FOR BHF USE

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0043158

Facility Name: Timber Point Healthcare Ctr

Address: 205 E Spring St (Number) Camp Point (City) 62320 (Zip Code)

County: Adams

Telephone Number: (217) 593 - 7734 **Fax #** (217) 593 - 6360

HFS ID Number:

Date of Initial License for Current Owners: 1998

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Edward N. Slack, CPA **Telephone Number:** (847) 628 - 8796
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/12 to 12/31/12 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) Edward N. Slack, CPA, Partner, Health and Human Services
(Firm Name & Address) Plante & Moran, PLLC, 2155 Point Boulevard, Suite 200 Elgin, Illinois 60123
(Telephone) (847) 628 - 8796 Fax # (248) 327 - 8417

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001
Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

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

III. STATISTICAL DATA

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

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

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

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

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

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

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 [X] Date 1998 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 110 and days of care provided 2,366

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

Page 3 Supplemental Schedule

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

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

Page 3 Supplemental Schedule - Other Admin. Staff Transportation

Payee	Amount	Allowable
Adam Zanger	5,692	5,692
Extended Care Consulting	1,016	1,016
Care Consultants of IL	18,852	18,852
Kime Gronewold	190	190
Laura Sepessy	869	869
Stotc Automotive	726	726
United Access of Springfield	2,297	2,297
Other	450	450
Alloc. - Extended Care Consulting	382	382
	30,474	30,474

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			6,910	6,910		6,910	48,574	55,484			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							67,797	67,797			32
33	Real Estate Taxes			20,035	20,035		20,035	(3,033)	17,002			33
34	Rent-Facility & Grounds			119,564	119,564		119,564	(118,588)	976			34
35	Rent-Equipment & Vehicles			27,519	27,519		27,519	493	28,012			35
36	Other (specify):* See Supplement											36
37	**TOTAL Ownership**			174,028	174,028		174,028	(4,757)	169,271			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		175,881	612,249	788,130		788,130		788,130			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			180,364	180,364		180,364		180,364			42
43	Other (specify):* See Supplement	11,539		4,090	15,629		15,629	(15,629)				43
44	**TOTAL Special Cost Centers**	11,539	175,881	796,703	984,123		984,123	(15,629)	968,494			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,676,176	411,880	1,910,725	3,998,781		3,998,781	(174,175)	3,824,606			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Page 4 Supplemental Schedule

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

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

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(8,840)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(68,631)	21		24
25	Fund Raising, Advertising and Promotional	(22,571)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,034)	20		28
29	Other-Attach Schedule See Supplemental	(33,289)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (134,365)		$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(39,810)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (39,810)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (174,175)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Timber Point Healthcare Ctr

ID# 0043158

Report Period Beginning: 01/01/12

Ending: 12/31/12

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Real Estate Tax Refund - Add Back	$ 8,414	33	1
2	Bank Charges	(12,755)	21	2
3	Collection Fees	(408)	21	3
4	Non-Allowable Legal Fees	(8,038)	19	4
5	Non-Allowable Expenses	(15,629)	43	5
6				6
7				7
8				8
9				9
10				10
11	Timber Point Associates, LLC			11
12	Bank Fee	(15)	21	12
13	Amortization	(4,858)	31	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(33,289)		49

STATE OF ILLINOIS

Summary A

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

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

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

STATE OF ILLINOIS

Summary B

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

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	45,369	3,205	0	0	0	0	0	0	0	0	48,574	30
31	Amortization of Pre-Op. & Org.	(4,858)	4,858	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,840)	74,644	1,993	0	0	0	0	0	0	0	0	67,797	32
33	Real Estate Taxes	8,414	(12,458)	1,011	0	0	0	0	0	0	0	0	(3,033)	33
34	Rent-Facility & Grounds	0	(118,588)	0	0	0	0	0	0	0	0	0	(118,588)	34
35	Rent-Equipment & Vehicles	0	0	493	0	0	0	0	0	0	0	0	493	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(5,284)	(6,175)	6,702	0	0	0	0	0	0	0	0	(4,757)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(15,629)	0	0	0	0	0	0	0	0	0	0	(15,629)	43
44	TOTAL Special Cost Centers	(15,629)	0	0	0	0	0	0	0	0	0	0	(15,629)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(134,365)	(6,160)	(93,555)	59,905	0	0	0	0	0	0	0	(174,175)	45

