FOR BHF USE

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2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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 Center, Inc.

Address: 205 East Spring Street (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 01/01/17 to 12/31/17 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, 200 N. Martingale Road, Suite 900 Schaumburg, IL 60173
(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' PREPARATION REPORT

Facility Name & ID Number Timber Point Healthcare Center, Inc. # 0043158 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	40,150	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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	22,075	3,556	3,541	29,172	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,075	3,556	3,541	29,172	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.66%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve 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 3,129

Medicare Intermediary National Government Services, Inc.

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/17 Fiscal Year: 12/31/17

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Timber Point Healthcare Center, Inc. # 0043158 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	142,306	28,725	5,049	176,080		176,080	108	176,188			1
2	Food Purchase		176,210		176,210		176,210	(1,548)	174,662			2
3	Housekeeping	101,076	23,812		124,888		124,888	650	125,538			3
4	Laundry	40,057	13,723	700	54,480		54,480		54,480			4
5	Heat and Other Utilities			121,457	121,457		121,457	805	122,262			5
6	Maintenance	105,738		94,213	199,951		199,951	9,397	209,348			6
7	Other (specify):* See Supplemental							441	441			7
8	**TOTAL General Services**	389,177	242,470	221,419	853,066		853,066	9,853	862,919			8
	B. Health Care and Programs											
9	Medical Director			2,279	2,279		2,279		2,279			9
10	Nursing and Medical Records	1,622,350	108,744	3,326	1,734,420		1,734,420		1,734,420			10
10a	Therapy	26,194			26,194		26,194		26,194			10a
11	Activities	70,381	11,892	200	82,473		82,473		82,473			11
12	Social Services	74,477		3,783	78,260		78,260		78,260			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* See Supplemental											15
16	**TOTAL Health Care and Programs**	1,793,402	120,636	9,588	1,923,626		1,923,626		1,923,626			16
	C. General Administration											
17	Administrative	157,314			157,314		157,314	11,203	168,517			17
18	Directors Fees											18
19	Professional Services			210,044	210,044		210,044	(124,582)	85,462			19
20	Dues, Fees, Subscriptions & Promotions			74,502	74,502		74,502	(19,642)	54,860			20
21	Clerical & General Office Expenses	183,014	12,888	419,653	615,555		615,555	(325,911)	289,644			21
22	Employee Benefits & Payroll Taxes			487,241	487,241		487,241	(8,100)	479,141			22
23	Inservice Training & Education			847	847		847		847			23
24	Travel and Seminar			2,367	2,367		2,367	21	2,388			24
25	Other Admin. Staff Transportation			53,261	53,261		53,261	538	53,799			25
26	Insurance-Prop.Liab.Malpractice			131,019	131,019		131,019	971	131,990			26
27	Other (specify):* See Supplemental							14,558	14,558			27
28	**TOTAL General Administration**	340,328	12,888	1,378,934	1,732,150		1,732,150	(450,944)	1,281,206			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,522,907	375,994	1,609,941	4,508,842		4,508,842	(441,091)	4,067,751			29

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

SEE ACCOUNTANTS' PREPARATION 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
01/01/17 - 12/31/17

Page 3 Supplemental Schedule

Description	Salaries	Supplies	Other	Total
Line 7 - Other General Services				
Alloc - Extended Care Consulting, LLC				-
Gen. Services - Employee Benefits			441	441
				-
				-
				-
				-
				-
Sub-Total	-	-	441	441
Line 15 - Other Health Care Services				
				-
				-
				-
				-
				-
				-
				-
Sub-Total	-	-	-	-
Line 27 - Other General Administration				
Alloc - Extended Care Consulting, LLC				-
Gen. Admin. - Employee Benefits			14,558	14,558
				-
				-
				-
				-
				-
Sub-Total	-	-	14,558	14,558

Timber Point Healthcare Center, Inc.
Medicaid Cost Report
01/01/17 - 12/31/17

Page 3 Supplemental Schedule - Other Staff Administration Travel Expense

Employee	Travel Purpose	Travel Destination	Travel Date	Expenses			Total
				Travel	Accomodations	Meals	
American Express	Business Matters	Various	Various	4,372			4,372
Angela Carver	Business Matters	Various	Various	6,227			6,227
Benedict Gallardo	Business Matters	Various	Various	8			8
Care Consultants of Illinois	Business Matters	Various	Various	1,096			1,096
Care Management Facility	Business Matters	Various	Various	6,645			6,645
Countryside Nursing - Am Ex	Business Matters	Various	Various	50			50
Extended Care Consulting	Business Matters	Various	Various	118			118
Golf Mill Ford	Business Matters	Various	Various	530			530
Laura Sepessy	Business Matters	Various	Various	4,675			4,675
Nicole Buehler	Business Matters	Various	Various	355			355
Pam Steinkuhler	Business Matters	Various	Various	305			305
Patricia Bedwell	Business Matters	Various	Various	27,140			27,140
Personal Mobility	Business Matters	Various	Various	852			852
Tyanne Neisen	Business Matters	Various	Various	888			888
							-
Alloc - Extended Care Consulting, LLC				538			538
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
Total				53,799	-	-	53,799

