



Facility Name & ID Number Timber Point Healthcare Ctr

# 0043158 Report Period Beginning: 01/01/12 Ending: 12/31/12

**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	110	Skilled (SNF)	110	40,260	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	110	TOTALS	110	40,260	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	15,864	3,080	3,205	22,149	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,864	3,080	3,205	22,149	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 55.01%

D. How many bed-hold days during this year were paid by the Department?

0 (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)

N/A

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 1998

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

YES  Date 1998 NO

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

YES  NO  If YES, enter number of beds certified 110 and days of care provided 2,366

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Timber Point Healthcare Ctr # 0043158 Report Period Beginning: 01/01/12 Ending: 12/31/12

**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
	<b>A. General Services</b>										
1	Dietary	145,092	13,513	5,910	164,515		164,515	115	164,630		1
2	Food Purchase		136,322		136,322		136,322	221	136,543		2
3	Housekeeping	93,400	15,436		108,836		108,836	220	109,056		3
4	Laundry	33,583	11,487		45,070		45,070		45,070		4
5	Heat and Other Utilities			96,795	96,795		96,795	319	97,114		5
6	Maintenance	113,546		81,736	195,282		195,282	4,212	199,494		6
7	Other (specify):* <a href="#">See Supplemental</a>							542	542		7
8	<b>TOTAL General Services</b>	385,621	176,758	184,441	746,820		746,820	5,629	752,449		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			4,805	4,805		4,805		4,805		9
10	Nursing and Medical Records	963,021	38,495	4,731	1,006,247		1,006,247		1,006,247		10
10a	Therapy	21,071			21,071		21,071		21,071		10a
11	Activities	42,481	10,295		52,776		52,776		52,776		11
12	Social Services	72,896	7	4,122	77,025		77,025		77,025		12
13	CNA Training										13
14	Program Transportation			1,123	1,123		1,123		1,123		14
15	Other (specify):* <a href="#">See Supplemental</a>										15
16	<b>TOTAL Health Care and Programs</b>	1,099,469	48,797	14,781	1,163,047		1,163,047		1,163,047		16
	<b>C. General Administration</b>										
17	Administrative	85,709			85,709		85,709	7,751	93,460		17
18	Directors Fees										18
19	Professional Services			201,294	201,294		201,294	(120,110)	81,184		19
20	Dues, Fees, Subscriptions & Promotions			29,269	29,269		29,269	(21,933)	7,336		20
21	Clerical & General Office Expenses	93,838	10,444	93,848	198,130		198,130	(31,258)	166,872		21
22	Employee Benefits & Payroll Taxes			286,357	286,357		286,357	(5,997)	280,360		22
23	Inservice Training & Education										23
24	Travel and Seminar			675	675		675	103	778		24
25	Other Admin. Staff Transportation			30,092	30,092		30,092	382	30,474		25
26	Insurance-Prop.Liab.Malpractice			99,237	99,237		99,237	450	99,687		26
27	Other (specify):* <a href="#">See Supplemental</a>							11,194	11,194		27
28	<b>TOTAL General Administration</b>	179,547	10,444	740,772	930,763		930,763	(159,418)	771,345		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,664,637	235,999	939,994	2,840,630		2,840,630	(153,789)	2,686,841		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

**Timber Point Healthcare Ctr  
 Medicaid Cost Report  
 01/01/12 - 12/31/12**

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**Page 3 Supplemental Schedule**

Description	Salaries	Supplies	Other
<b>Line 7 Detailed</b>			
Allocation - Extended Care Consulting: Emp. Ben.			542
Total	-	-	542
<b>Line 15 Detailed</b>			
Total	-	-	-
<b>Line 27 Detailed</b>			
Allocation - Extended Care Consulting: Emp. Ben.			11,194
Total	-	-	11,194

**Timber Point Healthcare Ctr  
Medicaid Cost Report  
01/01/12 - 12/31/12**

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**Page 3 Supplemental Schedule - Other Admin. Staff Transportation**

<b>Payee</b>	<b>Amount</b>	<b>Allowable</b>
Adam Zanger	5,692	5,692
Extended Care Consulting	1,016	1,016
Care Consultants of IL	18,852	18,852
Kime Gronewold	190	190
Laura Sepessy	869	869
Stotc Automotive	726	726
United Access of Springfield	2,297	2,297
Other	450	450
Alloc. - Extended Care Consulting	382	382

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30,474	30,474
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Facility Name & ID Number Timber Point Healthcare Ctr

#0043158

Report Period Beginning:

01/01/12

Ending:

12/31/12

## 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	
	<b>D. Ownership</b>											
30	Depreciation			6,910	6,910		6,910	48,574	55,484			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							67,797	67,797			32
33	Real Estate Taxes			20,035	20,035		20,035	(3,033)	17,002			33
34	Rent-Facility & Grounds			119,564	119,564		119,564	(118,588)	976			34
35	Rent-Equipment & Vehicles			27,519	27,519		27,519	493	28,012			35
36	Other (specify):* <b>See Supplement</b>											36
37	<b>TOTAL Ownership</b>			174,028	174,028		174,028	(4,757)	169,271			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		175,881	612,249	788,130		788,130		788,130			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			180,364	180,364		180,364		180,364			42
43	Other (specify):* <b>See Supplement</b>	11,539		4,090	15,629		15,629	(15,629)				43
44	<b>TOTAL Special Cost Centers</b>	11,539	175,881	796,703	984,123		984,123	(15,629)	968,494			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	1,676,176	411,880	1,910,725	3,998,781		3,998,781	(174,175)	3,824,606			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

