



Facility Name & ID Number TIMBER POINT HEALTHCARE CENTER

# 0043158 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	40,260	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			2,631	2,631	8
9	SNF/PED					9
10	ICF	17,214	5,453		22,667	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,214	5,453	2,631	25,298	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.84%

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 1/1/98

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 1/1/98 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 2,631

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number **TIMBER POINT HEALTHCARE CENTER** # **0043158** Report Period Beginning: **01/01/2008** Ending: **12/31/2008**

**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	151,536	11,379	5,754	168,669		168,669		168,669		1
2	Food Purchase		160,285		160,285		160,285	(744)	159,541		2
3	Housekeeping	82,143	15,417		97,560		97,560		97,560		3
4	Laundry	67,987	10,869		78,856		78,856		78,856		4
5	Heat and Other Utilities			130,537	130,537		130,537	50	130,587		5
6	Maintenance	59,208	25,070	26,178	110,456		110,456	8,556	119,012		6
7	Other (specify):*			16,977	16,977		16,977	21	16,998		7
8	<b>TOTAL General Services</b>	<b>360,874</b>	<b>223,020</b>	<b>179,446</b>	<b>763,340</b>		<b>763,340</b>	<b>7,883</b>	<b>771,223</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			3,600	3,600		3,600		3,600		9
10	Nursing and Medical Records	944,582	74,683	109,685	1,128,950		1,128,950	19,164	1,148,114		10
10a	Therapy	58,687	5,123	15,314	79,124		79,124	3,153	82,277		10a
11	Activities	41,844	5,985		47,829		47,829		47,829		11
12	Social Services	34,308		2,700	37,008		37,008		37,008		12
13	CNA Training										13
14	Program Transportation			4,437	4,437		4,437		4,437		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>1,079,421</b>	<b>85,791</b>	<b>135,736</b>	<b>1,300,948</b>		<b>1,300,948</b>	<b>22,317</b>	<b>1,323,265</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	61,640		30,000	91,640		91,640	31,899	123,539		17
18	Directors Fees										18
19	Professional Services			132,173	132,173		132,173	(76,904)	55,269		19
20	Dues, Fees, Subscriptions & Promotions			47,125	47,125		47,125	(40,380)	6,745		20
21	Clerical & General Office Expenses	66,470	19,500	105,127	191,097		191,097	(62,164)	128,933		21
22	Employee Benefits & Payroll Taxes			234,747	234,747		234,747		234,747		22
23	Inservice Training & Education			4,162	4,162		4,162	1,127	5,289		23
24	Travel and Seminar							41	41		24
25	Other Admin. Staff Transportation			12,209	12,209		12,209	2,960	15,169		25
26	Insurance-Prop.Liab.Malpractice			79,796	79,796		79,796	1,295	81,091		26
27	Other (specify):*							29,242	29,242		27
28	<b>TOTAL General Administration</b>	<b>128,110</b>	<b>19,500</b>	<b>645,339</b>	<b>792,949</b>		<b>792,949</b>	<b>(112,884)</b>	<b>680,065</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,568,405</b>	<b>328,311</b>	<b>960,521</b>	<b>2,857,237</b>		<b>2,857,237</b>	<b>(82,684)</b>	<b>2,774,553</b>		<b>29</b>

\*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
<b>1</b>	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	4,751
	REPAIRS & MAINTENANCE	1,003
		0
		5,754
<b>3</b>	<b>HOUSEKEEPING</b>	
		0
		0
		0
<b>4</b>	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
<b>5</b>	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	1,980
	ELECTRICITY	106,984
	WATER	16,643
	CABLE TV - LOBBY	4,930
		0
		130,537
<b>6</b>	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	6,251
	PAINTING & DECORATING	1,799
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	6,979
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	1,866
	FIRE SERVICE	9,283
		0
		0
		0
		0
		26,178
<b>7</b>	<b>OTHER</b>	
	SCAVENGER	16,977
	SECURITY SERVICE	0
		0
		0
		16,977
<b>9</b>	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	3,600
		3,600

