



Facility Name & ID Number Timber Point Hlthcare Center

# 0043158 Report Period Beginning: 01/01/14 Ending: 12/31/14

**III. STATISTICAL DATA**

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	110	Skilled (SNF)	110	40,150	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	14,787	3,113	3,622	21,522	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,787	3,113	3,622	21,522	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 53.60%

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

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

N/A

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES  NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES  NO

I. On what date did you start providing long term care at this location?

Date started 1998

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

YES  Date 1998 NO

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

YES  NO  If YES, enter number of beds certified 110 and days of care provided 3,145

Medicare Intermediary National Government Services

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/14 Fiscal Year: 12/31/14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Timber Point Hlthcare Center # 0043158 Report Period Beginning: 01/01/14 Ending: 12/31/14

**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	161,651	17,794	5,228	184,673		184,673	70	184,743		1
2	Food Purchase		165,151		165,151		165,151	(777)	164,374		2
3	Housekeeping	83,115	19,877		102,992		102,992	233	103,225		3
4	Laundry	41,462	13,797		55,259		55,259		55,259		4
5	Heat and Other Utilities			93,203	93,203		93,203	527	93,730		5
6	Maintenance	128,517		86,549	215,066		215,066	5,919	220,985		6
7	Other (specify):* <a href="#">See Supplemental</a>			68	68		68	355	423		7
8	<b>TOTAL General Services</b>	414,745	216,619	185,048	816,412		816,412	6,327	822,739		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			3,315	3,315		3,315		3,315		9
10	Nursing and Medical Records	1,006,547	75,596	5,399	1,087,542		1,087,542		1,087,542		10
10a	Therapy	60,905			60,905		60,905		60,905		10a
11	Activities	41,402	10,604		52,006		52,006		52,006		11
12	Social Services	73,922	136	4,080	78,138		78,138		78,138		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <a href="#">See Supplemental</a>										15
16	<b>TOTAL Health Care and Programs</b>	1,182,776	86,336	12,794	1,281,906		1,281,906		1,281,906		16
	<b>C. General Administration</b>										
17	Administrative	122,791		20,925	143,716		143,716	9,254	152,970		17
18	Directors Fees										18
19	Professional Services			222,785	222,785		222,785	(122,521)	100,264		19
20	Dues, Fees, Subscriptions & Promotions			73,069	73,069		73,069	(63,471)	9,598		20
21	Clerical & General Office Expenses	158,636	12,450	507,055	678,141		678,141	(458,088)	220,053		21
22	Employee Benefits & Payroll Taxes			296,815	296,815		296,815	(1,656)	295,159		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,244	4,244		4,244	120	4,364		24
25	Other Admin. Staff Transportation			52,555	52,555		52,555	590	53,145		25
26	Insurance-Prop.Liab.Malpractice			112,753	112,753		112,753	634	113,387		26
27	Other (specify):* <a href="#">See Supplemental</a>							11,535	11,535		27
28	<b>TOTAL General Administration</b>	281,427	12,450	1,290,201	1,584,078		1,584,078	(623,603)	960,475		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,878,948	315,405	1,488,043	3,682,396		3,682,396	(617,276)	3,065,120		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

**Timber Point Healthcare Center, Inc.**  
**Medicaid Cost Report**  
**01/01/14 - 12/31/14**

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**Page 3 Supplemental Schedule**

<u>Description</u>	<u>Salaries</u>	<u>Supplies</u>	<u>Other</u>
<b>Line 7 Detailed</b>			
Security			68
Alloc. - Extended Care Consulting, LLC			355
Total	-	-	423

**Line 15 Detailed**

Total	-	-	-
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**Line 27 Detailed**

Alloc. - Extended Care Consulting, LLC			11,535
Total	-	-	11,535

**Timber Point Healthcare Center, Inc.**  
**Medicaid Cost Report**  
**01/01/14 - 12/31/14**

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

Vendor	Amount	Allowable
Care Consultants of Illinois	4,316	4,316
Nicholas Skinner	327	327
Nancy Leapley	24	24
Judy McCallister	29	29
Nicole Buehler	3,945	3,945
Patricia Bedwell	15,476	15,476
Donald Steinkuhler	647	647
Shirley Gooding	48	48
Care Management Facility	1,095	1,095
Andrea Bloyd	2,737	2,737
Pam Steinkuhler	204	204
Other	5,310	5,310
Countryside American Express	17,056	17,056
Kim Campbell	190	190
Laura Sepessy	565	565
Karen Morg	120	120
Tialisa Vinyard	69	69
Enterprise Fleet Management	96	96
TCF Equipment	300	300
Alloc. - Extended Care Consulting	590	590
Total	53,145	53,145

Facility Name & ID Number **Timber Point Hlthcare Center**

#0043158

Report Period Beginning:

01/01/14

Ending:

12/31/14

## 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			44,941	44,941		44,941	47,292	92,233			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			15,052	15,052		15,052	122,862	137,914			32
33	Real Estate Taxes			26,588	26,588		26,588	1,139	27,727			33
34	Rent-Facility & Grounds			182,159	182,159		182,159	(180,911)	1,248			34
35	Rent-Equipment & Vehicles			22,119	22,119		22,119	347	22,466			35
36	Other (specify):* <a href="#">See Supplemental</a>											36
37	<b>TOTAL Ownership</b>			290,859	290,859		290,859	(9,271)	281,588			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		206,516	473,586	680,102		680,102		680,102			39
40	Barber and Beauty Shops			10	10		10		10			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			168,738	168,738		168,738		168,738			42
43	Other (specify):* <a href="#">See Supplemental</a>											43
44	<b>TOTAL Special Cost Centers</b>		206,516	642,334	848,850		848,850		848,850			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,878,948	521,921	2,421,236	4,822,105		4,822,105	(626,547)	4,195,558			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

