

Facility Name & ID Number TIMBER POINT HEALTHCARE CENTER

0043158 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

III. STATISTICAL DATA

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

	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	40,150	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	40,150	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			3,866	3,866	8
9	SNF/PED					9
10	ICF	20,122	5,778		25,900	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,122	5,778	3,866	29,766	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.14%

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)

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 01/01/1998

J. Was the facility purchased or leased after January 1, 1978?
YES Date 01/01/1998 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified _____ and days of care provided 3,866

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number **TIMBER POINT HEALTHCARE CENTER** # **0043158** Report Period Beginning: **01/01/2007** Ending: **12/31/2007**

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	157,927	15,096	6,379	179,402		179,402		179,402		1
2	Food Purchase		156,463		156,463		156,463	(660)	155,803		2
3	Housekeeping	73,253	17,055		90,308		90,308		90,308		3
4	Laundry	78,658	12,691		91,349		91,349		91,349		4
5	Heat and Other Utilities			134,851	134,851		134,851	6	134,857		5
6	Maintenance	51,476	36,900	25,391	113,767		113,767	4,356	118,123		6
7	Other (specify):*			13,628	13,628		13,628	36	13,664		7
8	TOTAL General Services	361,314	238,205	180,249	779,768		779,768	3,738	783,506		8
	B. Health Care and Programs										
9	Medical Director			4,800	4,800		4,800		4,800		9
10	Nursing and Medical Records	1,016,907	58,972	3,235	1,079,114		1,079,114	27,149	1,106,263		10
10a	Therapy	50,649	935	125,435	177,019		177,019	16,490	193,509		10a
11	Activities	38,581	8,688		47,269		47,269		47,269		11
12	Social Services	18,363		3,240	21,603		21,603		21,603		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,124,500	68,595	136,710	1,329,805		1,329,805	43,639	1,373,444		16
	C. General Administration										
17	Administrative	74,237		60,000	134,237		134,237	(2,763)	131,474		17
18	Directors Fees										18
19	Professional Services			261,999	261,999		261,999	(173,502)	88,497		19
20	Dues, Fees, Subscriptions & Promotions			58,429	58,429		58,429	(53,233)	5,196		20
21	Clerical & General Office Expenses	98,711	18,284	130,385	247,380		247,380	(93,040)	154,340		21
22	Employee Benefits & Payroll Taxes			268,046	268,046		268,046		268,046		22
23	Inservice Training & Education			4,609	4,609		4,609	938	5,547		23
24	Travel and Seminar			286	286		286	1,389	1,675		24
25	Other Admin. Staff Transportation			25,333	25,333		25,333	5,421	30,754		25
26	Insurance-Prop.Liab.Malpractice			82,995	82,995		82,995	1,169	84,164		26
27	Other (specify):*							38,695	38,695		27
28	TOTAL General Administration	172,948	18,284	892,082	1,083,314		1,083,314	(274,926)	808,388		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,658,762	325,084	1,209,041	3,192,887		3,192,887	(227,549)	2,965,338		29

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

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

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	5,443
	REPAIRS & MAINTENANCE	936
		0
		6,379
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	2,410
	ELECTRICITY	109,124
	WATER	17,079
	CABLE TV - LOBBY	6,238
		0
		134,851
6	MAINTENANCE	
	GROUNDS MAINTENANCE	6,247
	PAINTING & DECORATING	83
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	4,966
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	1,483
	FIRE SERVICE	12,612
		0
		0
		0
		0
		25,391
7	OTHER	
	SCAVENGER	13,574
	SECURITY SERVICE	54
		0
		0
		13,628
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	4,800
		4,800