LINE	SCHED REF	TOTAL
<b>10</b>	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	2,754
	PURCHASED SERVICES	224
	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	1,537
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B __-2	0
	RN CONSULTANT XVIII B 38-2	0
	THErapy CONTRACT SERVICES	105,170
		0
		109,685
<b>10a</b>	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	2,497
	SPEECH THERAPY SERVICES	279
	OCCUPATIONAL THERAPY SERVICES	1,738
	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
		15,314
<b>11</b>	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
<b>12</b>	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	2,700
		0
		2,700
<b>13</b>	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0

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

LINE	SCHED REF	TOTAL
<b>14</b>	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	4,437
		4,437
<b>17</b>	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	30,000
		30,000
	<b>DIRECTORS FEES</b>	
<b>18</b>	DIRECTORS FEES	0
		0
<b>19</b>	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	22,878
	ADMINISTRATIVE CONSULTANTS XIX C	75,000
	PROFESSIONAL FEES XIX C	34,295
		0
		132,173
<b>20</b>	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	40,505
	EMPLOYEE WANT ADS XIX F	1,681
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	473
	LICENSES & PERMITS XIX F	2,445
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	2,021
	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
		47,125
<b>21</b>	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	6,388
	OUTSIDE CLERICAL SERVICES	48,000
	PENALTIES / OVERDRAFT CHARGES VI 18	31,533
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	18,656
	MESSENGER SERVICE	550
		0
		105,127

LINE	SCHED REF	TOTAL
<b>22</b>	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	105,076
	UNEMPLOYMENT COMPENSATION XIX D	45,193
	WORKERS COMPENSATION INSURANC XIX D	53,417
	HOSPITALIZATION INSURANCE XIX D	28,173
	EMPLOYEE BENEFITS - OTHER XIX D	1,993
	EMPLOYEE PHYSICAL EXAMS XIX D	895
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
		0
		234,747
<b>23</b>	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	4,162
		4,162
<b>24</b>	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
<b>25</b>	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	12,209
		12,209
<b>26</b>	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	79,796
		79,796
<b>27</b>	<b>OTHER</b>	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

**960,521**

**TIMBER POINT HEALTHCARE CENTER  
SCHEDULES  
12/31/2008**

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

TOTAL FOOD PURCHASE	160,285
LESS SALES TAX	<u>(744)</u>
NET FOOD	159,541

TOTAL PATIENT CENSUS	25,298
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	75,894

ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>366</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	75,894
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	75,894

NET FOOD	159,541
DIVIDE TOTAL MEALS/YEAR	<u>75,894</u>

COST PER MEAL	2.10
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	<b>0</b>

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

#0043158

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

## 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			16,022	16,022		16,022	40,571	56,593			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			8,872	8,872		8,872	112,830	121,702			32
33	Real Estate Taxes			112,573	112,573		112,573	4,230	116,803			33
34	Rent-Facility & Grounds			122,147	122,147		122,147	(122,147)				34
35	Rent-Equipment & Vehicles			62,984	62,984		62,984	4,677	67,661			35
36	Other (specify):* <b>RENT OFFICE</b>			10,800	10,800		10,800	(10,800)				36
37	<b>TOTAL Ownership</b>			333,398	333,398		333,398	29,361	362,759			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		108,925	82,358	191,283		191,283		191,283			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			60,390	60,390		60,390		60,390			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		108,925	142,748	251,673		251,673		251,673			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,568,405	437,236	1,436,667	3,442,308		3,442,308	(53,323)	3,388,985			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	
	<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	(1,805)	30		9
10	Interest and Other Investment Income	(4,987)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(744)	2		13
14	Non-Care Related Interest	(8,872)	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	(31,533)	21		18
19	Entertainment		20		19
20	Contributions		20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(871)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(40,505)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,021)	20		28
29	Other-Attach Schedule	(41,091)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (132,429)		\$	30