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

VII. RELATED PARTIES

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$	Extended Care Consulting, LLC	100.00%	$ 115	$ 115	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	221	221	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	220	220	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	319	319	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	1,262	1,262	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	1,364	1,364	20
21	V	19	Professional Fees	114,000	Extended Care Consulting, LLC	100.00%	1,928	(112,072)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	1,672	1,672	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	5,707	5,707	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	103	103	24
25	V	25	Other Staff Admin. Transport.		Extended Care Consulting, LLC	100.00%	382	382	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	450	450	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	3,205	3,205	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	1,993	1,993	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	1,011	1,011	29
30	V	35	Rent - Equipment and Auto		Extended Care Consulting, LLC	100.00%	493	493	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 114,000			$ 20,445	$ * (93,555)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance	$	Extended Care Consulting, LLC	100.00%	$ 2,950	$ 2,950	15
16	V	06	Maintenance		Extended Care Consulting, LLC	100.00%			16
17	V	07	Employee Benefits		Extended Care Consulting, LLC	100.00%	542	542	17
18	V	07	Employee Benefits		Extended Care Consulting, LLC	100.00%			18
19	V	10	Nursing		Extended Care Consulting, LLC	100.00%			19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	6,387	6,387	20
21	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	44,829	44,829	21
22	V	21	Office and Clerical	15,813	Extended Care Consulting, LLC	100.00%	15,813		22
23	V	27	Employee Benefits		Extended Care Consulting, LLC	100.00%	9,410	9,410	23
24	V	27	Employee Benefits		Extended Care Consulting, LLC	100.00%	1,784	1,784	24
25	V	22	Employee Benefits	5,997	Extended Care Consulting, LLC	100.00%		(5,997)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 21,810			$ 81,715	$ * 59,905	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Health Insurance	$ 45,296	CCS VEBA	100.00%	$ 45,296	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 45,296			$ 45,296	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Adam Vales	Relative	Clerical	0	See Attached	0.44	1.11%	Alloc. Sal	$ 813	22 - 7	1
2	Sherwin Ray	Owner	Administration	33.33%	See Attached	4.68	11.70%	Alloc. Sal	18,226	17 - 1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 19,039		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,364,178	31	$ 7,101	$	22,149	$ 115	1
2	02	Food	Patient Days	1,364,178	31	13,586		22,149	221	2
3	03	Housekeeping	Patient Days	1,364,178	31	13,573		22,149	220	3
4	05	Utilities	Patient Days	1,364,178	31	19,636		22,149	319	4
5	06	Maintenance	Patient Days	1,364,178	31	77,756		22,149	1,262	5
6	17	Administrative	Patient Days	1,364,178	31	84,000		22,149	1,364	6
7	19	Professional Fees	Patient Days	1,364,178	31	118,750		22,149	1,928	7
8	20	Dues and Subscriptions	Patient Days	1,364,178	31	102,984		22,149	1,672	8
9	21	Office and Clerical	Patient Days	1,364,178	31	351,528		22,149	5,707	9
10	24	Seminar and Travel	Patient Days	1,364,178	31	6,315		22,149	103	10
11	25	Other Staff Admin. Transpor.	Patient Days	1,364,178	31	23,506		22,149	382	11
12	26	Insurance	Patient Days	1,364,178	31	27,741		22,149	450	12
13	30	Depreciation	Patient Days	1,364,178	31	197,424		22,149	3,205	13
14	32	Interest	Patient Days	1,364,178	31	122,765		22,149	1,993	14
15	33	Real Estate Taxes	Patient Days	1,364,178	31	62,275		22,149	1,011	15
16	35	Rent - Equipment and Auto	Patient Days	1,364,178	31	30,363		22,149	493	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,259,303	$		$ 20,445	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	06	Maintenance	Patient Days	1,364,178	31	$ 181,713	$ 181,713	22,149	$ 2,950	1
2	06	Maintenance	Direct Allocation	1	1			1		2
3	07	Employee Benefits	Patient Days	1,364,178	31	33,386		22,149	542	3
4	07	Employee Benefits	Direct Allocation	1	1			1		4
5	17	Administrative	Patient Days	1,364,178	31	393,362	393,362	22,149	6,387	5
6	21	Office and Clerical	Patient Days	1,364,178	31	2,761,089	2,761,089	22,149	44,829	6
7	21	Office and Clerical	Direct Allocation	1	1	15,813	15,813	1	15,813	7
8	27	Employee Benefits	Patient Days	1,364,178	31	579,570		22,149	9,410	8
9	27	Employee Benefits	Direct Allocation	1	1	1,784		1	1,784	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,966,717	$ 3,351,977		$ 81,715	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Health Insurance	Direct Allocation	1	1	$ 45,296	$	1	$ 45,296	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 45,296	$		$ 45,296	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Bayview Loan Servicing		X	Mortgage			$	$ 1,104,778			$ 74,644	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Extended Care Consulting	X		Line of Credit							1,993	6
7												7
8												8
9	TOTAL Facility Related						$	$ 1,104,778			$ 76,637	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13	Interest Income		X								(8,840)	13
14	TOTAL Non-Facility Related						$	$			$ (8,840)	14
15	TOTALS (line 9+line14)						$	$ 1,104,778			$ 67,797	15