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	427
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	0
	PHARMACY CONSULTANT XVIII B 39-2	2,808
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		3,235
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	95
	SPEECH THERAPY SERVICES	230
	OCCUPATIONAL THERAPY SERVICES	122
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	5,400
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	5,400
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
	THERAPY CONTRACT SERVICES	114,188
		125,435
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	3,240
		0
		3,240
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	60,000
18	DIRECTORS FEES	
	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	33,735
	ADMINISTRATIVE CONSULTANTS XIX C	150,000
	PROFESSIONAL FEES XIX C	78,264
		0
		261,999
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	52,212
	EMPLOYEE WANT ADS XIX F	885
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	604
	LICENSES & PERMITS XIX F	1,837
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	2,891
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	0
	PATIENT BACKGROUND CHECKS XIX F	0
		58,429
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	1,649
	OUTSIDE CLERICAL SERVICES	96,000
	PENALTIES / OVERDRAFT CHARGES VI 18	15,164
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	16,332
	MESSENGER SERVICE	1,240
		0
		130,385

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	123,961
	UNEMPLOYMENT COMPENSATION XIX D	43,943
	WORKERS COMPENSATION INSURANC XIX D	65,417
	HOSPITALIZATION INSURANCE XIX D	32,551
	EMPLOYEE BENEFITS - OTHER XIX D	2,174
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		0
		268,046
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	4,609
		4,609
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	286
		286
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	25,333
		25,333
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	82,995
		82,995
27	OTHER	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

1,209,041

**TIMBER POINT HEALTHCARE CENTER
SCHEDULES
12/31/2007**

**EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22**

TOTAL FOOD PURCHASE	156,463
LESS SALES TAX	<u>(660)</u>
NET FOOD	155,803

TOTAL PATIENT CENSUS	29,766
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	89,298

ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	89,298
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	89,298

NET FOOD	155,803
DIVIDE TOTAL MEALS/YEAR	<u>89,298</u>

COST PER MEAL	1.74
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	0

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Facility Name & ID Number **TIMBER POINT HEALTHCARE CENTER**

#0043158

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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			16,102	16,102		16,102	43,317	59,419			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,042	2,042		2,042	103,637	105,679			32
33	Real Estate Taxes			120,699	120,699		120,699	3,753	124,452			33
34	Rent-Facility & Grounds			138,864	138,864		138,864	(138,864)				34
35	Rent-Equipment & Vehicles			81,925	81,925		81,925	(20,441)	61,484			35
36	Other (specify):*											36
37	TOTAL Ownership			359,632	359,632		359,632	(8,598)	351,034			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		126,070	99,755	225,825		225,825	10,456	236,281			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			60,225	60,225		60,225		60,225			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		126,070	159,980	286,050		286,050	10,456	296,506			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,658,762	451,154	1,728,653	3,838,569		3,838,569	(225,691)	3,612,878			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				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	(2,267)	30		9
10	Interest and Other Investment Income	(28,316)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(660)	2		13
14	Non-Care Related Interest	(2,042)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(15,164)	21		18
19	Entertainment		20		19
20	Contributions		20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(7,679)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(52,212)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,891)	20		28
29	Other-Attach Schedule	(37,848)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (149,079)		\$	30

BHF USE ONLY					
48		49		50	
				51	
					52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(76,612)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (76,612)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (225,691)		37

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

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

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

ID# 0043158

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	MARKETING SALARIES	\$ (37,848)	21	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				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(37,848)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number TIMBER POINT HEALTHCARE CENTER# 0043158