Facility Name & ID Number Timber Point Healthcare Center, Inc. #0043158 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			22,915	22,915		22,915	46,718	69,633			30
31	Amortization of Pre-Op. & Org.			770	770		770	(770)				31
32	Interest			64,813	64,813		64,813	201,200	266,013			32
33	Real Estate Taxes			29,243	29,243		29,243	2,426	31,669			33
34	Rent-Facility & Grounds			196,087	196,087		196,087	(194,839)	1,248			34
35	Rent-Equipment & Vehicles			19,214	19,214		19,214	595	19,809			35
36	Other (specify):* See Supplemental											36
37	TOTAL Ownership			333,042	333,042		333,042	55,330	388,372			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		131,597	720,616	852,213		852,213	(131,597)	720,616			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			214,539	214,539		214,539		214,539			42
43	Other (specify):* See Supplemental	13,360			13,360		13,360	(13,360)				43
44	TOTAL Special Cost Centers	13,360	131,597	935,155	1,080,112		1,080,112	(144,957)	935,155			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,536,267	507,591	2,878,138	5,921,996		5,921,996	(530,718)	5,391,278			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Timber Point Healthcare Center, Inc.
Medicaid Cost Report
01/01/17 - 12/31/17

Page 4 Supplemental Schedule

Line 36 - Other Capital Costs

Description	Salaries	Supplies	Other	Total
				-
				-
				-
				-
				-
				-
				-
Sub-Total	-	-	-	-

Line 43 - Other Special Cost Centers

Non-Allowable	13,360			13,360
				-
				-
				-
				-
				-
				-
Sub-Total	13,360	-	-	13,360

Facility Name & ID Number Timber Point Healthcare Center, Inc. # 0043158 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	(2,283)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,862)	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				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	(386,435)	21		24
25	Fund Raising, Advertising and Promotional	(20,124)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Supplemental	(160,611)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (571,315)		$	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)	40,597		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 40,597		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (530,718)		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' PREPARATION REPORT

Timber Point Healthcare Center, Inc.

ID# 0043158

Report Period Beginning: 01/01/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Pharmacy Settlement (Extent of Expense)	$ (131,597)	39	1
2	Capitalized Assets < $2,500	2,421	06	2
3	Legal Fees - Non Allowable	(7,096)	19	3
4	Professional Fees - Non Allowable	(5,620)	19	4
5	Bank Charges	(3,931)	21	5
6	Amortization	(770)	31	6
7	Non-Allowable	(13,360)	43	7
8				8
9				9
10				10
11	Timber Point Associates, LLC			11
12	Office	(658)	21	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(160,611)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Timber Point Healthcare Center, Inc. # 0043158 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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	108	0	0	0	0	0	0	0	0	108	1
2	Food Purchase	(1,862)	0	314	0	0	0	0	0	0	0	0	(1,548)	2
3	Housekeeping	0	0	650	0	0	0	0	0	0	0	0	650	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	805	0	0	0	0	0	0	0	0	805	5
6	Maintenance	2,421	0	2,218	4,758	0	0	0	0	0	0	0	9,397	6
7	Other (specify):*	0	0	0	441	0	0	0	0	0	0	0	441	7
8	**TOTAL General Services**	559	0	4,095	5,199	0	0	0	0	0	0	0	9,853	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	1,660	9,543	0	0	0	0	0	0	0	11,203	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(12,716)	0	(111,866)	0	0	0	0	0	0	0	0	(124,582)	19
20	Fees, Subscriptions & Promotions	(20,124)	0	482	0	0	0	0	0	0	0	0	(19,642)	20
21	Clerical & General Office Expenses	(391,024)	658	4,769	59,686	0	0	0	0	0	0	0	(325,911)	21
22	Employee Benefits & Payroll Taxes	0	0	0	(8,100)	0	0	0	0	0	0	0	(8,100)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	21	0	0	0	0	0	0	0	0	21	24
25	Other Admin. Staff Transportation	0	0	538	0	0	0	0	0	0	0	0	538	25
26	Insurance-Prop.Liab.Malpractice	0	0	971	0	0	0	0	0	0	0	0	971	26
27	Other (specify):*	0	0	0	14,558	0	0	0	0	0	0	0	14,558	27
28	**TOTAL General Administration**	(423,864)	658	(103,425)	75,687	0	0	0	0	0	0	0	(450,944)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(423,305)	658	(99,330)	80,886	0	0	0	0	0	0	0	(441,091)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Timber Point Healthcare Center, Inc. # 0043158 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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	45,338	1,380	0	0	0	0	0	0	0	0	46,718	30
31	Amortization of Pre-Op. & Org.	(770)	0	0	0	0	0	0	0	0	0	0	(770)	31
32	Interest	(2,283)	194,839	8,644	0	0	0	0	0	0	0	0	201,200	32
33	Real Estate Taxes	0	0	2,426	0	0	0	0	0	0	0	0	2,426	33
34	Rent-Facility & Grounds	0	(194,839)	0	0	0	0	0	0	0	0	0	(194,839)	34
35	Rent-Equipment & Vehicles	0	0	595	0	0	0	0	0	0	0	0	595	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(3,053)	45,338	13,045	0	0	0	0	0	0	0	0	55,330	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	(131,597)	0	0	0	0	0	0	0	0	0	0	(131,597)	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):*	(13,360)	0	0	0	0	0	0	0	0	0	0	(13,360)	43
44	**TOTAL Special Cost Centers**	(144,957)	0	0	0	0	0	0	0	0	0	0	(144,957)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(571,315)	45,996	(86,285)	80,886	0	0	0	0	0	0	0	(530,718)	45