**Timber Point Healthcare Center, Inc.**  
**Medicaid Cost Report**  
**01/01/14 - 12/31/14**

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**Page 4 Supplemental Schedule**

Description	Salaries	Supplies	Other
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**Line 36 Detailed**

Total	-	-	-
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**Line 43 Detailed**

Total	-	-	-
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**VI. ADJUSTMENT DETAIL**

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

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(17,834)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,089)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(4,753)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(468,472)	21		24
25	Fund Raising, Advertising and Promotional	(62,185)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,053)	20		28
29	Other-Attach Schedule See Supplemental	(50,331)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (606,717)</b>		<b>\$</b>	<b>30</b>

**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)	(19,830)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (19,830)</b>		<b>36</b>
37	<b>TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)</b>	<b>\$ (626,547)</b>		<b>37</b>

\*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>			<b>\$</b>		<b>47</b>

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

SEE ACCOUNTANTS' COMPILATION REPORT

Timber Point Hlthcare Center

ID# 0043158

Report Period Beginning: 01/01/14

Ending: 12/31/14

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Other Income	\$ (11,945)	21	1
2	Collection Expense	(2,040)	19	2
3	Bank Charges	(9,702)	21	3
4	Theft Loss	(25)	21	4
5	Settlement	(6,947)	21	5
6	PY Expenses	(7,325)	21	6
7	Legal	(5,200)	19	7
8	Other Professional	(5,400)	19	8
9				9
10				10
11				11
12				12
13	Timber Point Associates, LLC			13
14	Professional Fees	(1,497)	19	14
15	Office and Clerical	(250)	21	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>	(50,331)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Timber Point Hlthcare Center# 0043158

Report Period Beginning:

01/01/14

Ending:

12/31/14

## 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	70	0	0	0	0	0	0	0	0	70	1
2	Food Purchase	(1,089)	0	312	0	0	0	0	0	0	0	0	(777)	2
3	Housekeeping	0	0	233	0	0	0	0	0	0	0	0	233	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	527	0	0	0	0	0	0	0	0	527	5
6	Maintenance	0	0	2,174	3,745	0	0	0	0	0	0	0	5,919	6
7	Other (specify):*	0	0	0	355	0	0	0	0	0	0	0	355	7
8	<b>TOTAL General Services</b>	<b>(1,089)</b>	<b>0</b>	<b>3,316</b>	<b>4,100</b>	<b>0</b>	<b>6,327</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	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<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>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	1,444	7,810	0	0	0	0	0	0	0	9,254	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(14,137)	1,497	(109,881)	0	0	0	0	0	0	0	0	(122,521)	19
20	Fees, Subscriptions & Promotions	(64,238)	0	767	0	0	0	0	0	0	0	0	(63,471)	20
21	Clerical & General Office Expenses	(509,419)	250	5,255	45,826	0	0	0	0	0	0	0	(458,088)	21
22	Employee Benefits & Payroll Taxes	0	0	0	(1,656)	0	0	0	0	0	0	0	(1,656)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	120	0	0	0	0	0	0	0	0	120	24
25	Other Admin. Staff Transportation	0	0	590	0	0	0	0	0	0	0	0	590	25
26	Insurance-Prop.Liab.Malpractice	0	0	634	0	0	0	0	0	0	0	0	634	26
27	Other (specify):*	0	0	0	11,535	0	0	0	0	0	0	0	11,535	27
28	<b>TOTAL General Administration</b>	<b>(587,794)</b>	<b>1,747</b>	<b>(101,071)</b>	<b>63,515</b>	<b>0</b>	<b>(623,603)</b>	<b>28</b>						
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(588,883)</b>	<b>1,747</b>	<b>(97,755)</b>	<b>67,615</b>	<b>0</b>	<b>(617,276)</b>	<b>29</b>						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Timber Point Hlthcare Center

# 0043158

Report Period Beginning:

01/01/14

Ending:

12/31/14

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	0	45,338	1,954	0	0	0	0	0	0	0	0	47,292	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(17,834)	140,249	447	0	0	0	0	0	0	0	0	122,862	32
33	Real Estate Taxes	0	0	1,139	0	0	0	0	0	0	0	0	1,139	33
34	Rent-Facility & Grounds	0	(180,911)	0	0	0	0	0	0	0	0	0	(180,911)	34
35	Rent-Equipment & Vehicles	0	0	347	0	0	0	0	0	0	0	0	347	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(17,834)</b>	<b>4,676</b>	<b>3,887</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>(9,271)</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>(606,717)</b>	<b>6,423</b>	<b>(93,868)</b>	<b>67,615</b>	<b>0</b>	<b>(626,547)</b>	<b>45</b>						

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6 Supp		See Page 6 - Supp		See Page 6 - Supp		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 180,911	Timber Point Associates, LLC	100.00%	\$	\$ (180,911)	1
2	V	32 Interest	345	Timber Point Associates, LLC	100.00%		(345)	2
3	V	19 Professional Fees		Timber Point Associates, LLC	100.00%	1,497	1,497	3
4	V	21 Office		Timber Point Associates, LLC	100.00%	250	250	4
5	V	26 Property Insurance		Timber Point Associates, LLC	100.00%			5
6	V	30 Depreciation		Timber Point Associates, LLC	100.00%	45,338	45,338	6
7	V	31 Amortization		Timber Point Associates, LLC	100.00%			7
8	V	32 Interest		Timber Point Associates, LLC	100.00%	140,594	140,594	8
9	V	33 Real Estate Taxes	26,588	Timber Point Associates, LLC	100.00%	26,588		9
10	V	36 Mortgage Insurance Premiums		Timber Point Associates, LLC	100.00%			10
11	V							11
12	V							12
13	V							13
14	Total		\$ 207,844			\$ 214,267	\$ * 6,423	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number