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

**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)	79,106		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 79,106		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (53,323)		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

ID# 0043158

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	MARKETING SALARY	\$ (37,337)	21	1
2	MARKETING TRAVEL	(3,754)	25	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	<b>Total</b>	(41,091)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number TIMBER POINT HEALTHCARE CENTER# 0043158

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

## 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	(744)	0	0	0	0	0	0	0	0	0	0	(744)	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	50	0	0	0	0	0	0	0	50	5
6	Maintenance	0	0	0	8,556	0	0	0	0	0	0	0	8,556	6
7	Other (specify):*	0	0	0	21	0	0	0	0	0	0	0	21	7
8	<b>TOTAL General Services</b>	<b>(744)</b>	<b>0</b>	<b>0</b>	<b>8,627</b>	<b>0</b>	<b>7,883</b>	<b>8</b>						
	<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	19,164	0	0	0	0	0	0	0	19,164	10
10a	Therapy	0	0	0	3,153	0	0	0	0	0	0	0	3,153	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>	<b>0</b>	<b>0</b>	<b>0</b>	<b>22,317</b>	<b>0</b>	<b>22,317</b>	<b>16</b>						
	<b>C. General Administration</b>													
17	Administrative	0	0	(30,000)	61,899	0	0	0	0	0	0	0	31,899	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(871)	0	(85,236)	9,203	0	0	0	0	0	0	0	(76,904)	19
20	Fees, Subscriptions & Promotions	(42,526)	0	0	2,146	0	0	0	0	0	0	0	(40,380)	20
21	Clerical & General Office Expenses	(68,870)	0	(48,000)	54,706	0	0	0	0	0	0	0	(62,164)	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	1,127	0	0	0	0	0	0	0	1,127	23
24	Travel and Seminar	0	0	0	41	0	0	0	0	0	0	0	41	24
25	Other Admin. Staff Transportation	(3,754)	0	0	6,714	0	0	0	0	0	0	0	2,960	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	1,295	0	0	0	0	0	0	0	1,295	26
27	Other (specify):*	0	0	0	29,242	0	0	0	0	0	0	0	29,242	27
28	<b>TOTAL General Administration</b>	<b>(116,021)</b>	<b>0</b>	<b>(163,236)</b>	<b>166,373</b>	<b>0</b>	<b>(112,884)</b>	<b>28</b>						
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(116,765)</b>	<b>0</b>	<b>(163,236)</b>	<b>197,317</b>	<b>0</b>	<b>(82,684)</b>	<b>29</b>						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number TIMBER POINT HEALTHCARE CENTER # 0043158 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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 (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	(1,805)	37,353	0	5,023	0	0	0	0	0	0	0	40,571	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(13,859)	101,986	0	24,703	0	0	0	0	0	0	0	112,830	32
33	Real Estate Taxes	0	0	0	4,230	0	0	0	0	0	0	0	4,230	33
34	Rent-Facility & Grounds	0	(122,147)	0	0	0	0	0	0	0	0	0	(122,147)	34
35	Rent-Equipment & Vehicles	0	0	0	4,677	0	0	0	0	0	0	0	4,677	35
36	Other (specify):*	0	0	(10,800)	0	0	0	0	0	0	0	0	(10,800)	36
37	<b>TOTAL Ownership</b>	<b>(15,664)</b>	<b>17,192</b>	<b>(10,800)</b>	<b>38,633</b>	<b>0</b>	<b>29,361</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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</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>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(132,429)</b>	<b>17,192</b>	<b>(174,036)</b>	<b>235,950</b>	<b>0</b>	<b>(53,323)</b>	<b>45</b>						