Facility Name & ID Number Timber Point Healthcare Center, Inc. # 0043158 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 194,839	Timber Point Associates, LLC	100.00%	$	$ (194,839)	1
2	V	32	Interest		Timber Point Associates, LLC	100.00%			2
3	V	20	Dues and Subscriptions		Timber Point Associates, LLC	100.00%			3
4	V	21	Office		Timber Point Associates, LLC	100.00%	658	658	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%	194,839	194,839	8
9	V	33	Real Estate Taxes	29,243	Timber Point Associates, LLC	100.00%	29,243		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			$ 224,082			$ 270,078	$ * 45,996	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Timber Point Healthcare Center, Inc. # 0043158 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Ray	33.33%	Beecher Manor Nursing and Rehab	Beecher, IL	Ex. Care Consulting	Evanston, IL	Home Office	1
2	Jakob Bakst	33.33%	Briar Place	Indian Head, IL	Ex. Care Clinical	Evanston, IL	Administrative	2
3	Eric Rothner	33.34%	Chateau Village Nursing and Rehab	Willowbrook, IL	2201 Main Street	Evanston, IL	Bldg. Company	3
4			Grasmere Place	Chicago, IL	CCS VEBA	Evanston, IL	Health Insurance	4
5			Lakewood Nursing and Rehab	Plainfield, IL	Vent Lease	Evanston, IL	Vent. Rental	5
6			Lemont Nursing and Rehab	Lemont, IL	Mac RX, LLC	Des Plaines, IL	Pharmacy	6
7			Prairie Manor Halth Care	Chicago Heights, IL	Reliable Medical	Des Plaines, IL	Medical Supply	7
8			Rainbow Beach Nursing Center	Chicago, IL				8
9			Sheridan Shores	Chicago, IL				9
10			South Suburban Rehabilitation Center	Chicago, IL				10
11			Tri-State Nursing and Rehab	Lansing, IL				11
12			Wheaton Care Center	Wheaton, IL	Timber Point			12
13			Kensington Place Nursing and Rehab	Chicago, IL	Associates, LLC	Camp Point, IL	Bldg. Company	13
14			Countryside Nursing and Rehab	Dolton, IL				14
15			Spring Creek Nursing and Rehab	Joliet, IL				15
16			Park House Nursing and Rehab	Chicago, IL				16
17			Timber Point Healthcare Center	Camp Point, IL				17
18			Prairie Village Healthcare Center	Jacksonville, IL				18
19			Major Hospital - Dyer	Dyer, IN				19
20			Major Hospital - Lake County	East Chicago, IN				20
21			Major Hospital - Sebo	Holbart, IN				21
22			Major Hospital - Lincolnshire	Merrillville, IN				22
23			Major Hospital - Munster	Munster, IN				23
24			McKinley Health Care Center	Canton, OH				24
25			St. James Manor	Crete, IL				25
26			St. James Manor - Assisted Living	Crete, IL				26
27			The Parc at Joliet	Joliet, IL				27
28			The Estates of Hyde Park	Chicago, IL				28
29			Rushville Nursing and Rehab	Rushville, IL				29
30			Paramount of Oak Park	Oak Park, IL				30

Facility Name & ID Number Timber Point Healthcare Center, Inc. # 0043158 Report Period Beginning: 01/01/17 Ending: 12/31/17