Timber Point Hlthcare Center

# 0043158

Report Period Beginning:

01/01/14

Ending:

12/31/14

## VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Sherwin I. Ray	33.33%	Avenue Care Nursing and Rehab	Chicago, IL	Ex. Care Consulting	Evanston, IL	Home Office	1
2	Jakob Bakst	33.33%	Beecher Manor Nursing and Rehab	Beecher, IL	Ex. Care Clinical	Evanston, IL	Administrative	2
3	Eric Rothner	33.34%	Briar Place	Indian Head, IL	CC Health Systems	Des Plaines, IL	Dietary & Suppl.	3
4			Chateau Village Nursing and Rehab	Willowbrook, IL	CCS VEBA	Evanston, IL	Health Insurance	4
5			Grasmere Place	Chicago, IL	2201 Main	Evanston, IL	Bldg. Company	5
6			Lakewood Nursing and Rehab	Plainfield, IL	Rothner Vents	Evanston, IL	Vent. Rental	6
7			Lemont Nursing and Rehab	Lemont, IL	Tricare Rehab	Hillside, IL	Therapy	7
8			Prairie Manor Halth Care	Chicago Heights, IL	Reliable Medical	Des Plaines, IL	Medical Supplies	8
9			Rainbow Beach Nursing Center	Chicago, IL	Harbor Light	Glen Ellyn, IL	Hospice	9
10			Sheridan Shores	Chicago, IL				10
11			South Suburban Rehabilitation Center	Chicago, IL	Timber Point			11
12			Tri-State Nursing and Rehab	Lansing, IL	Associates, LLC	Camp Point, IL	Bldg. Company	12
13			Wheaton Care Center	Wheaton, IL				13
14			Kensington Place Nursing and Rehab	Chicago, IL				14
15			Countryside Nursing and Rehab	Dolton, IL				15
16			Spring Creek Nursing and Rehab	Joliet, IL				16
17			Park House Nursing and Rehab	Chicago, IL				17
18			Timber Point Healthcare Center	Camp Point, IL				18
19			Prairie Village Healthcare Center	Jacksonville, IL				19
20			Major Hospital - Dyer	Dyer, IN				20
21			Major Hospital - Lake County	East Chicago, IN				21
22			Major Hospital - Sebo	Holbart, IN				22
23			Major Hospital - Lincolnshire	Merrillville, IN				23
24			Major Hospital - Munster	Munster, IN				24
25			McKinley Health Care Center	Canton, OH				25
26			St. James Manor	Crete, IL				26
27			The Parc at Joliet	Joliet, IL				27
28			The Estates of Hyde Park	Chicago, IL				28
29								29
30								30

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 Dietary	\$	Extended Care Consulting, LLC	100.00%	\$ 70	\$	70	15
16	V	2 Food		Extended Care Consulting, LLC	100.00%	312		312	16
17	V	3 Housekeeping		Extended Care Consulting, LLC	100.00%	233		233	17
18	V	5 Utilities		Extended Care Consulting, LLC	100.00%	527		527	18
19	V	6 Maintenance		Extended Care Consulting, LLC	100.00%	2,174		2,174	19
20	V	17 Administrative		Extended Care Consulting, LLC	100.00%	1,444		1,444	20
21	V	19 Professional Fees	114,000	Extended Care Consulting, LLC	100.00%	4,119		(109,881)	21
22	V	20 Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	767		767	22
23	V	21 Office and Clerical		Extended Care Consulting, LLC	100.00%	5,255		5,255	23
24	V	24 Seminar and Travel		Extended Care Consulting, LLC	100.00%	120		120	24
25	V	25 Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	590		590	25
26	V	26 Insurance		Extended Care Consulting, LLC	100.00%	634		634	26
27	V	30 Depreciation		Extended Care Consulting, LLC	100.00%	1,954		1,954	27
28	V	32 Interest		Extended Care Consulting, LLC	100.00%	447		447	28
29	V	33 Real Estate Taxes		Extended Care Consulting, LLC	100.00%	1,139		1,139	29
30	V	35 Rent - Equipment and Auto		Extended Care Consulting, LLC	100.00%	347		347	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 114,000			\$ 20,132	\$ *	(93,868)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6 Maintenance (Pooled)	\$	Extended Care Consulting, LLC	100.00%	\$ 3,745	\$ 3,745	15
16	V	6 Maintenance (Direct)		Extended Care Consulting, LLC	100.00%			16
17	V	7 Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	355	355	17
18	V	7 Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%			18
19	V	17 Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	7,810	7,810	19
20	V	21 Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	45,826	45,826	20
21	V	21 Office and Clerical (Direct)	17,633	Extended Care Consulting, LLC	100.00%	17,633		21
22	V	27 Emp. Gen. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	9,879	9,879	22
23	V	27 Emp. Gen. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	1,656	1,656	23
24	V	22 Employee Benefits	1,656				(1,656)	24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 19,289			\$ 86,904	\$ * 67,615	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 Dietary	\$	Care Centers Health Systems, Inc.	100.00%	\$	\$
16	V	10 Nursing		Care Centers Health Systems, Inc.	100.00%		
17	V	39 Ancillary		Care Centers Health Systems, Inc.	100.00%		
18	V						
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	<b>Total</b>		\$			\$ 0	\$ *