**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	\$ 122,147	TIMBER POINT ASSOCIATES LLC	100.00%	\$	\$ (122,147)	1
2	V	30 SL DEPRECIATION				33,620	33,620	2
3	V	32 INTEREST				101,986	101,986	3
4	V							4
5	V							5
6	V							6
7	V	30 DEPRECIATION		CAREPLUS REHAB		3,733	3,733	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 122,147			\$ 139,339	\$ * 17,192	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	\$ 30,000	CAREPLUS MGMT	100.00%	\$	\$ (30,000)
16	V	19 ADMIN CONSULT FEES	75,000				(75,000)
17	V	19 DATA PROCESSING FEES	10,236				(10,236)
18	V	21 CLERICAL FEES	48,000				(48,000)
19	V	36 OFFICE RENT	10,800				(10,800)
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		\$ 174,036			\$ 0	\$ * (174,036)

\* 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 MANAGEMENT	100.00%	\$ 50	\$	50	15
16	V	6 MAINT & REPAIRS				5,011		5,011	16
17	V	6 MAINTENANCE SALARIES				3,545		3,545	17
18	V	7 SECURITY				21		21	18
19	V	10 NURSING SALARIES				19,164		19,164	19
20	V	10a THERAPY SALARIES				3,144		3,144	20
21	V	10a REHAB SUPPLIES				9		9	21
22	V	17 ADMIN SALARIES				61,899		61,899	22
23	V	19 PROFESSIONAL FEES				9,203		9,203	23
24	V	20 ADVERTISING				2,146		2,146	24
25	V	21 OFFICE EXPENSE				12,189		12,189	25
26	V	21 OFFICE SALARIES				42,517		42,517	26
27	V	23 SEMINARS				1,127		1,127	27
28	V	24 TRAVEL				41		41	28
29	V	25 TRANSPORATION				6,714		6,714	29
30	V	26 INSURANCE				1,295		1,295	30
31	V	27 EMPLOYEE BENEFITS				29,242		29,242	31
32	V	30 DEPRECIATION				5,023		5,023	32
33	V	32 INTEREST				23,074		23,074	33
34	V	32 INTEREST TAG 18				1,482		1,482	34
35	V	32 INTEREST CP REHAB EQUIP				147		147	35
36	V	33 REAL ESTATE TAX TAG 18				4,230		4,230	36
37	V	35 EQUIPMENT RENT				4,677		4,677	37
38	V								38
39	Total		\$			\$ 235,950	\$ *	235,950	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: 01/01/2008 Ending: 12/31/2008

## 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	<b>CAREPLUS MGMT ALLOCATIONS:</b>								\$		1	
2	JACOB BAKST	DIR OPERATIONS			SEE ATTACHED			SALARY	13,194		17-7	2
3	SHERWIN I. RAY	ADMIN CONSULT			SCHEDULES			SALARY	13,194		17-7	3
4	ROSLYN INDICH	CONTROLLER A/P						SALARY	4,114		17-7	4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13								TOTAL	\$ 30,502			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:

**01/01/2008**

Ending: **2/31/2008**

**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	373,906	10	\$ 739	\$ 25,298	\$ 50	1
2	6	MAINT & REPAIRS	PATIENT DAYS	373,906	10	74,048	25,298	5,011	2
3	6	MAINTENANCE SALARIES	PATIENT DAYS	373,906	10	52,396	52,396	25,298	3,545
4	7	SECURITY	PATIENT DAYS	373,906	10	308	25,298	21	4
5	10	NURSING SALARIES	PATIENT DAYS	373,906	10	283,260	283,260	25,298	19,164
6	10a	THERAPY SALARIES	PATIENT DAYS	373,906	10	46,472	47,472	25,298	3,144
7	10a	REHAB SUPPLIES	PATIENT DAYS	373,906	10	132	25,298	9	7
8	17	ADMIN SALARIES	PATIENT DAYS	373,906	10	914,862	914,862	25,298	61,899
9	19	PROFESSIONAL FEES	PATIENT DAYS	373,906	10	136,016	25,298	9,203	9
10	20	ADVERTISING	PATIENT DAYS	373,906	10	31,710	25,298	2,146	10
11	21	OFFICE EXPENSE	PATIENT DAYS	373,906	10	180,149	25,298	12,189	11
12	21	OFFICE SALARIES	PATIENT DAYS	373,906	10	628,409	628,409	25,298	42,517
13	23	SEMINARS	PATIENT DAYS	373,906	10	16,659	25,298	1,127	13
14	24	TRAVEL	PATIENT DAYS	373,906	10	612	25,298	41	14
15	25	TRANSPORATION	PATIENT DAYS	373,906	10	99,225	25,298	6,714	15
16	26	INSURANCE	PATIENT DAYS	373,906	10	19,140	25,298	1,295	16
17	27	EMPLOYEE BENEFITS	PATIENT DAYS	373,906	10	432,184	25,298	29,242	17
18	30	DEPRECIATION	PATIENT DAYS	373,906	10	74,261	25,298	5,023	18
19	32	INTEREST	PATIENT DAYS	373,906	10	341,048	25,298	23,074	19
20	32	INTEREST TAG 18	PATIENT DAYS	373,906	10	21,878	25,298	1,482	20
21	32	INTEREST CP REHAB EQUIP	PATIENT DAYS	373,906	10	2,189	25,298	147	21
22	33	REAL ESTATE TAX TAG 18	PATIENT DAYS	373,906	10	62,515	25,298	4,230	22
23	35	EQUIPMENT RENT	PATIENT DAYS	373,906	10	69,127	25,298	4,677	23
24									24
25	TOTALS					\$ 3,487,339	\$ 1,926,399	\$ 235,950	25

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

# **0043158**

Report Period Beginning:

**01/01/2008**

Ending:

**12/31/2008**

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		7 Maturity Date	8 Interest Rate (4 Digits)	9 Reporting Period Interest Expense	10
		YES	NO				Original	Balance				
<b>A. Directly Facility Related</b>												
<b>Long-Term</b>												
1	RELATED PARTY: TIMBER POINT ASSOCIATES LLC						\$	\$			\$	1
2	AMCORE		X	MORTGAGE				1,240,520		8.0200	101,986	2
3												3
4												4
5	RELATED PARTY	X									24,703	5
<b>Working Capital</b>												
6												6
7												7
8												8
9	TOTAL Facility Related						\$	\$ 1,240,520			\$ 126,689	9
<b>B. Non-Facility Related*</b>												
10	IRS, IDR, ETC		X	LATE FEES							8,872	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ 8,872	14
15	TOTALS (line 9+line14)						\$	\$ 1,240,520			\$ 135,561	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 2007 report.		\$	<b>116,000</b>	<b>1</b>
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.)		\$	<b>113,073</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(2,927)</b>	<b>3</b>
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>115,500</b>	<b>4</b>
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		<b>5</b>
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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>112,573</b>	<b>7</b>

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	<b>2003</b>	<b>104,215</b>	<b>8</b>
	<b>2004</b>	<b>107,464</b>	<b>9</b>
	<b>2005</b>	<b>106,959</b>	<b>10</b>
	<b>2006</b>	<b>113,799</b>	<b>11</b>
	<b>2007</b>	<b>113,073</b>	<b>12</b>

**THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 102% OF THE PRIOR YEAR REAL ESTATE TAX BILL**

<b>FOR BHF USE ONLY</b>			
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2007	\$	<b>13</b>
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**NOTES:**

- Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
- 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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

**2007 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 2007 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 2007.