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			Sheffield Manor Assisted Living	Dyer, IN				1
2			Kenosha Estates	Kenosha, WI				2
3			Milwaukee Estates	Milwaukee, WI				3
4			Appleton	Appleton, WI				4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Timber Point Healthcare Center, Inc. # 0043158 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	1	Dietary	$	Extended Care Consulting, LLC	100.00%	$ 108	$ 108	15
16	V	2	Food		Extended Care Consulting, LLC	100.00%	314	314	16
17	V	3	Housekeeping		Extended Care Consulting, LLC	100.00%	650	650	17
18	V	5	Utilities		Extended Care Consulting, LLC	100.00%	805	805	18
19	V	6	Maintenance		Extended Care Consulting, LLC	100.00%	2,218	2,218	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	1,660	1,660	20
21	V	19	Professional Fees	114,000	Extended Care Consulting, LLC	100.00%	2,134	(111,866)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	482	482	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	4,769	4,769	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	21	21	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	538	538	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	971	971	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	1,380	1,380	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	8,644	8,644	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	2,426	2,426	29
30	V	35	Rent - Equipment and Auto		Extended Care Consulting, LLC	100.00%	595	595	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			$ 27,715	$ * (86,285)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Timber Point Healthcare Center, Inc. # 0043158 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	6	Maintenance (Pooled)	$	Extended Care Consulting, LLC	100.00%	$ 4,758	$ 4,758	15
16	V	6	Maintenance (Direct)		Extended Care Consulting, LLC	100.00%	0		16
17	V	7	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	441	441	17
18	V	7	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	0		18
19	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	9,543	9,543	19
20	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	59,686	59,686	20
21	V	21	Office and Clerical (Direct)	13,902	Extended Care Consulting, LLC	100.00%	13,902		21
22	V	27	Emp. Gen. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	13,377	13,377	22
23	V	27	Emp. Gen. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	1,181	1,181	23
24	V	22	Employee Benefits	8,100	Extended Care Consulting, LLC	100.00%		(8,100)	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			$ 22,002			$ 102,888	$ * 80,886	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Timber Point Healthcare Center, Inc. # 0043158 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	Employee Benefits	$ 197,215	CCS VEBA	100.00%	$ 197,215	$	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			$ 197,215			$ 197,215	$ *	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Timber Point Healthcare Center, Inc. # 0043158 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	Sherwin Ray	Shareholder	Administration	33.33%	See Supplemental	7.63	19.08%	Salary	$ 38,170	17 - 01	1
2	Adam Vales	Relative	Clerical	0.00%	See Supplemental	0.88	2.19%	Alloc. Salary	1,515	22 - 07	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 39,685		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

Timber Point Healthcare Center, Inc.
Medicaid Cost Report
01/01/17 - 12/31/17

Page 7 Supplemental Schedule

				Total Compensation			Alloc. Compensation	
Desciption	**Alloc. Hours**	**Total Hours**	**Alloc. Percentage**	**Salary**	**Emp. Benefits**		**Salary**	**Emp. Benefits**

Owners / Director Compensation

Sherwin Ray								
Timber Point Healthcare Center	7.63	40.00	19.08%	200,000	-		38,170	-
Prairie Village Healthcare Center	7.63	40.00	19.08%	200,000	-		38,170	-
Countryside Nursing & Rehab	18.13	40.00	45.33%	200,000	-		90,651	-
Rushville Nursing & Rehab	6.60	40.00	16.50%	200,000	-		33,010	-
							-	-
							-	-
							-	-
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							-	-
Total	40		100.00%				200,000	-

Timber Point Healthcare Center, Inc.
Medicaid Cost Report
01/01/17 - 12/31/17

Page 7 Supplemental Schedule

Desciption	Alloc. Hours	Total Hours	Alloc. Percentage	Total Compensation Salary	Total Compensation Emp. Benefits		Alloc. Compensation Salary	Alloc. Compensation Emp. Benefits
Owners / Director Compensation								
Adam Vales								
Timber Point Healthcare Center	0.88	40.00	2.19%	69,194	-		1,515	-
Prairie Village Healthcare Center	0.59	40.00	1.47%	69,194	-		1,020	-
Countryside Nursing & Rehab	1.19	40.00	2.98%	69,194	-		2,064	-
Kensington Place Nursing & Rehab	1.02	40.00	2.56%	69,194	-		1,768	-
Little Village	0.14	40.00	0.35%	69,194	-		240	-
Park House Nursing & Rehab	0.20	40.00	0.51%	69,194	-		350	-
Rushville Nursing & Rehab	0.55	40.00	1.37%	69,194	-		951	-
Other Entities	35.43	40.00	88.57%	69,194	-		61,286	-
							-	-
							-	-
							-	-
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							-	-
Total	40.00		100.00%				69,194	-

Facility Name & ID Number Timber Point Healthcare Center, Inc. # 0043158 Report Period Beginning: 01/01/17 Ending: 12/31/17

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: Timber Point Associates, LLC
Street Address: 205 East Spring Street
City / State / Zip Code: Camp Point, Illinois 62320
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' PREPARATION REPORT

Facility Name & ID Number Timber Point Healthcare Center, Inc. # 0043158 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	1	Dietary	Patient Days	1,476,506	37	$ 5,451	$	29,172	$ 108	1
2	2	Food	Patient Days	1,476,506	37	15,903		29,172	314	2
3	3	Housekeeping	Patient Days	1,476,506	37	32,901		29,172	650	3
4	5	Utilities	Patient Days	1,476,506	37	40,755		29,172	805	4
5	6	Maintenance	Patient Days	1,476,506	37	112,249		29,172	2,218	5
6	17	Administrative	Patient Days	1,476,506	37	84,000		29,172	1,660	6
7	19	Professional Fees	Patient Days	1,476,506	37	107,994		29,172	2,134	7
8	20	Dues and Subscriptions	Patient Days	1,476,506	37	24,409		29,172	482	8
9	21	Office and Clerical	Patient Days	1,476,506	37	241,371		29,172	4,769	9
10	24	Travel and Seminar	Patient Days	1,476,506	37	1,048		29,172	21	10
11	25	Other Staff Admin. Trans.	Patient Days	1,476,506	37	27,239		29,172	538	11
12	26	Insurance	Patient Days	1,476,506	37	49,139		29,172	971	12
13	30	Depreciation	Patient Days	1,476,506	37	69,861		29,172	1,380	13
14	32	Interest	Patient Days	1,476,506	37	437,528		29,172	8,644	14
15	33	Real Estate Taxes	Patient Days	1,476,506	37	122,769		29,172	2,426	15
16	35	Rent - Equipment and Auto	Patient Days	1,476,506	37	30,092		29,172	595	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,402,709	$		$ 27,715	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Timber Point Healthcare Center, Inc. # 0043158 Report Period Beginning: 01/01/17 Ending: 12/31/17