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

* 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.)

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 66,354	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 65,136	2
3. Under or (over) accrual (line 2 minus line 1).		$ (1,218)	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 26,634	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$ 20,035	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND** $ 36,863 **For** 09 **Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)		$ (28,449)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 17,002	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	113,073	8
	2008	113,776	9
	2009	62,670	10
	2010	63,193	11
	2011	64,125	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

2012 Real Estate Tax Accrual = $25,366 * 1.05 = $26,634

Extended Care Consulting, LLC (Allocation) - $1,011

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Timber Point Healthcare Ctr COUNTY Adams

FACILITY IDPH LICENSE NUMBER 0043158

CONTACT PERSON REGARDING THIS REPORT Edward N. Slack

TELEPHONE (847) 628 - 8796 FAX #: (248) 327 - 8417

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

Enter the tax index number and real estate tax assessed for 2011 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	03-0-0932-001-00	Nursing Home	$ 64,124.82	$ 64,124.82
2.	Allocation	Extended Care Consulting, LLC	$ 127,119.67	$ 803.34
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 191,244.49	$ 64,928.16

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

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

Page 10 Supplemental Schedule

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

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

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (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 [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1998	$ 118,000	1
2	Ext. Care Consult.			5,182	2
3	TOTALS			$ 123,182	3