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(660)	0	0	0	0	0	0	0	0	0	0	(660)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	6	0	0	0	0	0	0	0	6	5
6	Maintenance	0	0	0	4,356	0	0	0	0	0	0	0	4,356	6
7	Other (specify):*	0	0	0	36	0	0	0	0	0	0	0	36	7
8	TOTAL General Services	(660)	0	0	4,398	0	3,738	8						
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	27,149	0	0	0	0	0	0	0	27,149	10
10a	Therapy	0	13,165	0	3,325	0	0	0	0	0	0	0	16,490	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	TOTAL Health Care and Programs	0	13,165	0	30,474	0	43,639	16						
	C. General Administration													
17	Administrative	0	0	(60,000)	57,237	0	0	0	0	0	0	0	(2,763)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(7,679)	0	(170,472)	4,649	0	0	0	0	0	0	0	(173,502)	19
20	Fees, Subscriptions & Promotions	(55,103)	0	0	1,870	0	0	0	0	0	0	0	(53,233)	20
21	Clerical & General Office Expenses	(53,012)	0	(96,000)	55,972	0	0	0	0	0	0	0	(93,040)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	938	0	0	0	0	0	0	0	938	23
24	Travel and Seminar	0	0	0	1,389	0	0	0	0	0	0	0	1,389	24
25	Other Admin. Staff Transportation	0	0	0	5,421	0	0	0	0	0	0	0	5,421	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	1,169	0	0	0	0	0	0	0	1,169	26
27	Other (specify):*	0	0	0	38,695	0	0	0	0	0	0	0	38,695	27
28	TOTAL General Administration	(115,794)	0	(326,472)	167,340	0	(274,926)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(116,454)	13,165	(326,472)	202,212	0	(227,549)	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number TIMBER POINT HEALTHCARE CENTER # 0043158 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(2,267)	37,353	0	8,231	0	0	0	0	0	0	0	43,317	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(30,358)	107,122	0	26,873	0	0	0	0	0	0	0	103,637	32
33	Real Estate Taxes	0	0	0	3,753	0	0	0	0	0	0	0	3,753	33
34	Rent-Facility & Grounds	0	(138,864)	0	0	0	0	0	0	0	0	0	(138,864)	34
35	Rent-Equipment & Vehicles	0	(25,957)	0	5,516	0	0	0	0	0	0	0	(20,441)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(32,625)	(20,346)	0	44,373	0	(8,598)	37						
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	10,456	0	0	0	0	0	0	0	0	0	10,456	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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	10,456	0	0	0	0	0	0	0	0	0	10,456	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(149,079)	3,275	(326,472)	246,585	0	(225,691)	45						

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTACHED		CAREPLUS MGMT	SKOKIE	MGMT/CLERICAL
				TIMBER POINT ASSOCIATES LLC		REAL ESTATE
					SKOKIE	
				CAREPLUS REHABILITATIVE SERVICES		THERAPY
					SKOKIE	

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	\$ 138,864	TIMBER POINT ASSOCIATES LLC	100.00%	\$	\$ (138,864)	1
2	V	30 SL DEPRECIATION				33,620	33,620	2
3	V	32 INTEREST				104,062	104,062	3
4	V							4
5	V							5
6	V	10a THERAPY SERVICES	125,434	CAREPLUS REHAB INC			(125,434)	6
7	V	39 ANCILLARY SERVICES	99,628				(99,628)	7
8	V	10a THERAPY SERVICES				138,599	138,599	8
9	V	39 ANCILLARY SERVICES				110,084	110,084	9
10	V	35 RENTAL INCOME	25,957				(25,957)	10
11	V	30 DEPRECIATION				3,733	3,733	11
12	V	32 EQUIPMENT LOAN INTEREST				3,060	3,060	12
13	V							13
14	Total		\$ 389,883			\$ 393,158	\$ * 3,275	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	17 MANAGEMENT FEES	\$ 60,000	CAREPLUS MGMT INC	100.00%	\$	\$ (60,000)
16	V	19 ADMIN CONSULT FEES	150,000				(150,000)
17	V	19 DATA PROCESSING FEES	20,472				(20,472)
18	V	21 CLERICAL FEES	96,000				(96,000)
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
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		\$ 326,472			\$ 0	\$ * (326,472)