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) 941 - 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	6	Maintenance	Patient Days	1,476,506	37	$ 240,841	$ 240,841	29,172	$ 4,758	1
2	6	Maintenance	Direct	358,056	37	358,056	358,056			2
3	7	Emp. Ben. - Gen. Serv.	Patient Days	1,476,506	37	22,330		29,172	441	3
4	7	Emp. Ben. - Gen. Serv.	Direct	51,193	37	51,193				4
5	17	Administrative	Patient Days	1,476,506	37	483,002	483,002	29,172	9,543	5
6	21	Office and Clerical	Patient Days	1,476,506	37	3,020,951	3,020,951	29,172	59,686	6
7	21	Office and Clerical	Direct	498,631	37	498,631	498,631	13,902	13,902	7
8	27	Emp. Gen. - Gen. Admin.	Patient Days	1,476,506	37	677,040		29,172	13,377	8
9	27	Emp. Gen. - Gen. Admin.	Direct	74,203	37	74,203		1,181	1,181	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					$ 5,426,247	$ 4,601,481		$ 102,888	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Timber Point Healthcare Center, Inc. # 0043158 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	Employee Benefits	Direct Allocation	9,005,461	37	$ 9,005,461	$	197,215	$ 197,215	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					$ 9,005,461	$		$ 197,215	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Timber Point Healthcare Center, Inc. # 0043158 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	Atied Associates		X	Mortgage			$	$			$ 194,839	1
2												2
3												3
4												4
5												5
	Working Capital											
6	HFG		X	Line of Credit							64,813	6
7	Alloc. - Extended Care		X	Line of Credit							8,644	7
8			X	Auto Loan								8
9	TOTAL Facility Related						$	$			$ 268,296	9
	B. Non-Facility Related*											
10												10
11												11
12	Interest Income		X								(2,283)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (2,283)	14
15	TOTALS (line 9+line14)						$	$			$ 266,013	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' PREPARATION 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 Center, Inc. # 0043158 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	28,278	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.)	$	30,485	2
3. Under or (over) accrual (line 2 minus line 1).	$	2,207	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)	$	29,462	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	31,669	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	25,899	8
	2013	26,235	9
	2014	26,651	10
	2015	26,932	11
	2016	28,059	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

2017 Real Estate Tax Accrual = $28,059 * 1.05 = $29,462

Alloc. - Extended Care Consulting, LLC = $

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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Timber Point Healthcare Center, Inc. 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 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	03 - 0 - 0932 - 0001- 00	Long Term Care Facility	$ 28,059.14	$ 28,059.14
2.	Alloc. - Ext. Care Consulting	Long Term Care Facility	$ 181,041.32	$ 2,425.60
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 209,100.46	$ 30,484.74

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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

Facility Name & ID Number Timber Point Healthcare Center, Inc. # 0043158 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 [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).

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	Alloc. - Ext. Care			10,986	2
3	TOTALS			$ 128,986	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Timber Point Healthcare Center, Inc. # 0043158 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Timber Point Healthcare Center, Inc. (Operating Entity)										9
10											10
11	Various			2001	18,442						11
12	Various			2003	7,919						12
13	Various			2004	24,419						13
14	Various			2005	12,730						14
15	Various			2006	18,831						15
16	Various			2007	6,583						16
17	Various			2008	22,650						17
18	Various			2010	7,216						18
19	Various			2011	7,314						19
20	Various			2012	15,374						20
21	Driveway Repairs - East Entrance - Tear, gravel, and regrade			2013	12,925						21
22	Flooring - Front Lobby			2013	6,185						22
23	Flooring - Hallways and Common Areas			2014	3,116						23
24	Water Heater			2014	4,979						24
25	Flooring - Hallways and Common Areas			2014	5,955						25
26	Flooring - Hallways and Common Areas			2015	19,907						26
27	Sewer and Plumbing			2015	5,790						27
28	Flooring - Resident Rooms			2016	18,310						28
29	Flooring - Resident Rooms			2017	5,890						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.