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39 Ancillary	\$	Tricare Rehab	100.00%	\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0	\$ *

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39 Ancillary	\$	Reliable Medical of the Midwest, LLC		\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0	\$ *

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22 Employee Benefits	\$ 71,757	CCS VEBA	100.00%	\$ 71,757	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 71,757			\$ 71,757	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	39 Ancillary	\$	Vent Lease, LLC	100.00%	\$	\$
16	V	32 Interest		Vent Lease, LLC	100.00%		
17	V	30 Depreciation		Vent Lease, LLC	100.00%		
18	V						
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		\$			\$ 0	\$ *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number

Timber Point Hlthcare Center

# 0043158

Report Period Beginning:

01/01/14

Ending:

12/31/14

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Adam Vales	Relative	Clerical	0.00%	See Attached	0.62	1.55%	Salary	\$ 1,211	22 - 7	1
2	Sherwin Ray	Shareholder	Administration	33.33%	See Attached	5.38	13.45%	Salary	20,362	17 - 1	2
3								Mgmt. Fee	20,925	17 - 3	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 42,498		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Timber Point Hlthcare Center

# 0043158

Report Period Beginning:

01/01/14

Ending: 12/31/14

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

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

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Timber Point Hlthcare Center

# 0043158

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Patient Days	1,251,572	31	\$ 4,057	\$ 21,522	\$ 70	1
2	2	Food	Patient Days	1,251,572	31	18,150	21,522	312	2
3	3	Housekeeping	Patient Days	1,251,572	31	13,578	21,522	233	3
4	5	Utilities	Patient Days	1,251,572	31	30,626	21,522	527	4
5	6	Maintenance	Patient Days	1,251,572	31	126,400	21,522	2,174	5
6	17	Administrative	Patient Days	1,251,572	31	84,000	21,522	1,444	6
7	19	Professional Fees	Patient Days	1,251,572	31	239,560	21,522	4,119	7
8	20	Dues and Subscriptions	Patient Days	1,251,572	31	44,626	21,522	767	8
9	21	Office and Clerical	Patient Days	1,251,572	31	305,586	21,522	5,255	9
10	24	Travel and Seminar	Patient Days	1,251,572	31	6,989	21,522	120	10
11	25	Other Staff Admin. Trans.	Patient Days	1,251,572	31	34,307	21,522	590	11
12	26	Insurance	Patient Days	1,251,572	31	36,877	21,522	634	12
13	30	Depreciation	Patient Days	1,251,572	31	113,642	21,522	1,954	13
14	32	Interest	Patient Days	1,251,572	31	26,010	21,522	447	14
15	33	Real Estate Taxes	Patient Days	1,251,572	31	66,240	21,522	1,139	15
16	35	Rent - Equipment and Auto	Patient Days	1,251,572	31	20,168	21,522	347	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,170,816	\$	\$ 20,132	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Timber Point Hlthcare Center

# 0043158

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	6	Maintenance	Patient Days	1,251,572	31	\$ 217,811	\$ 217,811	21,522	\$ 3,745	1
2	6	Maintenance	Direct	1	1			1		2
3	7	Emp. Ben. - Gen. Serv.	Patient Days	1,251,572	31	20,665		21,522	355	3
4	7	Emp. Ben. - Gen. Serv.	Direct	1	1			1		4
5	17	Administrative	Patient Days	1,251,572	31	454,189	454,189	21,522	7,810	5
6	21	Office and Clerical	Patient Days	1,251,572	31	2,664,950	2,664,951	21,522	45,826	6
7	21	Office and Clerical	Direct	1	1	17,633	17,633	1	17,633	7
8	27	Emp. Gen. - Gen. Admin.	Patient Days	1,251,572	31	574,509	574,509	21,522	9,879	8
9	27	Emp. Gen. - Gen. Admin.	Direct	1	1	1,656		1	1,656	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 3,951,413	\$ 3,929,093		\$ 86,904	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Timber Point Hlthcare Center

# 0043158

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Care Centers Health Systems, Inc.  
 Street Address 200 Howard Avenue #246  
 City / State / Zip Code Des Plaines, Illinois 60018  
 Phone Number ( 224) 612 - 5662  
 Fax Number ( )

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Profit Margin %	77,896	21	\$ 77,896		\$	1
2	10	Nursing	Profit Margin %	234	21	234			2
3	39	Ancillary	Profit Margin %	97,004	21	97,004			3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 175,134		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Timber Point Hlthcare Center

# 0043158

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Tricare Rehab  
 Street Address 150 Fencil Lane  
 City / State / Zip Code Hillside, Illinois 60162  
 Phone Number ( 708) 449 - 9400  
 Fax Number ( 708) 449 - 9700

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	39	Ancillary	Profit Margin %	12	\$ 8,898,201	\$		\$
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
25	TOTALS				\$ 8,898,201	\$		\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Timber Point Hlthcare Center

# 0043158

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Reliable Medical of the Midwest, LLC  
 Street Address 200 Howard Avenue, Suite 246  
 City / State / Zip Code Des Plaines, Illinois 60018  
 Phone Number ( 847) 566 - 0800  
 Fax Number ( )

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	Ancillary	Profit Margin %		\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Timber Point Hlthcare Center

# 0043158

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	22	Employee Benefits	Direct Allocations	1	1	\$ 71,757	\$	1	\$ 71,757	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 71,757	\$		\$ 71,757	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Timber Point Hlthcare Center