(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>113,072.56</u>	\$ <u>113,072.56</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>113,072.56</u>	\$ <u>113,072.56</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

**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:

01/01/2008 Ending:

12/31/2008

**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:

01/01/2008 Ending: 12/31/2008

**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	\$ 32,450	39	\$ 32,450	\$	\$ 289,751	4
5											5
6											6
7											7
8	RELATED PARTY					1,861		1,861			8
	<b>Improvement Type**</b>										
9	REMODEL KITCHEN		1998		5,569	203	39	143	(60)	1,555	9
10	BUILDING SIGN		1998		2,101	76	39	54	(22)	578	10
11	AIR CONDITIONING SYSTEM REPAIR		1998		3,625	132	39	93	(39)	988	11
12	FLOORING		1998		4,027	146	39	103	(43)	1,060	12
13	GENERATOR		1999		10,509	382	39	269	(113)	2,432	13
14	LINE DRAPERY		2000		12,176	265	7	282	17	12,176	14
15	ROOF TOP A/C UNIT		2000		2,585	94	27.5	94		787	15
16	LIGHTING		2001		18,442	671	27.5	671		4,893	16
17	ROOFING		2001		36,940	1,343	27.5	1,343		10,688	17
18	PAINTING/STAINING		2001		29,485	1,072	27.5	1,072		7,996	18
19	ELEVATOR REPAIR		2001		5,200	189	27.5	189		1,409	19
20	FLOORING		2001		23,827	866	27.5	866		6,317	20
21	STEPS ON RAMP		2001		3,696	135	27.5	135		990	21
22	BASEMENT SEWER WORK		2003		2,810	102	27.5	102		455	22
23	WATER HEATER		2003		3,486	127	27.5	127		566	23
24	FIRE ALARM & ELECTRICAL WORK		2003		1,623	59	27.5	59		329	24
25	GUTTERS & DOWNSPOUTS/PATIO/METAL COVERS		2004		7,288	265	27.5	265		1,206	25
26	FIRE ALARM & ELECTRICAL WORK		2004		9,849	358	27.5	358		1,596	26
27	FLOORING		2004		3,465	126	27.5	126		570	27
28	SPRINKLERS/RAMP RAILING		2004		2,588	173	15	173		779	28
29	CARPET		2004		1,229	82	15	82		369	29
30	FIRE ALARM EQUIP/PLUMBING/DOOR		2005		9,804	357	27.5	357		1,234	30
31	SHED		2005		2,926	106	27.5	106		367	31
32	GUTTERS		2006		13,188	480	27.5	480		1,180	32
33	CENTRAL AC		2006		1,043	38	27.5	38		93	33
34	FIRE DOORS		2006		4,600	167	27.5	167		411	34
35	FRONT DOOR		2007		1,318	48	27.5	48		70	35
36	HOOD		2007		5,265	191	27.5	191		349	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

**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 RAMP & RAILING REPAIR	2008	\$ 5,450	\$ 182	15	\$ 182	\$	\$ 182	37
38 FIRE PROTECTION SYSTEM	2008	17,200	286	27.5	286		286	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)		\$ 1,371,314	\$ 43,032		\$ 42,772	\$ (260)	\$ 351,662	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:

**01/01/2008**

Ending:

**12/31/2008**

**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	\$ 7,437	\$ 10,262	\$ 2,825		\$ 53,885	71
72	Current Year Purchases	7,945	4,767	397	(4,370)		397	72
73	Fully Depreciated Assets	768					768	73
74	<b>RELATED PARTY</b>		3,162	3,162				74
75	<b>TOTALS</b>	\$ 109,409	\$ 15,366	\$ 13,821	\$ (1,545)		\$ 55,050	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	<b>TOTALS</b>			\$	\$	\$	\$		\$	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)	\$ 1,480,723	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 58,398	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 56,593	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (1,805)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 406,712	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	<b>TOTALS</b>	\$	\$	\$	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: NA

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: \$ 50,860 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			\$	\$ <u>12,124</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$ <u>12,124</u>	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. \_\_\_\_\_ /2009 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

\* 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><b>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</b></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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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**

<b>COMPLETED</b>		
1. From this facility		
2. From other facilities (f)		
<b>DROP-OUTS</b>		
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.