See Page 12A, Line 70 for total

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

Facility Name & ID Number Timber Point Healthcare Center, Inc. # 0043158 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	Timber Point Associates, LLC (Building Partnership)		$	$		$	$	$	37
38									38
39	Various	1998	15,322						39
40	Various	1999	10,509						40
41	Various	2000	2,585						41
42	Various	2000	12,177						42
43	Various	2001	99,148						43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,484,276	$		$	$	$	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Timber Point Healthcare Center, Inc. # 0043158 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	
1	Totals from Page 12A, Carried Forward		$ 1,484,276	$		$	$	$	1
2									2
3	Related Party Allocations - See Supplemental Schedules								3
4									4
5	Allocations - Extended Care Consulting, LLC	2007	91						5
6	Allocations - Extended Care Consulting, LLC	2009	54						6
7	Allocations - Extended Care Consulting, LLC	2010	533						7
8	Allocations - Extended Care Consulting, LLC	2011	192						8
9	Allocations - Extended Care Consulting, LLC	2012	63						9
10	Allocations - Extended Care Consulting, LLC	2014	876						10
11	Allocations - Extended Care Consulting, LLC	2016	1,051						11
12	Allocations - Extended Care Consulting, LLC	2017							12
13									13
14	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2002	15,140						14
15	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2002	12,507						15
16	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2003	14,739						16
17	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2005	732						17
18	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2009	132						18
19	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2014	1,268						19
20	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2015	208						20
21	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2016	823						21
22	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2017	1,427						22
23									23
24	Allocations - Extended Care Consulting, LLC / Dyer Building	2007	4,742						24
25									25
26									26
27									27
28									28
29									29
30									30
31	Depreciation - Timber Point Healthcare Center, Inc.			22,915		22,915		266,663	31
32	Depreciation - Timber Point Associates, LLC			45,338		45,338		1,045,741	32
33	Depreciation - Extended Care Consulting, LLC			1,380		1,380		102,629	33
34	TOTAL (lines 1 thru 33)		$ 1,538,854	$ 69,633		$ 69,633	$	$ 1,415,033	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Timber Point Healthcare Center, Inc. # 0043158 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 162,015	$	$	$		$	71
72	Current Year Purchases	4,686						72
73	Fully Depreciated Assets							73
74	See Supplemental	182,697						74
75	TOTALS	$ 349,398	$	$	$		$	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 HC	Bus		$ 58,427	$	$	$		$	76
77	Facility - Timber Point As	Van		23,698						77
78	Alloc. - Extended Care			3,566						78
79										79
80	TOTALS			$ 85,691	$	$	$		$	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)	$ 2,102,929	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 69,633	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 69,633	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)	$ 1,415,033	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.

Timber Point Healthcare Center, Inc.
Medicaid Cost Report
01/01/17 - 12/31/17

Page 13 - Related Party Furniture and Equipment Allocations

Desciption	Acquisiton Date	Grouping		Cost
Timber Point Associates, LLC	Prior	Furn. & Equipment		118,000
Extended Care Consulting, LLC	Prior	Furn. & Equipment		4,503
Extended Care Consulting, LLC	Current	Furn. & Equipment		-
Extended Care Consulting, LLC	Full	Furn. & Equipment		56,001
Extended Care Consulting, LLC	Full	Furn. & Equipment		4,193
				182,697

Facility Name & ID Number Timber Point Healthcare Center, Inc. # 0043158 Report Period Beginning: 01/01/17 Ending: 12/31/17

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [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	See Suppl.				1,248			5
6								6
7	TOTAL				$ 1,248 **			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.	/2018	$
13.	/2019	$
14.	/2020	$

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

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO

16. Rental Amount for movable equipment: $ 12,240 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	Facility	Ford Edge	$	$ 7,569	17
18					18
19					19
20					20
21	TOTAL		$	$ 7,569	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' PREPARATION REPORT

Timber Point Healthcare Center, Inc.
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Page 14 Supplemental Schedule

Desciption	Amount	Total
Building Rental		
Bruce 88 Storage	1,248	1,248
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
Total	1,248	1,248
Equipment Rental		
Pitney Bowes	60	60
Wells Fargo	701	701
Digital Copy System	1,745	1,745
Toshiba	2,045	2,045
Flynn Sales Services	7,000	7,000
Other	94	94
		-
Alloc. - Extended Care Consulting, LLC	595	595
		-
		-
		-
		-
		-
Total	12,240	12,240

Facility Name & ID Number Timber Point Healthcare Center, Inc. # 0043158 Report Period Beginning: 01/01/17 Ending: 12/31/17

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' PREPARATION REPORT

Facility Name & ID Number Timber Point Healthcare Center, Inc. # 0043158 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$		$ 310,814	$		$ 310,814	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			60,497			60,497	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			287,165			287,165	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				131,597		131,597	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Supplemental	39 - 02					0			12
13	Other (specify): See Supplemental	39 - 03				62,140			62,140	13
14	TOTAL			$		$ 720,616	$ 131,597		$ 852,213	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' PREPARATION REPORT

Timber Point Healthcare Center, Inc.
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Page 16 Supplemental Schedule

Description	Salaries	Supplies	Other	Total
Laboratory			27,541	27,541
Radiology			32,125	32,125
Ambulance			2,309	2,309
Hospital Tests			104	104
Other			61	61
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
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				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
Total	-	-	62,140	62,140

STATE OF ILLINOIS

Facility Name & ID Number Timber Point Healthcare Center, Inc. # 0043158 Report Period Beginning: 01/01/17 Ending: 12/31/17

