,933	5,084	129,641	

Timbercreek Rehab Hlth C Ctr

0047522

Period Beginning 1/1/2020
 Period End 12/31/2020

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		
		157,994
Non-Allowable Legal Settlement		
		(150,000)
Home Office Allocation		
Baker Tilly Virchow Krause LLP	Legal	589
Duane Morris	Legal	42,636
Lexis Nexis	Legal	11
Livingston, Barger, Brant, Schroeder	Legal	17,836
Miller, Hall, Triggs	Legal	68
Miscellaneous	Legal	25
SB2	Legal	1,180
SmithAmundsen LLC	Legal	2,812
Sorling Northrup	Legal	675
Capital Finance Group	Legal	5,575
Illinois Secretary of Sate	Legal	189
McGuire Woods	Legal	7,825
CliftonLarsonAllen	Accounting	1,569
Ginoli & Co.	Accounting	12,147
Ability Network	Computer Services	4,028
Allscripts	Computer Services	636
AOD Matrix Care	Computer Services	7,075
AT&T	Computer Services	8
ATS	Computer Services	386
CCH	Computer Services	23
Charter Communications	Computer Services	36
Citrix Systems	Computer Services	120
Comcast	Computer Services	41
ITSavvy	Computer Services	186
Kemper Technology	Computer Services	919
Miscellaneous	Computer Services	178
Pearl Technology	Computer Services	167
Stratus Networks	Computer Services	731
TR Professional	Computer Services	16
Creative Health Capital	Other Prof Fees	6,329
Mohr and Kerr	Other Prof Fees	11,528
Planning and Zoning Resource Company	Other Prof Fees	1,620
David Budde	Other Prof Fees	16
DJ Howard and Associates	Other Prof Fees	1,518
Getzler Henrich & Associates	Other Prof Fees	1,631
LRI Consulting Services	Other Prof Fees	1,649
McQuellon Consulting	Other Prof Fees	1,016
Miscellaneous	Other Prof Fees	142
Optimizer	Other Prof Fees	65
Registered Agent Solutions	Other Prof Fees	36
RSM McGladrey	Other Prof Fees	400
SB2	Other Prof Fees	511
Sedgwick CMS	Other Prof Fees	42,746
Tarver Program Consultants	Other Prof Fees	95
Total (agree to Schedule V, line 19, column 8)		<u>184,983</u>

**Timbercreek Rehab Hlth C Ctr
0047522**

Period Beginning 1/1/2020
Period End 12/31/2020

Schedule 21B

25. Administrative and Staff Transportation

Gas	\$	3,829
Auto Repairs		3,809
Mileage-Travel		2,944
Home Office Allocation		4,895
		<u>15,477</u>

Facility Name & ID Number Timbercreek Rehab Hlth C Ctr# 0047522Report Period Beginning: 1/1/2020Ending: 12/31/2020**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? 7 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 23,684 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.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 234,659
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. \$ 9,283
- (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. \$ 1,652
c. What percent of all travel expense relates to transportation of nurses and patients? 100
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? 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 and Company
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. No
Attach invoices and a summary of services for all architect and appraisal fees.