* 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	5 UTILITIES	\$	CAREPLUS MGMT INC	100.00%	\$ 6	\$	6	15
16	V	6 MAINT & REPAIRS				784		784	16
17	V	6 MAINTENANCE SALARIES				3,572		3,572	17
18	V	7 SECURITY				36		36	18
19	V	10 NURSING SALARIES				27,149		27,149	19
20	V	10a THERAPY SALARIES				2,526		2,526	20
21	V	10a REHAB SUPPLIES				799		799	21
22	V	17 ADMIN SALARIES				57,237		57,237	22
23	V	19 PROFESSIONAL FEES				4,649		4,649	23
24	V	20 ADVERTISING				1,870		1,870	24
25	V	21 OFFICE EXPENSE				14,314		14,314	25
26	V	21 OFFICE SALARIES				41,658		41,658	26
27	V	23 SEMINARS				938		938	27
28	V	24 TRAVEL				1,389		1,389	28
29	V	25 TRANSPORATION				5,421		5,421	29
30	V	26 INSURANCE				1,169		1,169	30
31	V	27 EMPLOYEE BENEFITS				38,695		38,695	31
32	V	30 DEPRECIATION				8,231		8,231	32
33	V	32 INTEREST				24,121		24,121	33
34	V	32 INTEREST TAG 18				2,552		2,552	34
35	V	32 INTEREST CP REHAB EQUIP				200		200	35
36	V	33 REAL ESTATE TAX TAG 18				3,753		3,753	36
37	V	35 EQUIPMENT RENT				5,516		5,516	37
38	V								38
39	Total		\$			\$ 246,585	\$ *	246,585	39

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

Facility Name & ID Number **TIMBER POINT HEALTHCARE CENTER** # **0043158** Report Period Beginning: **01/01/2007** Ending: **12/31/2007**

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	CAREPLUS MGMT ALLOCATIONS:								\$	1	
2	JACOB BAKST	DIR OPERATIONS			SEE ATTACHED	4		SALARY	11,017	17-7	2
3	SHERWIN I. RAY	ADMIN CONSULT			SCHEDULES	4		SALARY	11,017	17-7	3
4	ROSLYN INDICH	CONTROLLER A/P				4		SALARY	3,301	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 25,335		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 **TIMBER POINT HEALTHCARE CENTER**

0043158

Report Period Beginning:

01/01/2007

Ending: **2/31/2007**

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization CAREPLUS MGMT
 Street Address 8320 SKOKIE BLVD.
 City / State / Zip Code SKOKIE, IL 60077
 Phone Number (847) 329-1555
 Fax Number (847) 329-9555

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	5	UTILITIES	PATIENT DAYS	445,767	11	\$ 100	29,766	\$ 6	1
2	6	MAINT & REPAIRS	PATIENT DAYS	445,767	11	11,715	29,766	784	2
3	6	MAINTENANCE SALARIES	PATIENT DAYS	445,767	11	53,507	29,766	3,572	3
4	7	SECURITY	PATIENT DAYS	445,767	11	548	29,766	36	4
5	10	NURSING SALARIES	PATIENT DAYS	445,767	11	406,577	29,766	27,149	5
6	10a	THERAPY SALARIES	PATIENT DAYS	445,767	11	37,834	29,766	2,526	6
7	10a	REHAB SUPPLIES	PATIENT DAYS	445,767	11	11,963	29,766	799	7
8	17	ADMIN SALARIES	PATIENT DAYS	445,767	11	857,197	29,766	57,237	8
9	19	PROFESSIONAL FEES	PATIENT DAYS	445,767	11	69,630	29,766	4,649	9
10	20	ADVERTISING	PATIENT DAYS	445,767	11	28,013	29,766	1,870	10
11	21	OFFICE EXPENSE	PATIENT DAYS	445,767	11	214,347	29,766	14,314	11
12	21	OFFICE SALARIES	PATIENT DAYS	445,767	11	623,871	29,766	41,658	12
13	23	SEMINARS	PATIENT DAYS	445,767	11	14,052	29,766	938	13
14	24	TRAVEL	PATIENT DAYS	445,767	11	20,788	29,766	1,389	14
15	25	TRANSPORATION	PATIENT DAYS	445,767	11	81,177	29,766	5,421	15
16	26	INSURANCE	PATIENT DAYS	445,767	11	17,511	29,766	1,169	16
17	27	EMPLOYEE BENEFITS	PATIENT DAYS	445,767	11	579,494	29,766	38,695	17
18	30	DEPRECIATION	PATIENT DAYS	445,767	11	123,201	29,766	8,231	18
19	32	INTEREST	PATIENT DAYS	445,767	11	361,224	29,766	24,121	19
20	32	INTEREST TAG 18	PATIENT DAYS	445,767	11	38,177	29,766	2,552	20
21	32	INTEREST CP REHAB EQUIP	PATIENT DAYS	445,767	11	3,007	29,766	200	21
22	33	REAL ESTATE TAX TAG 18	PATIENT DAYS	445,767	11	56,199	29,766	3,753	22
23	35	EQUIPMENT RENT	PATIENT DAYS	445,767	11	82,599	29,766	5,516	23
24									24
25	TOTALS					\$ 3,692,731	\$ 1,978,986	\$ 246,585	25