# 0043158

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Vent Lease, LLC  
 Street Address 2201 Main Street  
 City / State / Zip Code Evanston, Illinois 60202  
 Phone Number ( 847) 905 - 3000  
 Fax Number ( 847) 491 - 9565

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	Ancillary	Profit Margin %	18	\$ 110,244	\$		\$	1
2	32	Depreciation	Direct	1	2,695				2
3	30	Interest	Direct	1	2,944				3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 115,883	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Timber Point Hlthcare Center

# 0043158

Report Period Beginning:

01/01/14

Ending:

12/31/14

**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			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	Bayview Loan Servicing		X	Mortgage			\$	\$			\$	26,938						
2	Atied Associates	X		Mortgage				947,409				113,656						
3	Creative Fleet Leasing		X	Bus Loan			54,990	50,269				1,705						
4																		
5																		
<b>Working Capital</b>																		
6	HFG		X	Line of Credit								13,347						
7	Alloc. - Extended Care	X		Line of Credit								447						
8																		
9	<b>TOTAL Facility Related</b>						\$ 54,990	\$ 997,678				\$ 156,093						
<b>B. Non-Facility Related*</b>																		
10																		
11																		
12	Interest Income		X									(17,834)						
13	Interest Income - Bldg. Part.		X									(345)						
14	<b>TOTAL Non-Facility Related</b>						\$	\$				\$ (18,179)						
15	<b>TOTALS (line 9+line14)</b>						\$ 54,990	\$ 997,678				\$ 137,914						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 0 Line # 36

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

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



**2013 LONG TERM CARE REAL ESTATE TAX STATEMENT**

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

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

Enter the tax index number and real estate tax assessed for 2013 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 2013.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>03-0-0932-001-00</u>	<u>Long Term Care Facility</u>	\$ <u>26,235.28</u>	\$ <u>26,235.28</u>
2. <u>Allocation</u>	<u>Long Term Care Facility</u>	\$ <u>162,082.08</u>	\$ <u>1,084.83</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>188,317.36</u></u>	\$ <u><u>27,320.11</u></u>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

**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 Hlthcare Center

# 0043158

Report Period Beginning:

01/01/14 Ending:

12/31/14

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 32,000 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

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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	Facility		1998	\$ 118,000	1
2	Alloc. - Ext. Care			5,488	2
3	TOTALS			\$ 123,488	3

SEE ACCOUNTANTS' COMPILATION REPORT

**XI. OWNERSHIP COSTS (continued)**

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

	1	2	3	4	5	6	7	8	9		
	Bed*s	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	110		1998		\$ 1,120,000	\$ 40,729	39	\$ 40,729		\$ 690,648	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Timber Point Healthcare Center, Inc. (Operating Entity)										
10											10
11	Various		2001		18,442	670	27.5	670		8,916	11
12	Various		2003		7,919	288	27.5	288		3,300	12
13	Various		2004		24,419	1,003	15 - 27.5	1,003		10,508	13
14	Various		2005		12,730	463	27.5	463		4,379	14
15	Various		2006		18,831	685	27.5	685		5,793	15
16	Various		2007		6,583	239	27.5	239		1,785	16
17	Various		2008		22,650	626	27.5	626		4,039	17
18	Various		2010		7,216	262	27.5	262		1,073	18
19	Kitchen Roof - Replacement		2011		4,938	180	27.5	180		658	19
20	Kitchen Exhaust Hood and Installation		2011		2,376	86	27.5	86		281	20
21	Kitchen Roof Top Unit - Replacement		2012		4,938	180	27.5	180		509	21
22	Flooring - Nurses Station		2012		6,461	235	27.5	235		548	22
23	Plumbing - PVC Piping from Basement to Outside Facility		2012		3,975	145	27.5	145		289	23
24	Driveway Repairs - East Entrance - Tear, gravel, and regrade		2013		12,925	470	27.5	470		666	24
25	Flooring - Front Lobby		2013		6,185	225	27.5	225		300	25
26	Flooring - Hallways / Common Areas		2014		3,116	76	27.5	76		76	26
27	Water Heater		2014		4,979	113	27.5	113		113	27
28	Flooring - Hallways / Common Areas		2014		5,955	18	27.5	18		18	28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Timber Point Associates, LLC (Building Partnership)		\$	\$		\$	\$	\$	37
38									38
39	Various	1998	15,322	557	27.5	557		9,169	39
40	Various	1999	10,509	382	27.5	382		5,747	40
41	Various	2000	2,585	93	27.5	93		1,365	41
42	Various	2000	12,177		27.5			12,177	42
43	Various	2001	99,148	3,577	27.5	3,577		49,921	43
44									44
45									45
46									46
47									47
48									48
49									49
50	Related Party Allocations - See Supplemental Schedules								50
51									51
52	Allocations - Extended Care Consulting, LLC	2007	79	4		4		32	52
53	Allocations - Extended Care Consulting, LLC	2009	47	2		2		14	53
54	Allocations - Extended Care Consulting, LLC	2010	464	23		23		116	54
55	Allocations - Extended Care Consulting, LLC	2011	167	8		8		33	55
56	Allocations - Extended Care Consulting, LLC	2013	55	3		3		8	56
57	Allocations - Extended Care Consulting, LLC	2014	763	38		38		38	57
58									58
59									59
60	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2002	7,563	194		194		2,384	60
61	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2002	6,248	532		532		6,248	61
62	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2003	7,353	627		627		7,363	62
63	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2005	366	39		39		325	63
64	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2009	66	3		3		20	64
65	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2014	1,054	53		53		53	65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,458,604	\$ 52,828		\$ 52,828	\$	\$ 828,912	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 126,564	\$ 2,131	\$ 2,131	\$	5 - 7	\$ 99,336	71
72	Current Year Purchases	15,546	1,790	1,790		5	1,790	72
73	Fully Depreciated Assets							73
74	See Supplemental	123,484	340	340			121,634	74
75	TOTALS	\$ 265,594	\$ 4,261	\$ 4,261	\$		\$ 222,760	75