**Timber Point Healthcare Ctr  
Medicaid Cost Report  
01/01/12 - 12/31/12**

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**Page 4 Supplemental Schedule**

<b>Description</b>	<b>Salaries</b>	<b>Supplies</b>	<b>Other</b>
<b>Line 36 Detailed</b>			
Total	-	-	-
<b>Line 43 Detailed</b>			
Non-Allowable Expenses	11,539		4,090
Total	11,539	-	4,090

**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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(8,840)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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				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	(68,631)	21		24
25	Fund Raising, Advertising and Promotional	(22,571)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,034)	20		28
29	Other-Attach Schedule See Supplemental	(33,289)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (134,365)		\$	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	
		<b>Amount</b>	<b>Reference</b>	
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)	(39,810)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (39,810)		36
37	<b>TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)</b>	\$ (174,175)		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	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

<b>BHF USE ONLY</b>							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT



Timber Point Healthcare Ctr

ID# 0043158

Report Period Beginning: 01/01/12

Ending: 12/31/12

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Real Estate Tax Refund - Add Back	\$ 8,414	33	1
2	Bank Charges	(12,755)	21	2
3	Collection Fees	(408)	21	3
4	Non-Allowable Legal Fees	(8,038)	19	4
5	Non-Allowable Expenses	(15,629)	43	5
6				6
7				7
8				8
9				9
10				10
11	Timber Point Associates, LLC			11
12	Bank Fee	(15)	21	12
13	Amortization	(4,858)	31	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	<b>Total</b>	(33,289)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Timber Point Healthcare Ctr# 0043158

Report Period Beginning:

01/01/12

Ending:

12/31/12

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	115	0	0	0	0	0	0	0	0	115	1
2	Food Purchase	0	0	221	0	0	0	0	0	0	0	0	221	2
3	Housekeeping	0	0	220	0	0	0	0	0	0	0	0	220	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	319	0	0	0	0	0	0	0	0	319	5
6	Maintenance	0	0	1,262	2,950	0	0	0	0	0	0	0	4,212	6
7	Other (specify):*	0	0	0	542	0	0	0	0	0	0	0	542	7
8	<b>TOTAL General Services</b>	0	0	2,137	3,492	0	0	0	0	0	0	0	5,629	8
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	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	<b>TOTAL Health Care and Programs</b>	0	0	0	0	0	0	0	0	0	0	0	0	16
	<b>C. General Administration</b>													
17	Administrative	0	0	1,364	6,387	0	0	0	0	0	0	0	7,751	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(8,038)	0	(112,072)	0	0	0	0	0	0	0	0	(120,110)	19
20	Fees, Subscriptions & Promotions	(23,605)	0	1,672	0	0	0	0	0	0	0	0	(21,933)	20
21	Clerical & General Office Expenses	(81,809)	15	5,707	44,829	0	0	0	0	0	0	0	(31,258)	21
22	Employee Benefits & Payroll Taxes	0	0	0	(5,997)	0	0	0	0	0	0	0	(5,997)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	103	0	0	0	0	0	0	0	0	103	24
25	Other Admin. Staff Transportation	0	0	382	0	0	0	0	0	0	0	0	382	25
26	Insurance-Prop.Liab.Malpractice	0	0	450	0	0	0	0	0	0	0	0	450	26
27	Other (specify):*	0	0	0	11,194	0	0	0	0	0	0	0	11,194	27
28	<b>TOTAL General Administration</b>	(113,452)	15	(102,394)	56,413	0	0	0	0	0	0	0	(159,418)	28
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	(113,452)	15	(100,257)	59,905	0	0	0	0	0	0	0	(153,789)	29

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Timber Point Healthcare Ctr# 0043158

Report Period Beginning:

01/01/12

Ending:

12/31/12

## 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)	
	<b>D. Ownership</b>													
30	Depreciation	0	45,369	3,205	0	0	0	0	0	0	0	0	48,574	30
31	Amortization of Pre-Op. & Org.	(4,858)	4,858	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,840)	74,644	1,993	0	0	0	0	0	0	0	0	67,797	32
33	Real Estate Taxes	8,414	(12,458)	1,011	0	0	0	0	0	0	0	0	(3,033)	33
34	Rent-Facility & Grounds	0	(118,588)	0	0	0	0	0	0	0	0	0	(118,588)	34
35	Rent-Equipment & Vehicles	0	0	493	0	0	0	0	0	0	0	0	493	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(5,284)</b>	<b>(6,175)</b>	<b>6,702</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(4,757)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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):*	(15,629)	0	0	0	0	0	0	0	0	0	0	(15,629)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(15,629)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(15,629)</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(134,365)</b>	<b>(6,160)</b>	<b>(93,555)</b>	<b>59,905</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(174,175)</b>	<b>45</b>