Facility Name & ID Number TIMBER POINT HEALTHCARE CENTER

0043158

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		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	RELATED PARTY: TIMBER POINT ASSOCIATES LLC						\$	\$				\$	1					
2	AMCORE		X	MORTGAGE				1,259,162				103,162	2					
3	CIB		X	CAPITAL IMPROVEMENT LOAN				1,968				900	3					
4													4					
5	RELATED PARTY	X										29,933	5					
	Working Capital																	
6													6					
7													7					
8													8					
9	TOTAL Facility Related						\$	\$ 1,261,130				\$ 133,995	9					
	B. Non-Facility Related*																	
10	IRS, IDR, ETC		X	LATE FEES								2,042	10					
11													11					
12													12					
13													13					
14	TOTAL Non-Facility Related						\$	\$				\$ 2,042	14					
15	TOTALS (line 9+line14)						\$	\$ 1,261,130				\$ 136,037	15					

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

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2006 report.	\$	109,100	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	113,799	2
3. Under or (over) accrual (line 2 minus line 1).	\$	4,699	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	116,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	120,699	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	92,159	8
	2003	104,215	9
	2004	107,464	10
	2005	106,959	11
	2006	113,799	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2006	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2006 TAX BILL.

NOTES:

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

IMPORTANT NOTICE

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

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

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

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

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME TIMBER POINT HEALTHCARE CENTER COUNTY ADAMS

FACILITY IDPH LICENSE NUMBER 0043158

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2006 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2006.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>03-0-0932-001-00</u>	<u>NURSING HOME</u>	\$ <u>113,798.94</u>	\$ <u>113,798.94</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>113,798.94</u>	\$ <u>113,798.94</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

Facility Name & ID Number TIMBER POINT HEALTHCARE CENTER

0043158

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

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				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number **TIMBER POINT HEALTHCARE CENTER**# **0043158**

Report Period Beginning:

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

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	110		1998		\$ 1,120,000	\$ 28,717	39	\$ 28,717	\$	\$ 257,301	4
5											5
6											6
7											7
8	RELATED PARTY					2,310		2,310			8
	Improvement Type**										
9	REMODEL KITCHEN		1998		5,569	203	39	143	(60)	1,412	9
10	BUILDING SIGN		1998		2,101	76	39	54	(22)	524	10
11	AIR CONDITIONING SYSTEM REPAIR		1998		3,625	132	39	93	(39)	895	11
12	FLOORING		1998		4,027	146	39	103	(43)	957	12
13	GENERATOR		1999		10,509	382	39	269	(113)	2,163	13
14	LINE DRAPERY		2000		12,176	265	7	1,087	822	11,894	14
15	ROOF TOP A/C UNIT		2000		2,585	94	27.5	94		693	15
16	LIGHTING		2001		18,442	671	27.5	671		4,222	16
17	ROOFING		2001		36,940	1,343	27.5	1,343		9,345	17
18	PAINTING/STAINING		2001		29,485	1,072	27.5	1,072		6,924	18
19	ELEVATOR REPAIR		2001		5,200	189	27.5	189		1,220	19
20	FLOORING		2001		23,827	866	27.5	866		5,451	20
21	STEPS ON RAMP		2001		3,696	135	27.5	135		855	21
22	BASEMENT SEWER WORK		2003		2,810	102	27.5	102		353	22
23	WATER HEATER		2003		3,486	127	27.5	127		439	23
24	FIRE ALARM & ELECTRICAL WORK		2003		1,623	59	27.5	59		270	24
25	GUTTERS & DOWNSPOUTS/PATIO/METAL COVERS		2004		7,288	265	27.5	265		941	25
26	FIRE ALARM & ELECTRICAL WORK		2004		9,849	358	27.5	358		1,238	26
27	FLOORING		2004		3,465	126	27.5	126		444	27
28	SPRINKLERS/RAMP RAILING		2004		2,588	173	15	173		606	28
29	CARPET		2004		1,229	82	15	82		287	29
30	FIRE ALARM EQUIP/PLUMBING/DOOR		2005		9,804	357	27.5	357		877	30
31	SHED		2005		2,926	106	27.5	106		261	31
32	GUTTERS		2006		13,188	480	27.5	480		700	32
33	CENTRAL AC		2006		1,043	38	27.5	38		55	33
34	FIRE DOORS		2006		4,600	167	27.5	167		244	34
35	FRONT DOOR		2007		1,318	22	27.5	22		22	35
36	HOOD		2007		5,265	88	27.5	88		88	36

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

See Page 12A, Line 70 for total

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

XI. OWNERSHIP COSTS (continued)

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

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,348,664	\$ 39,151		\$ 39,696	\$ 545	\$ 310,681	70

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

Facility Name & ID Number **TIMBER POINT HEALTHCARE CENTER**

0043158

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 100,696	\$ 12,881	\$ 10,069	\$ (2,812)	10 YRS	\$ 44,020	71
72	Current Year Purchases					10 YRS		72
73	Fully Depreciated Assets	768				10 YRS	768	73
74	RELATED PARTY		9,654	9,654				74
75	TOTALS	\$ 101,464	\$ 22,535	\$ 19,723	\$ (2,812)		\$ 44,788	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,450,128	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 61,686	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 59,419	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (2,267)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 355,469	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 81,925 Description: SEE SCHEDULE ATTACHED

(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>/2008</u>	\$ _____
13.	<u>/2009</u>	\$ _____
14.	<u>/2010</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.

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>
<p>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>		

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 36,536	\$		\$ 36,536	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			16,459			16,459	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			46,634			46,634	4
5	Physician Care		visits			126			126	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				108,181		108,181	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	LAB, RADIOLOGY Other (specify):						17,889		17,889	13
14	TOTAL			\$		\$ 99,755	\$ 126,070		\$ 225,825	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 **TIMBER POINT HEALTHCARE CENTER**

0043158

Report Period Beginning: **01/01/2007**

Ending:

12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2007**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 10,493	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,179,727		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	32,814		6
7	Other Prepaid Expenses	14,750		7
8	Accounts Receivable (owners or related parties)	851,415		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,089,199	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	88,925		15
16	Equipment, at Historical Cost	101,465		16
17	Accumulated Depreciation (book methods)	(94,640)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 95,750	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,184,949	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 818,028	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	111,775		30
31	Accrued Taxes Payable (excluding real estate taxes)	14,688		31
32	Accrued Real Estate Taxes(Sch.IX-B)	116,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,060,491	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,500,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,500,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,560,491	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (375,542)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,184,949	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (330,270)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (330,270)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(45,272)	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)	\$ (45,272)	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)	\$ (375,542)	24 *

* This must agree with page 17, line 47.

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

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,680,698	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,680,698	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	23,237	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 23,237	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		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	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	28,316	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 28,316	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	PATIENT TRANSPORTATION	61,046	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 61,046	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,793,297	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	779,768	31
32	Health Care	1,329,805	32
33	General Administration	1,083,314	33
	B. Capital Expense		
34	Ownership	359,632	34
	C. Ancillary Expense		
35	Special Cost Centers	225,825	35
36	Provider Participation Fee	60,225	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,838,569	40
41	Income before Income Taxes (line 30 minus line 40)**	(45,272)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (45,272)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.