D. Vehicle Costs. (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Alloc. - Ext. Care Consult.			\$ 3,103	\$ 88	\$ 88	\$		\$ 2,753	76
77	Facility - Timber Point Ass	Van		23,698					23,698	77
78	Facility - Timber Point HC	Bus		58,427	35,056	35,056			35,056	78
79										79
80	TOTALS			\$ 85,228	\$ 35,144	\$ 35,144	\$		\$ 61,507	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,932,914 81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 92,233 82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 92,233 83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,113,179 85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

**Timber Point Healthcare Center, Inc.**  
**Medicaid Cost Report**  
**01/01/14 - 12/31/14**

**Page 13 Supplemental Schedule**

Description	Cost	Depreciation	Accumulated Depreciation
<b>Related Party 1 - Timber Point Associates, LLC</b>			
Prior	118,000		118,000
Current			
Total	118,000	-	118,000
<b>Related Party 2 - Extended Care Consulting, LLC</b>			
Prior	2,118	212	1,381
Current	1,272	128	159
Total	3,390	340	1,540
<b>Related Party 3 - Extended Care Consulting, LLC / 2201 Main, LLC</b>			
Prior	2,094		2,094
Current			
Total	2,094	-	2,094
<b>Related Party 4 - Vent Lease (Matrix Software)</b>			
Prior			
Current			
Total	-	-	-
<b>Total</b>	<b>123,484</b>	<b>340</b>	<b>121,634</b>

Facility Name & ID Number Timber Point Hlthcare Center

# 0043158

Report Period Beginning: 01/01/14

Ending: 12/31/14

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: N/A - Related Party

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

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	See							5
6	Supplement				1,248			6
7	TOTAL				\$ 1,248			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12.	<u>/2015</u>	\$ _____
13.	<u>/2016</u>	\$ _____
14.	<u>/2017</u>	\$ _____

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: \$ 20,003 Description: See Supplemental Schedule

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Facility</u>	<u>Ford</u>	\$ _____	\$ <u>2,463</u>	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ <u>2,463</u>	21

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

**Timber Point Healthcare Center, Inc.**  
**Medicaid Cost Report**  
**01/01/14 - 12/31/14**

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

<b>Vendor</b>	<b>Amount</b>
Bruce 88 Storage	1,248
Total	<u>1,248</u>

**Page 14 Supplemental Schedule - Equipment Rental**

<b>Vendor</b>	<b>Amount</b>
Digital Copy System	3,218
Flynn Sales Services	8,400
Wells Fargo	2,863
Accelerated	5,100
Other	75
Alloc. - Extended Care Consulting, LLC	347
Total	<u>20,003</u>

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)							
			Units of Service	Cost	Units	Cost						
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	206,976	\$		\$	206,976	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				12,509				12,509	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				221,884				221,884	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39 - 02	# of prescripts					187,070			187,070	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify): <a href="#">See Supplemental</a>	39 - 02						19,446			19,446	12
13	Other (specify): <a href="#">See Supplemental</a>	39 - 03						32,217			32,217	13
14	TOTAL			\$		\$	473,586	\$	206,516	\$	680,102	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

**Timber Point Hlthcare Center  
Medicaid Cost Report  
01/01/14 - 12/31/14**

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**Page 16 Supplemental Schedule**

<b>Description</b>	<b>Supplies</b>	<b>Other</b>
Medical Supplies	2,767	
Feeding Tube Supplement	244	
Oxygen	14,988	
Therapy and Rehab Supplies	1,447	
Wheelchairs and Walkers		699
Low Pressure Mattress		1,968
Food Pump		685
Laboratory		11,842
Radiology		1,035
Ambulance		1,523
Other		14,465
Total	<u>19,446</u>	<u>32,217</u>

Facility Name & ID Number **Timber Point Hlthcare Center**

# **0043158**

Report Period Beginning: **01/01/14**

Ending:

**12/31/14**

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **12/31/14**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$	\$ <b>12,724</b>	1
2	Cash-Patient Deposits	<b>21,187</b>	<b>21,187</b>	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <b>556,631</b> )	<b>1,126,403</b>	<b>1,126,403</b>	3
4	Supply Inventory (priced at <b>Cost - FIFO</b> )			4
5	Short-Term Investments			5
6	Prepaid Insurance	<b>32,899</b>	<b>32,899</b>	6
7	Other Prepaid Expenses	<b>6,546</b>	<b>6,546</b>	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <b>See Supplemental Schedule</b>			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ <b>1,187,035</b>	\$ <b>1,199,759</b>	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		<b>118,000</b>	13
14	Buildings, at Historical Cost		<b>1,120,000</b>	14
15	Leasehold Improvements, at Historical Cost	<b>166,812</b>	<b>306,553</b>	15
16	Equipment, at Historical Cost	<b>202,911</b>	<b>344,609</b>	16
17	Accumulated Depreciation (book methods)	<b>(193,462)</b>	<b>(1,103,189)</b>	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): <b>See Supplemental Schedule</b>			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ <b>176,261</b>	\$ <b>785,973</b>	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ <b>1,363,296</b>	\$ <b>1,985,732</b>	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ <b>842,555</b>	\$ <b>842,555</b>	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	<b>19,803</b>	<b>19,803</b>	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	<b>101,949</b>	<b>101,949</b>	30
31	Accrued Taxes Payable (excluding real estate taxes)	<b>4,476</b>	<b>4,476</b>	31
32	Accrued Real Estate Taxes(Sch.IX-B)		<b>27,547</b>	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<b>See Supplemental Schedule</b>	<b>1,296,126</b>	<b>1,440,078</b>	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ <b>2,264,909</b>	\$ <b>2,436,408</b>	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	<b>50,269</b>	<b>50,269</b>	39
40	Mortgage Payable		<b>947,409</b>	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<b>See Supplemental Schedule</b>			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ <b>50,269</b>	\$ <b>997,678</b>	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ <b>2,315,178</b>	\$ <b>3,434,086</b>	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ <b>(951,882)</b>	\$ <b>(1,448,354)</b>	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ <b>1,363,296</b>	\$ <b>1,985,732</b>	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**Timber Point Hlthcare Center  
Medicaid Cost Report  
01/01/14 - 12/31/14**