**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
See Page 6 - Supp		See Page 6 - Supp		See Page 6 - 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:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 118,588	Timber Point Associates, LLC	100.00%	\$	\$ (118,588)	1
2	V	33 Real Estate Tax Refund	36,863	Timber Point Associates, LLC	100.00%		(36,863)	2
3	V	21 Bank Fees		Timber Point Associates, LLC	100.00%	15	15	3
4	V	30 Depreciation		Timber Point Associates, LLC	100.00%	45,369	45,369	4
5	V	31 Amortization		Timber Point Associates, LLC	100.00%	4,858	4,858	5
6	V	32 Interest		Timber Point Associates, LLC	100.00%	74,644	74,644	6
7	V	33 Real Estate Taxes		Timber Point Associates, LLC	100.00%	24,405	24,405	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 155,451			\$ 149,291	\$ * (6,160)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number

Timber Point Healthcare Ctr

# 0043158

Report Period Beginning:

01/01/12

Ending:

12/31/12

## 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	Sherwin I. Ray	33.33%	Avenue Care Nursing and Rehab	Chicago, IL	Ext. Care Consult.	Evanston, IL	Home Office	1
2	Jakob Bakst	33.33%	Beecher Manor Nursing and Rehab	Beecher, IL	Ext. Care Clinical	Evanston, IL	Administrative	2
3	Eric Rothner	33.34%	Briar Place	Indian Head, IL	CC Health Systems	Des Plaines, IL	Dietary & Suppl.	3
4			Chateau Village Nursing and Rehab	Willowbrook, IL	CCS VEBA	Evanston, IL	Health Insurance	4
5			Grasmere Place	Chicago, IL	2201 Main	Evanston, IL	Bldg. Company	5
6			Lakewood Nursing and Rehab	Plainfield, IL	Rothner Vents	Evanston, IL	Vent. Rental	6
7			Lemont Nursing and Rehab	Lemont, IL	Tricare Rehab	Hillside, IL	Therapy	7
8			Prairie Manor Halth Care	Chicago Heights, IL	Reliable Medical	Des Plaines, IL	Medical Supplies	8
9			Rainbow Beach Nursing Center	Chicago, IL	Harbor Light	Glen Ellyn, IL	Hospice	9
10			Sheridan Shores	Chicago, IL				10
11			Snow Vally Nursing and Rehab	Lisle, IL				11
12			South Suburban Rehabilitation Center	Chicago, IL	Timber Point			12
13			Tri-State Nursing and Rehab	Lansing, IL	Associates, LLC	Camp Point, IL	Bldg. Company	13
14			Wheaton Care Center	Wheaton, IL				14
15			Boulevard Care Nursing and Rehab	Chicago, IL				15
16			Countryside Nursing and Rehab	Dolton, IL				16
17			Hillcrest Nursing and Rehab	Joliet, IL				17
18			Oak Park Healthcare Center	Oak Park, IL				18
19			Park House Nursing and Rehab	Chicago, IL				19
20			Timber Point Healthcare Center	Camp Point, IL				20
21			Prairie Village Healthcare Center	Jacksonville, IL				21
22			Dyer Nursing and Rehab	Dyer, IN				22
23			Lake County Nursing and Rehab	East Chicago, IN				23
24			Sebos Nursing and Rehab	Holbart, IN				24
25			Sheffield Manor Nursing Center	Indianapolis, IN				25
26			McKinley Health Care Center	Canton, OH				26
27			Homestead Nursing and Rehab	Lincoln, NE				27
28			Lancaster Manor	Lincoln, NE				28
29			Golden Plaines	Hutchinson, KS				29
30								30

SEE ACCOUNTANTS' COMPILATION REPORT

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	01 Dietary	\$	Extended Care Consulting, LLC	100.00%	\$ 115	\$	115	15
16	V	02 Food		Extended Care Consulting, LLC	100.00%	221		221	16
17	V	03 Housekeeping		Extended Care Consulting, LLC	100.00%	220		220	17
18	V	05 Utilities		Extended Care Consulting, LLC	100.00%	319		319	18
19	V	06 Maintenance		Extended Care Consulting, LLC	100.00%	1,262		1,262	19
20	V	17 Administrative		Extended Care Consulting, LLC	100.00%	1,364		1,364	20
21	V	19 Professional Fees	114,000	Extended Care Consulting, LLC	100.00%	1,928		(112,072)	21
22	V	20 Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	1,672		1,672	22
23	V	21 Office and Clerical		Extended Care Consulting, LLC	100.00%	5,707		5,707	23
24	V	24 Seminar and Travel		Extended Care Consulting, LLC	100.00%	103		103	24
25	V	25 Other Staff Admin. Transport.		Extended Care Consulting, LLC	100.00%	382		382	25
26	V	26 Insurance		Extended Care Consulting, LLC	100.00%	450		450	26
27	V	30 Depreciation		Extended Care Consulting, LLC	100.00%	3,205		3,205	27
28	V	32 Interest		Extended Care Consulting, LLC	100.00%	1,993		1,993	28
29	V	33 Real Estate Taxes		Extended Care Consulting, LLC	100.00%	1,011		1,011	29
30	V	35 Rent - Equipment and Auto		Extended Care Consulting, LLC	100.00%	493		493	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		\$ 114,000			\$ 20,445	\$ *	(93,555)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	06 Maintenance	\$	Extended Care Consulting, LLC	100.00%	\$ 2,950	\$ 2,950	15
16	V	06 Maintenance		Extended Care Consulting, LLC	100.00%			16
17	V	07 Employee Benefits		Extended Care Consulting, LLC	100.00%	542	542	17
18	V	07 Employee Benefits		Extended Care Consulting, LLC	100.00%			18
19	V	10 Nursing		Extended Care Consulting, LLC	100.00%			19
20	V	17 Administrative		Extended Care Consulting, LLC	100.00%	6,387	6,387	20
21	V	21 Office and Clerical		Extended Care Consulting, LLC	100.00%	44,829	44,829	21
22	V	21 Office and Clerical	15,813	Extended Care Consulting, LLC	100.00%	15,813		22
23	V	27 Employee Benefits		Extended Care Consulting, LLC	100.00%	9,410	9,410	23
24	V	27 Employee Benefits		Extended Care Consulting, LLC	100.00%	1,784	1,784	24
25	V	22 Employee Benefits	5,997	Extended Care Consulting, LLC	100.00%		(5,997)	25
26	V							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		\$ 21,810			\$ 81,715	\$ * 59,905	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	22 Health Insurance	\$ 45,296	CCS VEBA	100.00%	\$ 45,296	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 45,296			\$ 45,296	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT



Facility Name &amp; ID Number

Timber Point Healthcare Ctr

# 0043158

Report Period Beginning:

01/01/12

Ending:

12/31/12

## 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	Adam Vales	Relative	Clerical	0	See Attached	0.44	1.11%	Alloc. Sal	\$ 813	22 - 7	1
2	Sherwin Ray	Owner	Administration	33.33%	See Attached	4.68	11.70%	Alloc. Sal	18,226	17 - 1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 19,039		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Timber Point Healthcare Ctr

# 0043158

Report Period Beginning:

01/01/12

Ending: 12/31/12

**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 \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Timber Point Healthcare Ctr

# 0043158

Report Period Beginning:

01/01/12

Ending: 12/31/12

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 Extended Care Consulting, LLC  
 Street Address 2201 Main Street  
 City / State / Zip Code Evanston, Illinois 60202  
 Phone Number ( 847) 905 - 3000  
 Fax Number ( 847) 491 - 9565

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	01	Dietary	Patient Days	1,364,178	31	\$ 7,101	\$ 22,149	\$ 115	1
2	02	Food	Patient Days	1,364,178	31	13,586	22,149	221	2
3	03	Housekeeping	Patient Days	1,364,178	31	13,573	22,149	220	3
4	05	Utilities	Patient Days	1,364,178	31	19,636	22,149	319	4
5	06	Maintenance	Patient Days	1,364,178	31	77,756	22,149	1,262	5
6	17	Administrative	Patient Days	1,364,178	31	84,000	22,149	1,364	6
7	19	Professional Fees	Patient Days	1,364,178	31	118,750	22,149	1,928	7
8	20	Dues and Subscriptions	Patient Days	1,364,178	31	102,984	22,149	1,672	8
9	21	Office and Clerical	Patient Days	1,364,178	31	351,528	22,149	5,707	9
10	24	Seminar and Travel	Patient Days	1,364,178	31	6,315	22,149	103	10
11	25	Other Staff Admin. Transpor.	Patient Days	1,364,178	31	23,506	22,149	382	11
12	26	Insurance	Patient Days	1,364,178	31	27,741	22,149	450	12
13	30	Depreciation	Patient Days	1,364,178	31	197,424	22,149	3,205	13
14	32	Interest	Patient Days	1,364,178	31	122,765	22,149	1,993	14
15	33	Real Estate Taxes	Patient Days	1,364,178	31	62,275	22,149	1,011	15
16	35	Rent - Equipment and Auto	Patient Days	1,364,178	31	30,363	22,149	493	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,259,303	\$	\$ 20,445	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Timber Point Healthcare Ctr

# 0043158

Report Period Beginning:

01/01/12

Ending: 12/31/12

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 Extended Care Consulting, LLC  
 Street Address 2201 Main Street  
 City / State / Zip Code Evanston, Illinois 60202  
 Phone Number ( 847) 905 - 3000  
 Fax Number ( 847) 491 - 9565

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	06	Maintenance	Patient Days	1,364,178	31	\$ 181,713	\$ 181,713	22,149	\$ 2,950	1
2	06	Maintenance	Direct Allocation	1	1			1		2
3	07	Employee Benefits	Patient Days	1,364,178	31	33,386		22,149	542	3
4	07	Employee Benefits	Direct Allocation	1	1			1		4
5	17	Administrative	Patient Days	1,364,178	31	393,362	393,362	22,149	6,387	5
6	21	Office and Clerical	Patient Days	1,364,178	31	2,761,089	2,761,089	22,149	44,829	6
7	21	Office and Clerical	Direct Allocation	1	1	15,813	15,813	1	15,813	7
8	27	Employee Benefits	Patient Days	1,364,178	31	579,570		22,149	9,410	8
9	27	Employee Benefits	Direct Allocation	1	1	1,784		1	1,784	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	TOTALS					\$ 3,966,717	\$ 3,351,977		\$ 81,715	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Timber Point Healthcare Ctr

# 0043158

Report Period Beginning:

01/01/12

Ending: 12/31/12

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 CCS VEBA  
 Street Address 2201 Main Street  
 City / State / Zip Code Evanston, Illinois 60202  
 Phone Number ( 847) 905 - 3000  
 Fax Number ( 847) 491 - 9565

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	22	Health Insurance	1	1	\$ 45,296	\$	1	\$ 45,296	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 45,296	\$		\$ 45,296	25

SEE ACCOUNTANTS' COMPILATION REPORT





**2011 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Timber Point Healthcare Ctr COUNTY Adams  
 FACILITY IDPH LICENSE NUMBER 0043158  
 CONTACT PERSON REGARDING THIS REPORT Edward N. Slack  
 TELEPHONE (847) 628 - 8796 FAX #: (248) 327 - 8417

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2011 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 2011.

(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>03-0-0932-001-00</u>	<u>Nursing Home</u>	\$ <u>64,124.82</u>	\$ <u>64,124.82</u>
2. <u>Allocation</u>	<u>Extended Care Consulting, LLC</u>	\$ <u>127,119.67</u>	\$ <u>803.34</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>191,244.49</u></u>	\$ <u><u>64,928.16</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?  X  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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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



**Timber Point Healthcare Ctr  
Medicaid Cost Report  
01/01/12 - 12/31/12**

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**Page 10 Supplemental Schedule**

<b>Vendor</b>	<b>Description</b>	<b>Amount</b>
<b>Appeal Costs</b>		
Skidelsky & Associates	2009 Real Estate Taxes	12,285
Skidelsky & Associates	2012 Real Estate Taxes	7,750
Total - Line 5 Total		20,035
<b>Refunds</b>		
Adams County	2009 Real Estate Tax Refund	36,863
Total		36,863
<b>Refund Adjustment</b>		
Appeal Costs		20,035
Real Estate Tax Refund		36,863
Appeal Costs		20,035
Remainder		16,828
1/2 of Remainder		8,414
Total - Line 6 Total		28,449

Facility Name & ID Number Timber Point Healthcare Ctr

# 0043158

Report Period Beginning:

01/01/12 Ending:

12/31/12

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 32,000 B. General Construction Type: Exterior Brick Frame Steel Number of Stories \_\_\_\_\_

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:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1998</u>	<u>\$ 118,000</u>	1
2	<u>Ext. Care Consult.</u>			<u>5,182</u>	2
3	<b>TOTALS</b>			<b>\$ 123,182</b>	3

SEE ACCOUNTANTS' COMPILATION REPORT

**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	
	Bed* FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	110	1998		\$ 1,120,000	\$ 40,727	27.5	\$ 40,727		\$ 609,191	4
5										5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9										9
10	Various		2001	18,442	670	27.5	670		7,575	10
11	Various		2003	7,919	288	27.5	288		2,724	11
12	Various		2004	24,419	1,003	15 - 27.5	1,003		8,502	12
13	Various		2005	12,730	463	27.5	463		3,453	13
14	Various		2006	18,831	685	27.5	685		4,423	14
15	Various		2007	6,583	239	27.5	239		1,306	15
16	Various		2008	22,650	626	27.5	626		2,788	16
17	Handicap Ramp		2010	3,986	145	27.5	145		308	17
18	Install Duct		2010	3,230	118	27.5	118		240	18
19	Kitchen Roof Top Replacement		2011	4,938	247	20	247		411	19
20	Kitchen Exhaust Hood and Installation		2011	2,376	475	5	475		594	20
21	Kitchen Roof top Unit Replacement		2012	4,938	150	27.5	150		150	21
22	Flooring - Nurses Station		2012	6,461	78	27.5	78		78	22
23	Plumbing - PVC Piping from Basement to Outside Facility		2012	3,975		27.5				23
24										24
25										25
26										26
27	Timber Point Associates, LLC (Building Partnership)									27
28										28
29	Various		1998	15,322	557	27.5	557		8,055	29
30	Various		1999	10,509	382	27.5	382		4,984	30
31	Various		2000	2,585	94	27.5	94		1,163	31
32	Various		2000	12,177	3	27.5	3		12,177	32
33	Various		2001	99,148	3,605	27.5	3,605		41,842	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