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/17 (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	$ 23,315	$ 31,836	1
2	Cash-Patient Deposits	23,793	23,793	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 835,178)	862,910	862,910	3
4	Supply Inventory (priced at Cost / FIFO)			4
5	Short-Term Investments			5
6	Prepaid Insurance	45,552	45,552	6
7	Other Prepaid Expenses	7,876	7,876	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental Schedule			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 963,446	$ 971,967	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	219,131	358,872	15
16	Equipment, at Historical Cost	227,502	369,200	16
17	Accumulated Depreciation (book methods)	(266,663)	(1,312,404)	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 Schedule	1,091	1,091	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 181,061	$ 654,759	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,144,507	$ 1,626,726	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 315,542	$ 315,542	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	21,767	21,767	28
29	Short-Term Notes Payable	1,594,530	1,594,530	29
30	Accrued Salaries Payable	166,586	166,586	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,136	8,136	31
32	Accrued Real Estate Taxes(Sch.IX-B)		29,462	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule	1,835,346	2,921,058	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,941,907	$ 5,057,081	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	18,419	18,419	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 18,419	$ 18,419	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,960,326	$ 5,075,500	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,815,819)	$ (3,448,774)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,144,507	$ 1,626,726	48

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*(See instructions.)

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Description	Operating	Building	Total
Line 9 - Other Current Assets			
			-
			-
			-
			-
			-
Sub-Total	-	-	-
Line 23 - Long Term Assets			
Financing Costs (Net of Amortization)	1,091		1,091
			-
			-
			-
			-
Sub-Total	1,091	-	1,091
Line 36 - Other Current Liability			
Due to Affiliated Entities	1,835,346		1,835,346
			-
			-
			-
			-
Sub-Total	1,835,346	-	1,835,346
Line 43 - Long term Liabilities			
			-
			-
			-
			-
			-
Sub-Total	-	-	-

Facility Name & ID Number Timber Point Healthcare Center, Inc. # 0043158 Report Period Beginning: 01/01/17 Ending: 12/31/17

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,967,076)	1
2	Restatements (describe):		2
3	**Rounding**	2	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,967,074)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	151,255	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)**	$ 151,255	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)**	$ (2,815,819)	24 *

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

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Facility Name & ID Number Timber Point Healthcare Center, Inc. # 0043158 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 5,651,949	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,651,949	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	199,146	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 199,146	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	1,898	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)**	$ 1,898	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,283	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,283	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	217,975	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 217,975	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,073,251	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	853,066	31
32	Health Care	1,923,626	32
33	General Administration	1,732,150	33
	B. Capital Expense		
34	Ownership	333,042	34
	C. Ancillary Expense		
35	Special Cost Centers	865,573	35
36	Provider Participation Fee	214,539	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,921,996	40
41	**Income before Income Taxes (line 30 minus line 40)****	151,255	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 151,255	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,204,930	44
45	Private Pay - Net Inpatient Revenue	578,626	45
46	Medicare - Net Inpatient Revenue	1,664,489	46
47	Other-(specify) Insurance - Net Inpatient Revenue	177,295	47
48	Other-(specify) Hospice - Net Inpatient Revenue	26,609	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,651,949	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A 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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Description	Amount	Total
Transportation Revenue	26,416	26,416
Pharmacy Settlement	191,559	191,559
		-
		-
		-
		-
		-
		-
		-
		-
		-
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		-
		-
		-
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		-
		-
Total	217,975	217,975

Facility Name & ID Number Timber Point Healthcare Center, Inc. # 0043158 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	1,960	2,130	$ 77,408	$ 36.34	1
2	Assistant Director of Nursing					2
3	Registered Nurses	19,037	20,276	601,492	29.67	3
4	Licensed Practical Nurses	9,197	9,985	211,540	21.19	4
5	CNAs & Orderlies	44,505	46,335	562,934	12.15	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,908	2,123	26,194	12.34	8
9	Activity Director	1,850	2,042	28,521	13.97	9
10	Activity Assistants	3,757	4,203	41,860	9.96	10
11	Social Service Workers	3,840	4,195	74,477	17.75	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,718	14,881	142,306	9.56	15
16	Dishwashers					16
17	Maintenance Workers	6,178	6,749	105,738	15.67	17
18	Housekeepers	10,327	11,433	101,076	8.84	18
19	Laundry	4,032	4,500	40,057	8.90	19
20	Administrator	1,851	2,119	119,144	56.23	20
21	Assistant Administrator					21
22	Other Administrative	293	295	38,170	129.39	22
23	Office Manager					23
24	Clerical	7,347	7,722	183,014	23.70	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	2,645	3,037	40,003	13.17	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	7,315	7,844	142,333	18.15	33
34	TOTAL (lines 1 - 33)	139,760	149,869	$ 2,536,267 *	$ 16.92	34