---

Page 17 Supplemental Schedule

Description	Operating	After Consolidation
<b>Line 9 - Other Current Assets</b>		
Total	-	-
<b>Line 23 - Other Long Term Assets</b>		
Total	-	-
<b>Line 36 - Other Current Liabilities</b>		
Due to Related Parties	1,296,126	1,440,078
Total	1,296,126	1,440,078
<b>Line 43 - Other Long Term Liabilities</b>		
Total	-	-

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ (420,336)	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<u>Rounding</u>	5	<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>	\$ (420,331)	<b>6</b>
<b>A. Additions (deductions):</b>			
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(531,551)	<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>	\$ (531,551)	<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>	\$ (951,882)	<b>24</b> *

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,156,011	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,156,011	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	104,764	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 104,764	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***	17,834	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 17,834	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	11,945	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 11,945	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,290,554	30

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	816,412	31
32	Health Care	1,281,906	32
33	General Administration	1,584,078	33
<b>B. Capital Expense</b>			
34	Ownership	290,859	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	680,112	35
36	Provider Participation Fee	168,738	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,822,105	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(531,551)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (531,551)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 2,051,759	44
45	Private Pay - Net Inpatient Revenue	456,474	45
46	Medicare - Net Inpatient Revenue	1,384,736	46
47	Other-(specify) <u>Hospice - Net Inpatient Revenue</u>	49,277	47
48	Other-(specify) <u>Insurance - Net Inpatient Revenue</u>	213,765	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 4,156,011	49

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

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

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

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

**SEE ACCOUNTANTS' COMPILATION REPORT**



Facility Name & ID Number Timber Point Hlthcare Center

# 0043158

Report Period Beginning:

01/01/14

Ending:

12/31/14

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,940	2,147	\$ 66,056	\$ 30.77	1
2	Assistant Director of Nursing	978	1,015	27,488	27.08	2
3	Registered Nurses	14,543	15,788	423,454	26.82	3
4	Licensed Practical Nurses	6,260	6,674	125,151	18.75	4
5	CNAs & Orderlies	30,875	32,825	346,797	10.57	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,646	4,062	60,905	14.99	8
9	Activity Director	1,673	1,869	24,100	12.89	9
10	Activity Assistants	1,709	1,936	17,302	8.94	10
11	Social Service Workers	3,810	4,214	73,922	17.54	11
12	Dietician					12
13	Food Service Supervisor	2,133	2,190	32,695	14.93	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,666	14,393	128,956	8.96	15
16	Dishwashers					16
17	Maintenance Workers	8,968	9,855	128,517	13.04	17
18	Housekeepers	8,557	9,486	83,115	8.76	18
19	Laundry	3,926	4,569	41,462	9.07	19
20	Administrator	1,956	2,138	102,429	47.91	20
21	Assistant Administrator					21
22	Other Administrative	280	282	20,362	72.21	22
23	Office Manager					23
24	Clerical	6,205	6,740	158,636	23.54	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	1,425	1,631	17,601	10.79	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	111,550	121,814	\$ 1,878,948 *	\$ 15.42	34

**B. CONSULTANT SERVICES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$ 5,228	01 - 03	35
36	Medical Director	3,315	09 - 03	36
37	Medical Records Consultant	836	10 - 03	37
38	Nurse Consultant			38
39	Pharmacist Consultant	4,563	10 - 03	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant	4,080	12 - 03	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 18,022		49

**C. CONTRACT NURSES**

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

\*\* See instructions.

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Andrea Bloyd	Administrator	0	\$ 102,429	Workers' Compensation Insurance	\$ 62,493	IDPH License Fee	\$	
Sherwin Ray	Administration	33.33	20,362	Unemployment Compensation Insurance	12,127	Advertising: Employee Recruitment	1,309	
				FICA Taxes	141,916	Health Care Worker Background Check	4,914	
				Employee Health Insurance	71,757	(Indicate # of checks performed )		
				Employee Meals		<u>Patient Background Checks</u>		
				Illinois Municipal Retirement Fund (IMRF)*		Advertising and Public Relations	64,238	
				Employee Physicals	62	Dues and Subscriptions	1,067	
				Holiday Expense	1,000	Licenses	1,541	
				Other Employee Welfare	5,804	Alloc. - Extended Care Consulting	767	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 122,791					
B. Administrative - Other								
Description			Amount					
Sherwin Ray - Management Fee			\$ 20,925					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 20,925					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Description	Amount	
Extended Care Consulting, LLC	Home Office		\$ 114,000			Out-of-State Travel	\$	
Personnel Planners, Inc.	Unemployment Consultant		2,350					
Plante & Moran, PLLC	Accounting		19,522					
Krupnick, Bokor & Kagda	Accounting		3,825			In-State Travel		
Frost, Ruttenberg & Rothblatt, PC	Accounting		228					
Propay Payroll Services	Data Processing / IT		11,725					
Medifax / EDI	Data Processing / IT		1,087			Seminar Expense	4,244	
E-Health Data Solutions	Data Processing / IT		5,775			Alloc. - Extended Care Consulting	120	
American Data	Data Processing / IT		3,221					
MDI / Achieve	Data Processing / IT		2,417					
Matrix Care	Data Processing / IT		6,683			Entertainment Expense	( )	
See Supplemental Schedule			51,952					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 222,785	TOTAL	\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 4,364	