SEE ACCOUNTANTS' COMPILATION REPORT

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9		
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37		\$	\$		\$	\$	\$	37	
38	<u>Related Party Allocations - See Supplemental Schedules</u>								38
39								39	
40	<u>2007</u>	<u>75</u>	<u>4</u>	<u>20</u>	<u>4</u>		<u>22</u>	40	
41	<u>2009</u>	<u>45</u>	<u>2</u>	<u>20</u>	<u>2</u>		<u>9</u>	41	
42	<u>2010</u>	<u>438</u>	<u>22</u>	<u>20</u>	<u>22</u>		<u>66</u>	42	
43	<u>2011</u>	<u>158</u>	<u>8</u>	<u>20</u>	<u>8</u>		<u>16</u>	43	
44	<u>2012</u>	<u>52</u>	<u>3</u>	<u>20</u>	<u>3</u>		<u>3</u>	44	
45								45	
46	<u>2002</u>	<u>7,141</u>	<u>183</u>	<u>39</u>	<u>183</u>		<u>183</u>	46	
47	<u>2002</u>	<u>5,899</u>	<u>539</u>	<u>10</u>	<u>539</u>		<u>539</u>	47	
48	<u>2003</u>	<u>6,952</u>	<u>635</u>	<u>10</u>	<u>635</u>		<u>635</u>	48	
49	<u>2005</u>	<u>345</u>	<u>37</u>	<u>10</u>	<u>37</u>		<u>37</u>	49	
50	<u>2009</u>	<u>62</u>	<u>3</u>	<u>10</u>	<u>3</u>		<u>3</u>	50	
51								51	
52								52	
53								53	
54								54	
55								55	
56								56	
57								57	
58								58	
59								59	
60								60	
61								61	
62								62	
63								63	
64								64	
65								65	
66								66	
67								67	
68								68	
69								69	
70	<b>TOTAL (lines 4 thru 69)</b>	<b>\$ 1,422,386</b>	<b>\$ 51,992</b>		<b>\$ 51,992</b>	<b>\$</b>	<b>\$ 711,477</b>	<b>70</b>	

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*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	\$ 113,416	\$ 1,258	\$ 1,258	\$	5 - 7	\$ 96,220	71
72	Current Year Purchases	4,130	466	466		5	466	72
73	Fully Depreciated Assets							73
74	See Supplemental	185,068	1,265	1,265			183,161	74
75	TOTALS	\$ 302,614	\$ 2,989	\$ 2,989	\$		\$ 279,847	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	Facility - Timber Point	Van		\$ 23,698	\$	\$	\$	5	\$ 23,698	76
77	Alloc. - Extended Care			2,516	503	503		5	2,516	77
78										78
79										79
80	TOTALS			\$ 26,214	\$ 503	\$ 503	\$		\$ 26,214	80

E. Summary of Care-Related Assets

	1	2		
	Reference	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)	\$ 1,874,396	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 55,484	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 55,484	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,017,538	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					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.

SEE ACCOUNTANTS' COMPILATION REPORT

**Timber Point Healthcare Ctr  
Medicaid Cost Report  
01/01/12 - 12/31/12**

**Page 13 Supplemental Schedule**

Description	Cost	Depreciation	Accumulated Depreciation
<b>Related Party 1 - Timber Point Associates, LLC</b>			
Prior	118,000		118,000
Current			
Total	118,000	-	118,000
<b>Related Party 2 - Extended Care Consulting</b>			
Prior	47,699	168	46,662
Current			
Total	47,699	168	46,662
<b>Related Party 3 - Extended Care Consulting / 2201 Mail LLC</b>			
Prior	1,977	196	1,955
Current			
Total	1,977	196	1,955
<b>Related Party 4 - Extended Care Consulting - Matrix Software</b>			
Prior	17,392	901	16,544
Current			
Total	17,392	901	16,544
<b>Total</b>	<b>185,068</b>	<b>1,265</b>	<b>183,161</b>

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A - Related Party  
 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	See Supp.				976			6
7	TOTAL				\$ 976			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: \$ 28,012 Description: See Supplemental Schedule  
 (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

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.	<u>/2013</u>	\$ _____
13.	<u>/2014</u>	\$ _____
14.	<u>/2015</u>	\$ _____

\* 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.

SEE ACCOUNTANTS' COMPILATION REPORT

**Timber Point Healthcare Ctr  
Medicaid Cost Report  
01/01/12 - 12/31/12**

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**Page 14 Supplemental Schedule - Building and Fixed Equipment**

Vendor	Description	Amount
Bruce 88 Storage	Off-Site Storage Rental	976
Total		976

**Page 14 Supplemental Schedule - Equipment Rental**

Vendor	Description	Amount
Flynn Sales & Service	Copier	8,400
Denman Medical Equipment	Medical Equipment	2,906
Ecolab	Various	170
Digital Copy System	Copier	2,839
Care Consultants of Illinois	Medical Equipment	17
Accelerated Care Plus	Medical Equipment	9,347
Keokok Area Medical	Medical Equipment	854
Wells Fargo Financial Lease		1,424
Extended Care Consulting		2,241
Muzak, LLC		(754)
Other		75
Alloc. - Extended Care Consulting		493
Total		28,012



**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	<b>TOTALS</b>	\$	\$	\$	\$
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)	
<b>TOTAL TRAINED</b>	

- (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.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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

	Service	1 Schedule V Line & Column Reference	2		3		4		6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)		
			Staff		Outside Practitioner (other than consultant)								
			Units of Service	Cost	Units	Cost							
1	Licensed Occupational Therapist	39 - 03	hrs	\$			\$	253,045	\$		\$	253,045	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs					58,105				58,105	2
3	Licensed Recreational Therapist		hrs										3
4	Licensed Physical Therapist	39 - 03	hrs					288,513				288,513	4
5	Physician Care		visits										5
6	Dental Care		visits										6
7	Work Related Program		hrs										7
8	Habilitation		hrs										8
9	Pharmacy	39 - 02	# of prescripts						124,678			124,678	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs										10
11	Academic Education		hrs										11
12	Other (specify): <a href="#">See Supplemental</a>	39 - 02							51,203			51,203	12
13	Other (specify): <a href="#">See Supplemental</a>	39 - 03							12,586			12,586	13
14	TOTAL			\$			\$	612,249	\$	175,881	\$	788,130	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.