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	110		1998		$ 1,120,000	$ 40,727	27.5	$ 40,727	$	$ 609,191	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10	Various			2001	18,442	670	27.5	670		7,575	10
11	Various			2003	7,919	288	27.5	288		2,724	11
12	Various			2004	24,419	1,003	15 - 27.5	1,003		8,502	12
13	Various			2005	12,730	463	27.5	463		3,453	13
14	Various			2006	18,831	685	27.5	685		4,423	14
15	Various			2007	6,583	239	27.5	239		1,306	15
16	Various			2008	22,650	626	27.5	626		2,788	16
17	Handicap Ramp			2010	3,986	145	27.5	145		308	17
18	Install Duct			2010	3,230	118	27.5	118		240	18
19	Kitchen Roof Top Replacement			2011	4,938	247	20	247		411	19
20	Kitchen Exhaust Hood and Installation			2011	2,376	475	5	475		594	20
21	Kitchen Roof top Unit Replacement			2012	4,938	150	27.5	150		150	21
22	Flooring - Nurses Station			2012	6,461	78	27.5	78		78	22
23	Plumbing - PVC Piping from Basement to Outside Facility			2012	3,975		27.5				23
24											24
25											25
26											26
27	Timber Point Associates, LLC (Building Partnership)										27
28											28
29	Various			1998	15,322	557	27.5	557		8,055	29
30	Various			1999	10,509	382	27.5	382		4,984	30
31	Various			2000	2,585	94	27.5	94		1,163	31
32	Various			2000	12,177	3	27.5	3		12,177	32
33	Various			2001	99,148	3,605	27.5	3,605		41,842	33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38	Related Party Allocations - See Supplemental Schedules								38
39									39
40	Allocations - Extended Care Consulting	2007	75	4	20	4		22	40
41	Allocations - Extended Care Consulting	2009	45	2	20	2		9	41
42	Allocations - Extended Care Consulting	2010	438	22	20	22		66	42
43	Allocations - Extended Care Consulting	2011	158	8	20	8		16	43
44	Allocations - Extended Care Consulting	2012	52	3	20	3		3	44
45									45
46	Allocations - Extended Care Consulting / 2201 Main LLC	2002	7,141	183	39	183		183	46
47	Allocations - Extended Care Consulting / 2201 Main LLC	2002	5,899	539	10	539		539	47
48	Allocations - Extended Care Consulting / 2201 Main LLC	2003	6,952	635	10	635		635	48
49	Allocations - Extended Care Consulting / 2201 Main LLC	2005	345	37	10	37		37	49
50	Allocations - Extended Care Consulting / 2201 Main LLC	2009	62	3	10	3		3	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)		$ 1,422,386	$ 51,992		$ 51,992	$	$ 711,477	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 113,416	$ 1,258	$ 1,258	$	5 - 7	$ 96,220	71
72	Current Year Purchases	4,130	466	466		5	466	72
73	Fully Depreciated Assets							73
74	See Supplemental	185,068	1,265	1,265			183,161	74
75	TOTALS	$ 302,614	$ 2,989	$ 2,989	$		$ 279,847	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility - Timber Point	Van		$ 23,698	$	$	$	5	$ 23,698	76
77	Alloc. - Extended Care			2,516	503	503		5	2,516	77
78										78
79										79
80	TOTALS			$ 26,214	$ 503	$ 503	$		$ 26,214	80

E. Summary of Care-Related Assets

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

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Page 13 Supplemental Schedule

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

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

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. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	See Supp.				976			6
7	TOTAL				$ 976 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

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.	/2013	$
13.	/2014	$
14.	/2015	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 28,012 Description: See Supplemental Schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Timber Point Healthcare Ctr
Medicaid Cost Report
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Page 14 Supplemental Schedule - Building and Fixed Equipment

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

Page 14 Supplemental Schedule - Equipment Rental

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

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

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Timber Point Healthcare Ctr
Medicaid Cost Report
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Page 16 Supplemental Schedule

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

STATE OF ILLINOIS

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

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/12 (last day of reporting year)

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

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

Page 17 Supplemental Schedule

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

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

XVI. STATEMENT OF CHANGES IN EQUITY

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,214,634	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,214,634	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	310,976	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 310,976	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	8,840	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 8,840	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	28,740	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 28,740	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,563,190	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	746,820	31
32	Health Care	1,163,047	32
33	General Administration	930,763	33
	B. Capital Expense		
34	Ownership	174,028	34
	C. Ancillary Expense		
35	Special Cost Centers	803,759	35
36	Provider Participation Fee	180,364	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,998,781	40
41	**Income before Income Taxes (line 30 minus line 40)****	564,409	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 564,409	43