TAX RETURN PREPARED ON CASH BASIS

*** 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 **TIMBER POINT HEALTHCARE CENTER**

0043158

Report Period Beginning: **01/01/2007**

Ending: **12/31/2007**

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,008	2,121	\$ 54,864	\$ 25.87	1
2	Assistant Director of Nursing	2,048	2,128	47,029	22.10	2
3	Registered Nurses	4,078	4,463	78,814	17.66	3
4	Licensed Practical Nurses	14,903	16,103	330,529	20.53	4
5	CNAs & Orderlies	45,328	48,959	457,440	9.34	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,076	4,377	50,649	11.57	8
9	Activity Director	2,063	2,293	21,627	9.43	9
10	Activity Assistants	2,044	2,133	16,954	7.95	10
11	Social Service Workers	2,017	2,143	18,363	8.57	11
12	Dietician					12
13	Food Service Supervisor	2,024	2,081	27,386	13.16	13
14	Head Cook	6,620	7,230	71,757	9.92	14
15	Cook Helpers/Assistants	6,880	7,286	58,784	8.07	15
16	Dishwashers					16
17	Maintenance Workers	5,725	6,202	51,476	8.30	17
18	Housekeepers	9,672	10,316	73,253	7.10	18
19	Laundry	8,712	9,734	78,658	8.08	19
20	Administrator	1,992	2,169	74,237	34.23	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,998	4,321	98,711	22.84	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,873	2,125	21,506	10.12	31
32	Other Health C: <u>MDS COORD</u>	2,074	2,178	26,725	12.27	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	128,135	138,362	\$ 1,658,762 *	\$ 11.99	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	M	\$ 5,443	1-3	35
36	Medical Director	O	4,800	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	2,808	10-3	39
40	Physical Therapy Consultant	L	5,400	10a-3	40
41	Occupational Therapy Consultant	Y	5,400	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	3,240	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 27,091		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)		\$		53

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	
ANDREA MILLER	ADMINISTRATOR		\$ 74,237	Workers' Compensation Insurance	\$ 65,417	IDPH License Fee	\$	
			0	Unemployment Compensation Insurance	43,943	Advertising: Employee Recruitment	885	
			0	FICA Taxes	123,961	Health Care Worker Background Check	0	
				Employee Health Insurance	32,551	(Indicate # of checks performed)		
				Employee Meals	0	Patient Background Checks	0	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	0	
				EMPLOYEE BENEFITS - OTHER	2,174	MARKETING/ADV/PROMO	55,103	
				EMPLOYEE PHYSICAL EXAMS	0	LICENSES/DUES/SUBSCRIPTIONS	2,441	
				PENSION/PROFIT SHARING PLANS	0	MGMT CO ALLOC	1,870	
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC	0	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense (0	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(52,212)	
						Yellow page advertising	(2,891)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 74,237	TOTAL (agree to Schedule V, line 22, col.8)	\$ 268,046	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 5,196	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
MANAGEMENT FEES			\$ 60,000			\$	Out-of-State Travel	\$
							In-State Travel	
								286
							MGMT CO ALLOC	1,389
							Seminar Expense	
								0
							Entertainment Expense (
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 60,000	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	\$ 1,675
C. Professional Services								
Vendor/Payee	Type		Amount					
			\$					
SEE SCHEDULE ATTACHED			261,999					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 261,999					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number TIMBER POINT HEALTHCARE CENTER# 0043158Report Period Beginning: 01/01/2007Ending: 12/31/2007**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (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? _____
- (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? _____
- (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 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 9,670 Line 10-2
- (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. _____
- (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. \$ 60,225
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? N/A Indicate the amount. \$ _____
- (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. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
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: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (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