SEE ACCOUNTANTS' COMPILATION REPORT

**Timber Point Healthcare Ctr  
Medicaid Cost Report  
01/01/12 - 12/31/12**

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**Page 16 Supplemental Schedule**

Description	Supplies	Other
Ambulance		721
Food Pump		121
Hospital Services		652
Laboratory		10,575
Medical Supplies	36,960	
Other Services	471	27
Oxygen	8,805	
Radiology		456
Therapy and Rehab Supplies	4,967	
Wheelchairs and Walkers		34
Total	51,203	12,586

Facility Name & ID Number **Timber Point Healthcare Ctr**# **0043158**Report Period Beginning: **01/01/12**Ending: **12/31/12****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/12**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 2,222	\$ 2,877	1
2	Cash-Patient Deposits	23,574	23,574	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>426,927</u> )	1,726,136	1,726,136	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	36,906	36,906	6
7	Other Prepaid Expenses	42,081	42,081	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Supplemental</u>	192	30,939	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,831,111	\$ 1,862,513	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		118,000	13
14	Buildings, at Historical Cost		1,120,000	14
15	Leasehold Improvements, at Historical Cost	133,652	273,393	15
16	Equipment, at Historical Cost	119,920	261,618	16
17	Accumulated Depreciation (book methods)	(143,267)	(962,377)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Supplemental</u>			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 110,305	\$ 810,634	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,941,416	\$ 2,673,147	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 890,854	\$ 890,854	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	14,045	14,045	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	90,071	90,071	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,491	3,491	31
32	Accrued Real Estate Taxes(Sch.IX-B)		26,634	32
33	Accrued Interest Payable		6,184	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>See Supplemental</u>	1,389,695	1,528,473	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,388,156	\$ 2,559,752	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,104,778	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>See Supplemental</u>			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 1,104,778	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,388,156	\$ 3,664,530	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (446,740)	\$ (991,383)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,941,416	\$ 2,673,147	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**Timber Point Healthcare Ctr  
Medicaid Cost Report  
01/01/12 - 12/31/12**

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**Page 17 Supplemental Schedule**

Description	Operating	After Consolidation
<b>Line 9 - Other Current Assets</b>		
Due from Employees	192	192
Real Estate Tax Escrow		30,747
Total	192	30,939
<b>Line 23 - Other Long Term Assets</b>		
Total	-	-
<b>Line 36 - Other Current Liabilities</b>		
Due from Related Entities	1,389,695	1,528,473
Total	1,389,695	1,528,473
<b>Line 43 - Other Long Term Liabilities</b>		
Total	-	-

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(1,011,149)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(1,011,149)</b>	<b>6</b>
<b>A. Additions (deductions):</b>			
<b>7</b>	NET Income (Loss) (from page 19, line 43)	\$ <b>564,409</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>564,409</b>	<b>17</b>
<b>B. Transfers (Itemize):</b>			
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(446,740)</b>	<b>24</b> *

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,214,634	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,214,634	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	310,976	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 310,976	8
<b>C. Other Operating Revenue</b>			
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		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	8,840	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 8,840	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	28,740	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 28,740	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,563,190	30

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	746,820	31
32	Health Care	1,163,047	32
33	General Administration	930,763	33
<b>B. Capital Expense</b>			
34	Ownership	174,028	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	803,759	35
36	Provider Participation Fee	180,364	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,998,781	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	564,409	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 564,409	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 1,165,841	44
45	Private Pay - Net Inpatient Revenue	427,391	45
46	Medicare - Net Inpatient Revenue	2,276,304	46
47	Other-(specify) <u>Hospice - Net Patient Service Revenue</u>	8,975	47
48	Other-(specify) <u>Insurance - Net Patient Service Revenue</u>	336,123	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 4,214,634	49

\* This must agree with page 4, line 45, column 4.  
 \*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Not Finished 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.

**SEE ACCOUNTANTS' COMPILATION REPORT**





Facility Name & ID Number Timber Point Healthcare Ctr

# 0043158

Report Period Beginning:

01/01/12

Ending:

12/31/12

**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	1,953	2,215	\$ 70,542	\$ 31.85	1
2	Assistant Director of Nursing	1,890	2,101	55,574	26.45	2
3	Registered Nurses	10,249	11,494	292,827	25.48	3
4	Licensed Practical Nurses	8,523	9,483	150,929	15.92	4
5	CNAs & Orderlies	34,880	37,218	373,996	10.05	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,734	1,899	21,071	11.10	8
9	Activity Director	1,571	1,843	21,667	11.76	9
10	Activity Assistants	2,158	2,397	20,814	8.68	10
11	Social Service Workers	3,872	4,301	72,896	16.95	11
12	Dietician					12
13	Food Service Supervisor	1,863	2,150	25,007	11.63	13
14	Head Cook					14
15	Cook Helpers/Assistants	3,332	3,890	35,040	9.01	15
16	Dishwashers	8,875	10,085	85,045	8.43	16
17	Maintenance Workers	8,153	9,020	113,546	12.59	17
18	Housekeepers	9,525	11,020	93,400	8.48	18
19	Laundry	3,218	3,796	33,583	8.85	19
20	Administrator	1,907	2,145	67,483	31.46	20
21	Assistant Administrator					21
22	Other Administrative	253	253	18,226	72.04	22
23	Office Manager					23
24	Clerical	4,261	4,705	93,838	19.94	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	1,613	1,804	19,153	10.61	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Non-Allowable</u>	320	320	11,539	36.06	33
34	TOTAL (lines 1 - 33)	110,149	122,141	\$ 1,676,176 *	\$ 13.72	34