SEE ACCOUNTANTS' PREPARATION 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		$ 5,049	01 - 03	35
36	Medical Director		2,279	10 - 03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,326	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		200	11 - 03	44
45	Social Service Consultant		3,783	12 - 03	45
46	Other(specify)				46
47	See Supplemental				47
48					48
49	TOTAL (lines 35 - 48)		$ 14,637		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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Description	CC Reference	Hours Worked	Hours Paid	Salary	Average Rate	Hours Paid	Contracted Cost
Nursing Home Employees							
Ward Clerk	10	5,128	5,468	61,491	11.25		
MDS / Care Plan Coordinator	10	2,187	2,376	67,482	28.40		
Non-Allowable	43			13,360	-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
Total		7,315	7,844	142,333	18.15		
Contracted Services							
N/A							
Total						-	-

Facility Name & ID Number Timber Point Healthcare Center, Inc. # 0043158 Report Period Beginning: 01/01/17 Ending: 12/31/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Andrea Lewis	Administrator	0	$ 119,144
Sherwin Ray	Administration	33.33%	38,170
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 157,314

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, LLC	Home Office	$ 114,000
Plante & Moran, PLLC	Accounting	26,800
Marcum, LLP	Accounting	129
Personnel Planners, Inc.	Unemployment Consultant	1,185
Falkenberg, Fieweger Ives, LLP	Legal	1,460
Foley & Lardner	Legal	57
Ogletree, Deakins & Nash	Legal	4,662
Robbins, Salomon & Patt	Legal	2,700
Holly Turner, Esq.	Legal	2,786
Much Shelist	Legal	323
Ability Network	Data Processing / IT	4,993
See Supplemental Schedule		50,949
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 210,044

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 107,685
Unemployment Compensation Insurance	32,281
FICA Taxes	181,116
Employee Health Insurance	148,079
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	9,980
TOTAL (agree to Schedule V, line 22, col.8)	$ 479,141

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	36,488
Health Care Worker Background Check	2,280
(Indicate # of checks performed)	
Patient Background Checks	
Dues and Subscriptions	11,798
Licenses and Fees	1,822
Advertising and Promotion	20,124
Alloc. - Extended Care Consulting	482
Less: Public Relations Expense	( )
Non-allowable advertising	(20,124)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 54,860

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,367
Alloc. - Extended Care Consulting	21
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,388

* Attach copy of IMRF notifications

**See instructions.

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Page 21 Supplemental Schedule - Other Professional Fees

Vendor	Service Description	Amount	Total
MatrixCare	Data Processing / IT	13,764	13,764
National Datacare Corporation	Data Processing / IT	2,515	2,515
ProPay Payroll Services	Data Processing / IT	16,272	16,272
Relias Learning	Data Processing / IT	2,966	2,966
ETC Computerland	Data Processing / IT	401	401
Other	Data Processing / IT	3,229	3,229
Blymas	Tax Credits	5,159	5,159
Other	Other	1,023	1,023
Non-Allowable	Various	5,620	5,620
			-
			-
			-
			-
			-
			-
			-
			-
			-
			-
			-
			-
			-
			-
			-
			-
			-
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			-
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			-
			-
			-
			-
Total		50,949	50,949

Timber Point Healthcare Center, Inc.
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Page 21 Supplemental Schedule - Legal Invoice Detail

Vendor	Service Description	Invoice Date	Amount	Non-Allowable	Allowable
Falkenberg	Non-Allowable		721	721	-
Falkenberg	Non-Allowable		323	323	-
Holly Turner, Esq.	Non-Allowable		247	247	-
Much Shelist	Non-Allowable		93	93	-
Foley & Lardner	Non-Allowable		57	57	-
Much Shelist	401(K) Plan		116		116
Falkenberg	Non-Allowable		339	339	-
Much Shelist	401(K) Plan		95		95
Holly Turner, Esq.	Non-Allowable		247	247	-
Holly Turner, Esq.	Non-Allowable		247	247	-
Falkenberg	Non-Allowable		56	56	-
Falkenberg	Non-Allowable		21	21	-
Much Shelist	401(K) Plan		19		19
Holly Turner, Esq.	Non-Allowable		238	238	-
Holly Turner, Esq.	Non-Allowable		256	256	-
Holly Turner, Esq.	Non-Allowable		247	247	-
Ogletree, Deakins Nash	Employee Labor Matters		1,900		1,900
Holly Turner, Esq.	Non-Allowable		257	257	-
Holly Turner, Esq.	Non-Allowable		247	247	-
Ogletree, Deakins Nash	Employee Labor Matters		2,762		2,762
Holly Turner, Esq.	Non-Allowable		290	290	-
Robbins, Salomon & Patt	Non-Allowable		2,700	2,700	-
Holly Turner, Esq.	Non-Allowable		264	264	-
Holly Turner, Esq.	Non-Allowable		248	248	-
					-
					-
					-
					-
					-
					-
Total			11,988	7,096	4,891

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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? **Yes**
If YES, give association name and amount. **ICLTC - $10,226**

(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. $ **15,927** 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.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **214,539**
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' PREPARATION 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. $ **0**

(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? **Yes** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **26,416**
c. What percent of all travel expense relates to transportation of nurses and patients? **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? **Yes**
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? **Yes**
See page 39 of the instructions for details.
Attach invoices and a summary of services for all architect and appraisal fees