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

\*\*See instructions.

**Timber Point Healthcare Center, Inc.**  
**Medicaid Cost Report**  
**01/01/14 - 12/31/14**

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

Vendor	Type	Amount
Care Consultants of Illinois	Data Processing / IT	2,839
Singer Networks	Data Processing / IT	2,693
Care Management Facility	Data Processing / IT	14,178
Nebo Systems	Data Processing / IT	318
Paragon Micro	Data Processing / IT	1,534
National Datacare Corporation	Data Processing / IT	1,546
Ability Network	Data Processing / IT	980
Dell	Data Processing / IT	6,047
Other	Data Processing / IT	768
Burke, Warren, MacKay & Serritella, P.C.	Legal	1,176
Williams, Montgomery & John, Ltd.	Legal	3,101
Holly Turner	Legal	250
Roff Goffman	Legal	3
Chuhak & Tecsccon	Legal	921
Foley & Lardner	Legal	1,602
Grabowski Law Services, LLC	Collections	2,040
HFG	Other	5,400
Blymas	Accountant / Tax Consultant	3,654
Limitless Technology	Other	1,084
Other	Other	1,818
Total		51,952

**Timber Point Hlthcare Center  
Medicaid Cost Report  
01/01/14 - 12/31/14**

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

Firm Name	Invoice Date	Description of Services	Allowable Amount	Non-Allowable Amount
Williams, Montgomery & John, Ltd.	01/20/14	Non-Allowable		61
Burke, Warren, MacKay & Serritella, P.C.	01/23/14	Non-Allowable		122
Williams, Montgomery & John, Ltd.	02/01/14	Non-Allowable		82
Burke, Warren, MacKay & Serritella, P.C.	02/28/14	Non-Allowable		119
Williams, Montgomery & John, Ltd.	03/19/14	Non-Allowable		41
Burke, Warren, MacKay & Serritella, P.C.	03/27/14	Non-Allowable		36
Williams, Montgomery & John, Ltd.	04/30/14	Non-Allowable		94
Burke, Warren, MacKay & Serritella, P.C.	05/15/14	Non-Allowable		83
Williams, Montgomery & John, Ltd.	05/15/14	Non-Allowable		33
Burke, Warren, MacKay & Serritella, P.C.	05/18/14	Non-Allowable		99
Williams, Montgomery & John, Ltd.	07/11/14	Non-Allowable		8
Burke, Warren, MacKay & Serritella, P.C.	07/23/14	Non-Allowable		13
Chuhak & Tecsccon	07/31/14	Non-Allowable		492
Burke, Warren, MacKay & Serritella, P.C.	08/15/14	Non-Allowable		17
Chuhak & Tecsccon	08/31/14	Non-Allowable		247
Williams, Montgomery & John, Ltd.	09/11/14	Non-Allowable		947
Burke, Warren, MacKay & Serritella, P.C.	09/22/14	Non-Allowable		298
Chuhak & Tecsccon	09/22/14	Non-Allowable		(186)
Roff Goffman	09/26/14	Non-Allowable		3
Williams, Montgomery & John, Ltd.	10/15/14	Non-Allowable		526
Burke, Warren, MacKay & Serritella, P.C.	10/23/14	Non-Allowable		26
Chuhak & Tecsccon	10/31/14	Non-Allowable		178
Chuhak & Tecsccon	10/31/14	Non-Allowable		89
Chuhak & Tecsccon	10/31/14	Non-Allowable		101
Foley & Lardner	11/07/14	Corporate Matter - Review Cost Reports	193	
Burke, Warren, MacKay & Serritella, P.C.	11/18/14	Non-Allowable		72
Burke, Warren, MacKay & Serritella, P.C.	11/18/14	Non-Allowable		263
Williams, Montgomery & John, Ltd.	11/19/14	Non-Allowable		1,014
Foley & Lardner	12/11/14	Corporate Matter - Review Cost Reports	1,410	
Williams, Montgomery & John, Ltd.	12/16/14	Non-Allowable		70
Burke, Warren, MacKay & Serritella, P.C.	12/31/14	Non-Allowable		30
Holly Turner	12/31/14	Other Legal	250	
Williams, Montgomery & John, Ltd.	12/31/14	Non-Allowable		226
Total			1,852	5,200

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

(See instructions.)

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

SEE ACCOUNTANTS' COMPILATION REPORT

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 5 - 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 2,660 Line 10 - 02
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 168,738  
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.

**SEE ACCOUNTANTS' COMPILATION REPORT**

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
  - a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
  - b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
  - c. What percent of all travel expense relates to transportation of nurses and patients? 100 Ln 14
  - d. Have vehicle usage logs been maintained? Yes
  - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
  - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
  - g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes  
Attach invoices and a summary of services for all architect and appraisal fees