**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	\$ 5,910	01 - 03	35
36	Medical Director	4,805	09 - 03	36
37	Medical Records Consultant			37
38	Nurse Consultant	4,090	10 - 03	38
39	Pharmacist Consultant	4,731	10 - 03	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant	4,122	12 - 03	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 23,658		49

**C. CONTRACT NURSES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$		50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Adam Zanger	Administrator	0	\$ 67,483	Workers' Compensation Insurance	\$ 70,754	IDPH License Fee	\$ 1,990	
Sherwin Ray	Administration	33.33	18,226	Unemployment Compensation Insurance	33,100	Advertising: Employee Recruitment	514	
				FICA Taxes	124,455	Health Care Worker Background Check	2,296	
				Employee Health Insurance	45,296	(Indicate # of checks performed )		
				Employee Meals		<u>Patient Background Checks</u>		
				Illinois Municipal Retirement Fund (IMRF)*		<u>Dues and Subscriptions</u>	93	
				Employee Physicals	1,239	<u>Licenses and Fees</u>	771	
				Other Employee Welfare	4,516	<u>Advertising and Promotion</u>	23,605	
				Holiday Expense	1,000	<u>Alloc. - Extended Care Consulting</u>	1,672	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 85,709					
B. Administrative - Other								
Description			Amount					
			\$					
TOTAL (agree to Schedule V, line 17, col. 3)			\$					
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Description	Amount	
Extended Care Consulting	Home Office		\$ 114,000			Out-of-State Travel	\$	
Plante & Moran, PLLC	Accounting		27,400					
Frost, Ruttenberg & Rothblatt	Accounting		1,500					
Burke, Warren, McKay	Legal		4,632			In-State Travel		
Williams Montgomery & John	Legal		1,672					
Chuhak & Tecson, P.C.	Legal		3,406					
Extended Care Consulting	Legal		785					
Meyer Magence	Legal		250			Seminar Expense	675	
Randy Frese	Legal		123			<u>Alloc. - Extended Care Consulting</u>	103	
Personnel Planners	Unemployment Consultant		690					
Care Consultants of Illinois	Computer Maintenance		10,366					
See Supplemental Schedule			36,470			Entertainment Expense	( )	
TOTAL (agree to Schedule V, line 19, column 3)			\$ 201,294	TOTAL		(agree to Sch. V, line 24, col. 8)		
(If total legal fees exceed \$5,000, attach copy of invoices.)						TOTAL	\$ 778	

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

**Timber Point Healthcare Ctr  
Medicaid Cost Report  
01/01/12 - 12/31/12**

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**Page 21 Supplemental Schedule - Other Professional Fees**

<b>Vendor</b>	<b>Type</b>	<b>Amount</b>
National Datacare Corporation	Computer Maintenance	655
Sysco Central Illinois	Computer Maintenance	480
Singer Networks, LLC	Computer Maintenance	(3,848)
American Data	Data Processing	3,934
Care Consultants of Illinois	Data Processing	66
E-Health Data Solutions	Data Processing	6,075
Extended Care Consulting	Data Processing	1,624
MDI Achieve	Data Processing	4,743
Medifax-EDI	Data Processing	551
National Datacare Corporation	Data Processing	1,251
Nebo Systems, Inc.	Data Processing	130
PRO Payroll Solutions	Data Processing	7,537
Paycor	Data Processing	1,926
Other	Data Processing	176
Care Consultants of Illinois	Other Professional	(121)
Extended Care Consulting	Other Professional	1,580
Personnel Planners	Other Professional	890
HFG	Other Professional	8,626
Transitions	Other Professional	195
Total		36,470

**Timber Point Healthcare Ctr  
Medicaid Cost Report  
01/01/12 - 12/31/12**

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**Page 21 Supplemental Schedule - Legal Invoice Detail**

<b>Vendor</b>	<b>Date</b>	<b>Amount</b>
Burke, Warren, McKay		4,632
Williams Montgomery & John		1,672
Chuhak & Tecson, P.C.		3,406
Extended Care Consulting		785
Meyer Magence		250
Randy Frese		123
Page 5 - Non Allowable Legal Expense		(8,038)
Total		<u><u>2,830</u></u>

Total legal expense is less than \$5,000. Per the instructions, there is no need to include copies of the legal invoices with the filed Medicaid Cost Report.

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

(See instructions.)

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Timber Point Healthcare Ctr

# 0043158

Report Period Beginning:

01/01/12

Ending:

12/31/12

**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. N/A
- (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. \$ \_\_\_\_\_ Line Ln 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. \$ 180,364  
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? No Indicate the amount. \$ N/A
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? Ln 14  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No  
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. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A
- (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? Yes  
Attach invoices and a summary of services for all architect and appraisal fees

**SEE ACCOUNTANTS' COMPILATION REPORT**