**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	\$		\$ 34,104	\$		\$ 34,104	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			7,878			7,878	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			40,376			40,376	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				103,819		103,819	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):	39-2					5,106		5,106	13
14	<b>TOTAL</b>			\$		\$ 82,358	\$ 108,925		\$ 191,283	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 &amp; ID Number TIMBER POINT HEALTHCARE CENTER

# 0043158

Report Period Beginning: 01/01/2008

Ending:

12/31/2008

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008

(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	\$ 4,399	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,468,167		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	21,177		6
7	Other Prepaid Expenses	9,848		7
8	Accounts Receivable (owners or related parties)	334,688		8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,838,279	\$	10
	<b>B. Long-Term Assets</b>			
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	111,575		15
16	Equipment, at Historical Cost	109,409		16
17	Accumulated Depreciation (book methods)	(110,662)		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	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 110,322	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 1,948,601	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 535,578	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	111,428		30
31	Accrued Taxes Payable (excluding real estate taxes)	11,447		31
32	Accrued Real Estate Taxes(Sch.IX-B)	115,500		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 773,953	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	1,718,745		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 1,718,745	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 2,492,698	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ (544,097)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 1,948,601	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(375,540)</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>(375,540)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(168,557)	<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>(168,557)</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>(544,097)</b>	<b>24</b> *

\* 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	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 3,230,202	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,230,202	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	23,916	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 23,916	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***	4,987	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 4,987	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>PATIENT TRANSPORTATION</b>	14,646	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 14,646	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,273,751	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	763,340	31
32	Health Care	1,300,948	32
33	General Administration	792,949	33
	<b>B. Capital Expense</b>		
34	Ownership	333,398	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	191,283	35
36	Provider Participation Fee	60,390	36
	<b>D. Other Expenses (specify):</b>		
37	<b>OUT-OF-PERIOD EXPENSES</b>		37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,442,308	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(168,557)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (168,557)	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: **01/01/2008**

Ending:

**12/31/2008**

**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	2,000	2,088	\$ 57,203	\$ 27.40	1
2	Assistant Director of Nursing	1,904	2,080	44,673	21.48	2
3	Registered Nurses	4,864	5,172	128,214	24.79	3
4	Licensed Practical Nurses	15,681	17,411	273,647	15.72	4
5	CNAs & Orderlies	34,115	37,315	366,888	9.83	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,308	4,615	58,687	12.72	8
9	Activity Director	1,986	2,281	24,476	10.73	9
10	Activity Assistants	2,017	2,139	17,368	8.12	10
11	Social Service Workers	1,875	2,139	34,308	16.04	11
12	Dietician					12
13	Food Service Supervisor	1,589	1,768	19,236	10.88	13
14	Head Cook	5,720	6,069	70,297	11.58	14
15	Cook Helpers/Assistants	7,528	7,926	62,003	7.82	15
16	Dishwashers					16
17	Maintenance Workers	3,674	3,904	59,208	15.17	17
18	Housekeepers	9,687	10,428	82,143	7.88	18
19	Laundry	7,392	7,937	67,987	8.57	19
20	Administrator	1,992	2,184	61,640	28.22	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,824	4,296	66,470	15.47	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	1,928	2,109	22,246	10.55	31
32	Other Health Care(specify)	2,127	2,214	51,711	23.36	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	114,211	124,075	\$ 1,568,405 *	\$ 12.64	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	M	\$ 4,751	1-3	35
36	Medical Director	O	3,600	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	1,537	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	2,700	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 23,388		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





Facility Name & ID Number TIMBER POINT HEALTHCARE CENTER# 0043158Report Period Beginning: 01/01/2008Ending: 12/31/2008**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. \$ 7,409 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. \$ 60,390  
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