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

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

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

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

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

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Page 19 Supplemental Schedule

Description	Total	Adjustment
Line 28 - Other Revenue		
PP Income and Expense Adjustments	28,740	
Total	28,740	

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

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,953	2,215	$ 70,542	$ 31.85	1
2	Assistant Director of Nursing	1,890	2,101	55,574	26.45	2
3	Registered Nurses	10,249	11,494	292,827	25.48	3
4	Licensed Practical Nurses	8,523	9,483	150,929	15.92	4
5	CNAs & Orderlies	34,880	37,218	373,996	10.05	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,734	1,899	21,071	11.10	8
9	Activity Director	1,571	1,843	21,667	11.76	9
10	Activity Assistants	2,158	2,397	20,814	8.68	10
11	Social Service Workers	3,872	4,301	72,896	16.95	11
12	Dietician					12
13	Food Service Supervisor	1,863	2,150	25,007	11.63	13
14	Head Cook					14
15	Cook Helpers/Assistants	3,332	3,890	35,040	9.01	15
16	Dishwashers	8,875	10,085	85,045	8.43	16
17	Maintenance Workers	8,153	9,020	113,546	12.59	17
18	Housekeepers	9,525	11,020	93,400	8.48	18
19	Laundry	3,218	3,796	33,583	8.85	19
20	Administrator	1,907	2,145	67,483	31.46	20
21	Assistant Administrator					21
22	Other Administrative	253	253	18,226	72.04	22
23	Office Manager					23
24	Clerical	4,261	4,705	93,838	19.94	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,613	1,804	19,153	10.61	31
32	Other Health Care(specify)					32
33	Other(specify) Non-Allowable	320	320	11,539	36.06	33
34	TOTAL (lines 1 - 33)	110,149	122,141	$ 1,676,176 *	$ 13.72	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 5,910	01 - 03	35
36	Medical Director		4,805	09 - 03	36
37	Medical Records Consultant				37
38	Nurse Consultant		4,090	10 - 03	38
39	Pharmacist Consultant		4,731	10 - 03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		4,122	12 - 03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 23,658		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Adam Zanger	Administrator	0	$ 67,483
Sherwin Ray	Administration	33.33	18,226
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 85,709

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Extended Care Consulting	Home Office	$ 114,000
Plante & Moran, PLLC	Accounting	27,400
Frost, Ruttenberg & Rothblatt	Accounting	1,500
Burke, Warren, McKay	Legal	4,632
Williams Montgomery & John	Legal	1,672
Chuhak & Tecson, P.C.	Legal	3,406
Extended Care Consulting	Legal	785
Meyer Magence	Legal	250
Randy Frese	Legal	123
Personnel Planners	Unemployment Consultant	690
Care Consultants of Illinois	Computer Maintenance	10,366
See Supplemental Schedule		36,470
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 201,294

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 70,754
Unemployment Compensation Insurance	33,100
FICA Taxes	124,455
Employee Health Insurance	45,296
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	1,239
Other Employee Welfare	4,516
Holiday Expense	1,000
TOTAL (agree to Schedule V, line 22, col.8)	$ 280,360

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	514
Health Care Worker Background Check	2,296
(Indicate # of checks performed)	
Patient Background Checks	
Dues and Subscriptions	93
Licenses and Fees	771
Advertising and Promotion	23,605
Alloc. - Extended Care Consulting	1,672
Less: Public Relations Expense	( )
Non-allowable advertising	(22,571)
Yellow page advertising	(1,034)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,336

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	675
Alloc. - Extended Care Consulting	103
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 778

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

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Page 21 Supplemental Schedule - Other Professional Fees

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

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Page 21 Supplemental Schedule - Legal Invoice Detail

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

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

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

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	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

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

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ _____ Line **Ln 10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **180,364**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

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? **Ln 14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees