

		FOR BHF USE					

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2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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.

<p>I. IDPH License ID Number: <u>0043158</u></p> <p>Facility Name: <u>Timber Point Healthcare Center, Inc.</u></p> <p>Address: <u>205 East Spring Street</u> <u>Camp Point</u> <u>62320</u> Number City Zip Code</p> <p>County: <u>Adams</u></p> <p>Telephone Number: <u>(217) 593 - 7734</u> Fax # <u>(217) 593 - 6360</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>1998</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Edward N. Slack, CPA</u> Telephone Number: <u>(847) 628 - 8796</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/18</u> to <u>12/31/18</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%"> <tr> <td style="width:20%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td style="vertical-align: top;">Paid Preparer</td> <td>(Signed) _____ (Date) _____ (Print Name and Title) <u>Edward N. Slack, CPA</u> <u>Partner, Health and Human Services</u> (Firm Name & Address) <u>Plante & Moran, PLLC</u> <u>200 N. Martingale Road, Suite 900 Schaumburg, IL 60173</u> (Telephone) <u>(847) 628 - 8796</u> Fax # <u>(248) 327 - 8417</u></td> </tr> </table> <p align="right">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</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) <u>Edward N. Slack, CPA</u> <u>Partner, Health and Human Services</u> (Firm Name & Address) <u>Plante & Moran, PLLC</u> <u>200 N. Martingale Road, Suite 900 Schaumburg, IL 60173</u> (Telephone) <u>(847) 628 - 8796</u> Fax # <u>(248) 327 - 8417</u>
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SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Timber Point Healthcare Center, Inc.

0043158 Report Period Beginning: 01/01/18 Ending: 12/31/18

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	119	Skilled (SNF)	119	43,435	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	119	TOTALS	119	43,435	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	21,779	2,905	3,936	28,620	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,779	2,905	3,936	28,620	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.89%

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

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

I. On what date did you start providing long term care at this location? Date started 1998

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

K. Was the facility certified for Medicare during the reporting year? YES NO If YES, enter number of beds certified 110 and days of care provided 3,351

Medicare Intermediary National Government Services, Inc.

IV. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/18 Fiscal Year: 12/31/18

* 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: 01/01/18 Ending: 12/31/18

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	153,765	28,340	10,194	192,299		192,299	111	192,410		1
2	Food Purchase		184,858		184,858		184,858	(858)	184,000		2
3	Housekeeping	134,497	16,902		151,399		151,399	603	152,002		3
4	Laundry	48,047	22,485		70,532		70,532		70,532		4
5	Heat and Other Utilities			117,626	117,626		117,626	902	118,528		5
6	Maintenance	77,685	3,501	110,018	191,204		191,204	9,920	201,124		6
7	Other (specify):* See Supplemental							442	442		7
8	TOTAL General Services	413,994	256,086	237,838	907,918		907,918	11,120	919,038		8
	B. Health Care and Programs										
9	Medical Director			3,195	3,195		3,195		3,195		9
10	Nursing and Medical Records	1,546,331	122,154	21,219	1,689,704		1,689,704		1,689,704		10
10a	Therapy	25,470			25,470		25,470		25,470		10a
11	Activities	76,051	14,294		90,345		90,345		90,345		11
12	Social Services	65,648	1,131	938	67,717		67,717		67,717		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* See Supplemental										15
16	TOTAL Health Care and Programs	1,713,500	137,579	25,352	1,876,431		1,876,431		1,876,431		16
	C. General Administration										
17	Administrative	174,913			174,913		174,913	10,797	185,710		17
18	Directors Fees										18
19	Professional Services			208,400	208,400		208,400	(132,568)	75,832		19
20	Dues, Fees, Subscriptions & Promotions			85,918	85,918		85,918	(30,110)	55,808		20
21	Clerical & General Office Expenses	181,169	5,865	651,353	838,387		838,387	(384,438)	453,949		21
22	Employee Benefits & Payroll Taxes			409,164	409,164		409,164	(9,938)	399,226		22
23	Inservice Training & Education			2,374	2,374		2,374		2,374		23
24	Travel and Seminar			2,780	2,780		2,780	210	2,990		24
25	Other Admin. Staff Transportation			67,189	67,189		67,189	557	67,746		25
26	Insurance-Prop.Liab.Malpractice			240,129	240,129		240,129	1,013	241,142		26
27	Other (specify):* See Supplemental							16,298	16,298		27
28	TOTAL General Administration	356,082	5,865	1,667,307	2,029,254		2,029,254	(528,179)	1,501,075		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,483,576	399,530	1,930,497	4,813,603		4,813,603	(517,059)	4,296,544		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
 01/01/18 - 12/31/18

Page 3 Supplemental Schedule

Description	Salaries	Supplies	Other	Total
Line 7 - Other General Services				
Extended Care Consulting, LLC				-
Employee Benefits			442	442
				-
				-
				-
				-
Sub-Total	<u>-</u>	<u>-</u>	<u>442</u>	<u>442</u>
Line 15 - Other Health Care Services				
				-
				-
				-
				-
				-
				-
Sub-Total	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>
Line 27 - Other General Administration				
Extended Care Consulting, LLC				-
Employee Benefits			16,298	16,298
				-
				-
				-
				-
Sub-Total	<u>-</u>	<u>-</u>	<u>16,298</u>	<u>16,298</u>

Timber Point Healthcare Center, Inc.
 Medicaid Cost Report
 01/01/18 - 12/31/18

Page 3 Supplemental Schedule - Other Staff Administration Travel Expense

Employee	Travel Purpose	Travel Destination	Travel Date	Expenses			Total
				Travel	Accommodations	Meals	
American Express	Various	Various	Various	30,323	-	-	30,323
Care Management Facility	Various	Various	Various	20,807	-	-	20,807
Patricia Bedwell	Various	Various	Various	4,667	-	-	4,667
Contessa Sullivan	Various	Various	Various	2,683	-	-	2,683
Andrea Lewis	Various	Various	Various	2,048	-	-	2,048
Donald Steinkuhler	Various	Various	Various	1,513	-	-	1,513
Erika Burkel	Various	Various	Various	928	-	-	928
Nicole Buehler	Various	Various	Various	704	-	-	704
Tjaden's	Various	Various	Various	700	-	-	700
Wagner Garage	Various	Various	Various	684	-	-	684
Todd F. Vinyard	Various	Various	Various	543	-	-	543
Laura Sepessy	Various	Various	Various	488	-	-	488
Area Fabricators	Various	Various	Various	326	-	-	326
Kimberly Johnson	Various	Various	Various	239	-	-	239
Nanna Odonnell	Various	Various	Various	185	-	-	185
Angela Carver	Various	Various	Various	160	-	-	160
Kyle Cooper	Various	Various	Various	90	-	-	90
Pam Steinkuhler	Various	Various	Various	52	-	-	52
Emma Waterkotte	Various	Various	Various	27	-	-	27
Sandy Stabler	Various	Various	Various	22	-	-	22
							-
Extended Care Consulting, LLC				557	-	-	557
							-
							-
							-
							-
							-
							-
							-
							-
Total				67,746	-	-	67,746

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			21,094	21,094		21,094	46,811	67,905			30
31	Amortization of Pre-Op. & Org.			770	770		770	(770)				31
32	Interest			80,421	80,421		80,421	197,994	278,415			32
33	Real Estate Taxes							31,591	31,591			33
34	Rent-Facility & Grounds			225,132	225,132		225,132	(223,884)	1,248			34
35	Rent-Equipment & Vehicles			17,789	17,789		17,789	277	18,066			35
36	Other (specify):* See Supplemental											36
37	TOTAL Ownership			345,206	345,206		345,206	52,019	397,225			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		141,639	781,918	923,557		923,557		923,557			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			217,588	217,588		217,588		217,588			42
43	Other (specify):* See Supplemental	20,607			20,607		20,607	(20,607)				43
44	TOTAL Special Cost Centers	20,607	141,639	999,506	1,161,752		1,161,752	(20,607)	1,141,145			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,504,183	541,169	3,275,209	6,320,561		6,320,561	(485,647)	5,834,914			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
 01/01/18 - 12/31/18

Page 4 Supplemental Schedule

Description	Salaries	Supplies	Other	Total
Line 36 - Other Capital Costs				
				-
				-
				-
				-
				-
				-
				-
Sub-Total	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>
Line 43 - Other Special Cost Centers				
Non-Allowable	20,607			20,607
				-
				-
				-
				-
				-
				-
Sub-Total	<u>20,607</u>	<u>-</u>	<u>-</u>	<u>20,607</u>

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(9,476)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,084)	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	(10,717)	21		18
19	Entertainment				19
20	Contributions	(500)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(439,695)	21		24
25	Fund Raising, Advertising and Promotional	(30,719)	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	(45,886)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (538,077)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	52,430		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 52,430		36
37	TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)	\$ (485,647)		37

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

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

		1	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.			\$	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

BHF USE ONLY							
48		49		50		51	52

Timber Point Healthcare Center, Inc.

ID# 0043158

Report Period Beginning: 01/01/18

Ending: 12/31/18

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Fixed Assets < \$2,500	\$ 2,406	06	1
2	Other Professional	(21,723)	19	2
3	Theft Loss	(32)	21	3
4	Bank Charges	(4,727)	21	4
5	Amortization	(770)	31	5
6	Non-Allowable	(20,607)	43	6
7				7
8	Timber Point Associates, LLC			8
9	Administration	(433)	21	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(45,886)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Timber Point Healthcare Center, Inc.# 0043158

Report Period Beginning:

01/01/18

Ending:

12/31/18

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	111	0	0	0	0	0	0	0	0	111	1
2	Food Purchase	(1,084)	0	226	0	0	0	0	0	0	0	0	(858)	2
3	Housekeeping	0	0	603	0	0	0	0	0	0	0	0	603	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	902	0	0	0	0	0	0	0	0	902	5
6	Maintenance	2,406	0	2,414	5,100	0	0	0	0	0	0	0	9,920	6
7	Other (specify):*	0	0	0	442	0	0	0	0	0	0	0	442	7
8	TOTAL General Services	1,322	0	4,256	5,542	0	0	0	0	0	0	0	11,120	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	865	9,932	0	0	0	0	0	0	0	10,797	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(21,723)	0	(110,845)	0	0	0	0	0	0	0	0	(132,568)	19
20	Fees, Subscriptions & Promotions	(31,219)	0	1,109	0	0	0	0	0	0	0	0	(30,110)	20
21	Clerical & General Office Expenses	(455,604)	433	5,691	65,042	0	0	0	0	0	0	0	(384,438)	21
22	Employee Benefits & Payroll Taxes	0	0	0	(9,938)	0	0	0	0	0	0	0	(9,938)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	210	0	0	0	0	0	0	0	0	210	24
25	Other Admin. Staff Transportation	0	0	557	0	0	0	0	0	0	0	0	557	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,013	0	0	0	0	0	0	0	0	1,013	26
27	Other (specify):*	0	0	0	16,298	0	0	0	0	0	0	0	16,298	27
28	TOTAL General Administration	(508,546)	433	(101,400)	81,334	0	0	0	0	0	0	0	(528,179)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(507,224)	433	(97,144)	86,876	0	0	0	0	0	0	0	(517,059)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Timber Point Healthcare Center, Inc.# 0043158

Report Period Beginning:

01/01/18

Ending:

12/31/18

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	45,338	1,473	0	0	0	0	0	0	0	0	46,811	30
31	Amortization of Pre-Op. & Org.	(770)	0	0	0	0	0	0	0	0	0	0	(770)	31
32	Interest	(9,476)	194,839	12,631	0	0	0	0	0	0	0	0	197,994	32
33	Real Estate Taxes	0	29,045	2,546	0	0	0	0	0	0	0	0	31,591	33
34	Rent-Facility & Grounds	0	(223,884)	0	0	0	0	0	0	0	0	0	(223,884)	34
35	Rent-Equipment & Vehicles	0	0	277	0	0	0	0	0	0	0	0	277	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(10,246)	45,338	16,927	0	0	0	0	0	0	0	0	52,019	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):*	(20,607)	0	0	0	0	0	0	0	0	0	0	(20,607)	43
44	TOTAL Special Cost Centers	(20,607)	0	0	0	0	0	0	0	0	0	0	(20,607)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(538,077)	45,771	(80,217)	86,876	0	0	0	0	0	0	0	(485,647)	45

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 223,884	Timber Point Associates, LLC	100.00%	\$	\$ (223,884)	1
2	V	32 Interest		Timber Point Associates, LLC	100.00%			2
3	V	19 Professional Fees		Timber Point Associates, LLC	100.00%			3
4	V	21 Office		Timber Point Associates, LLC	100.00%	433	433	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		Timber Point Associates, LLC	100.00%	29,045	29,045	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		\$ 223,884			\$ 269,655	\$ * 45,771	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:

01/01/18

Ending:

12/31/18

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Timber Point Healthcare Center, Inc.

0043158

Report Period Beginning:

01/01/18

Ending:

12/31/18

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			Naperville Manor	Naperville, IL				5
6			South Holland Manor	South Holland, IL				6
7			Westmont Manor	Westmont, IL				7
8			Wheaton Care Center	Wheaton, IL				8
9			Estates of Hyde Park	Hyde Park, IL				9
10			Major Hospital - Spring Mill	Merrillville, IN				10
11			Major Hospital - Spring Mill AL	Merrillville, IN				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

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 Dietary	\$	Extended Care Consulting, LLC	100.00%	\$ 111	\$	111	15
16	V	2 Food		Extended Care Consulting, LLC	100.00%	226		226	16
17	V	3 Housekeeping		Extended Care Consulting, LLC	100.00%	603		603	17
18	V	5 Utilities		Extended Care Consulting, LLC	100.00%	902		902	18
19	V	6 Maintenance		Extended Care Consulting, LLC	100.00%	2,414		2,414	19
20	V	17 Administrative		Extended Care Consulting, LLC	100.00%	865		865	20
21	V	19 Professional Fees	114,000	Extended Care Consulting, LLC	100.00%	3,155		(110,845)	21
22	V	20 Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	1,109		1,109	22
23	V	21 Office and Clerical		Extended Care Consulting, LLC	100.00%	5,691		5,691	23
24	V	24 Seminar and Travel		Extended Care Consulting, LLC	100.00%	210		210	24
25	V	25 Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	557		557	25
26	V	26 Insurance		Extended Care Consulting, LLC	100.00%	1,013		1,013	26
27	V	30 Depreciation		Extended Care Consulting, LLC	100.00%	1,473		1,473	27
28	V	32 Interest		Extended Care Consulting, LLC	100.00%	12,631		12,631	28
29	V	33 Real Estate Taxes	120	Extended Care Consulting, LLC	100.00%	2,666		2,546	29
30	V	35 Rent - Equipment and Auto		Extended Care Consulting, LLC	100.00%	277		277	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		\$ 114,120			\$ 33,903	\$ *	(80,217)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6 Maintenance (Pooled)	\$	Extended Care Consulting, LLC	100.00%	\$ 5,100	\$ 5,100	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%	442	442	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%	9,932	9,932	19
20	V	21 Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	65,042	65,042	20
21	V	21 Office and Clerical (Direct)	16,149	Extended Care Consulting, LLC	100.00%	16,149		21
22	V	27 Emp. Gen. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	14,993	14,993	22
23	V	27 Emp. Gen. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	1,305	1,305	23
24	V	22 Employee Benefits	9,938	Extended Care Consulting, LLC	100.00%		(9,938)	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		\$ 26,087			\$ 112,963	\$ * 86,876	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22 Employee Benefits	\$ 192,164	CCS VEBA	100.00%	\$ 192,164	\$	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		\$ 192,164			\$ 192,164	\$ *	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: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Sherwin Ray	Shareholder	Administration	33.33%	See Supplemental	9.31	23.27%	Salary	\$ 46,549	17 - 01	1
2	Adam Vales	Relative	Clerical	0.00%	See Supplemental	0.91	2.28%	Alloc. Salary	1,725	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	\$ 48,274		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' PREPARATION REPORT

Timber Point Healthcare Center, Inc.
 Medicaid Cost Report
 01/01/18 - 12/31/18

Page 7 Supplemental Schedule

Description	Alloc. Hours	Total Hours	Alloc. Percentage	Total Compensation		Alloc. Compensation		
				Salary	Mgmt. Fees	Salary	Mgmt. Fees	
Owners / Director Compensation								
Sherwin Ray							-	-
Timber Point Healthcare Center	9.31	40.00	23.27%	200,000	-		46,549	-
Prairie Village Healthcare Center	9.31	40.00	23.27%	200,000	-		46,549	-
Countryside Nursing & Rehab	14.08	40.00	35.20%	200,000	-		70,397	-
Rushville Nursing & Rehab	7.30	40.00	18.25%	200,000	-		36,505	-
							-	-
							-	-
							-	-
							-	-
							-	-
							-	-
							-	-
							-	-
							-	-
							-	-
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							-	-
							-	-
							-	-
							-	-
							-	-
							-	-
							-	-
							-	-
							-	-
							-	-
							-	-
Total	<u>40</u>		<u>100.00%</u>				<u>200,000</u>	<u>-</u>

Timber Point Healthcare Center, Inc.
 Medicaid Cost Report
 01/01/18 - 12/31/18

Page 7 Supplemental Schedule

Description	Alloc. Hours	Total Hours	Alloc. Percentage	Total Compensation		Alloc. Compensation	
				Salary	Mgmt. Fees	Salary	Mgmt. Fees
Owners / Director Compensation							
Adam Vales							
Timber Point Healthcare Center	0.91	40.00	2.28%	75,808	-	1,725	-
Prairie Village Healthcare Center	0.74	40.00	1.85%	75,808	-	1,402	-
Countryside Nursing & Rehab	1.26	40.00	3.15%	75,808	-	2,388	-
Kensington Place Nursing & Rehab	1.18	40.00	2.95%	75,808	-	2,236	-
Little Village	0.31	40.00	0.78%	75,808	-	588	-
Rushville Nursing & Rehab	0.59	40.00	1.48%	75,808	-	1,118	-
Other Entities	35.01	40.00	87.53%	75,808	-	66,351	-
						-	-
						-	-
						-	-
						-	-
						-	-
						-	-
						-	-
						-	-
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						-	-
						-	-
						-	-
						-	-
						-	-
						-	-
						-	-
						-	-
Total	<u>40</u>		<u>100.00%</u>			<u>75,808</u>	<u>-</u>

Facility Name & ID Number Timber Point Healthcare Center, Inc.

0043158

Report Period Beginning:

01/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Timber Point Healthcare Center, Inc.

0043158

Report Period Beginning:

01/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Patient Days	1,389,746	40	\$ 5,386	\$ 28,620	\$ 111	1
2	2	Food	Patient Days	1,389,746	40	10,961	28,620	226	2
3	3	Housekeeping	Patient Days	1,389,746	40	29,295	28,620	603	3
4	5	Utilities	Patient Days	1,389,746	40	43,781	28,620	902	4
5	6	Maintenance	Patient Days	1,389,746	40	117,234	28,620	2,414	5
6	17	Administrative	Patient Days	1,389,746	40	42,000	28,620	865	6
7	19	Professional Fees	Patient Days	1,389,746	40	153,207	28,620	3,155	7
8	20	Dues and Subscriptions	Patient Days	1,389,746	40	53,847	28,620	1,109	8
9	21	Office and Clerical	Patient Days	1,389,746	40	276,330	28,620	5,691	9
10	24	Travel and Seminar	Patient Days	1,389,746	40	10,217	28,620	210	10
11	25	Other Staff Admin. Trans.	Patient Days	1,389,746	40	27,054	28,620	557	11
12	26	Insurance	Patient Days	1,389,746	40	49,193	28,620	1,013	12
13	30	Depreciation	Patient Days	1,389,746	40	71,516	28,620	1,473	13
14	32	Interest	Patient Days	1,389,746	40	613,328	28,620	12,631	14
15	33	Real Estate Taxes	Patient Days	1,389,746	40	129,471	28,620	2,666	15
16	35	Rent - Equipment and Auto	Patient Days	1,389,746	40	13,470	28,620	277	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,646,290	\$	\$ 33,903	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Timber Point Healthcare Center, Inc.

0043158

Report Period Beginning:

01/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Extended Care Consulting, LLC
 Street Address 2201 Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905 - 3000
 Fax Number (847) 941 - 9565

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	6	Maintenance	Patient Days	1,389,746	40	\$ 247,664	\$ 247,664	28,620	\$ 5,100	1
2	6	Maintenance	Direct	357,298	40	357,298	357,298			2
3	7	Emp. Ben. - Gen. Serv.	Patient Days	1,389,746	40	21,482		28,620	442	3
4	7	Emp. Ben. - Gen. Serv.	Direct	47,140	40	47,140				4
5	17	Administrative	Patient Days	1,389,746	40	482,303	482,303	28,620	9,932	5
6	21	Office and Clerical	Patient Days	1,389,746	40	3,158,355	3,158,355	28,620	65,042	6
7	21	Office and Clerical	Direct	484,472	40	484,472	484,472	16,149	16,149	7
8	27	Emp. Gen. - Gen. Admin.	Patient Days	1,389,746	40	728,044		28,620	14,993	8
9	27	Emp. Gen. - Gen. Admin.	Direct	72,742	40	72,742		1,305	1,305	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					\$ 5,599,500	\$ 4,730,092		\$ 112,963	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Timber Point Healthcare Center, Inc.

0043158

Report Period Beginning:

01/01/18

Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	22	Employee Benefits	Direct Allocation	8,429,403	\$ 8,429,403	\$	192,164	\$ 192,164	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				\$ 8,429,403	\$		\$ 192,164	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Timber Point Healthcare Center, Inc. # 0043158 Report Period Beginning: 01/01/18 Ending: 12/31/18

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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Atied Associates		X				\$	\$		\$ 194,839	1									
2											2									
3											3									
4											4									
5											5									
Working Capital																				
6	HFG, LLC		X	Line of Credit						79,646	6									
7	Extended Care Cons., LLC		X	Line of Credit						12,631	7									
8			X	Auto Loan						775	8									
9	TOTAL Facility Related						\$	\$		\$ 287,891	9									
B. Non-Facility Related*																				
10											10									
11											11									
12	Interest Income		X							(9,476)	12									
13											13									
14	TOTAL Non-Facility Related						\$	\$		\$ (9,476)	14									
15	TOTALS (line 9+line14)						\$	\$		\$ 278,415	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 0 Line # 36 - 03

* 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.)

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2017 report.		\$	29,462	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.)		\$	31,206	2
3. Under or (over) accrual (line 2 minus line 1).		\$	1,744	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	29,967	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.)		\$	164	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.)		\$	(284)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	31,591	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2013	26,235	8
	2014	26,651	9
	2015	26,932	10
	2016	28,059	11
	2017	28,540	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

2018 Real Estate Tax Accrual = \$28,540 * 1.05 * \$29,967

Extended Care Consulting, LLC - RE Tax Allocation = \$2,666

NOTES:

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

SEE ACCOUNTANTS' PREPARATION REPORT

2017 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 2017 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 2017.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>03 - 0 - 0932 - 0001 - 00</u>	<u>Long Term Care Facility</u>	\$ <u>28,540.06</u>	\$ <u>28,540.06</u>
2. <u>Alloc. - Ext. Care Consulting</u>	<u>Long Term Care Facility</u>	\$ <u>190,923.89</u>	\$ <u>2,666.28</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>219,463.95</u></u>	\$ <u><u>31,206.34</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

Facility Name & ID Number Timber Point Healthcare Center, Inc.

0043158

Report Period Beginning:

01/01/18 Ending:

12/31/18

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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

Blank lines for listing other business entities.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized: 3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs: (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a numbered column. Rows include Facility, Ext. Care Con. LLC, and TOTALS.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number **Timber Point Healthcare Center, Inc.**

0043158

Report Period Beginning:

01/01/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Bed* FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	110	1998		\$ 1,120,000	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Timber Point Healthcare Center, Inc. (Operating Entity)									
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.

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Timber Point Healthcare Center, Inc.

0043158

Report Period Beginning:

01/01/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Timber Point Associates, LLC (Building Partnership)		\$	\$		\$	\$	\$	37
38									38
39	Various	1998	15,322						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:

01/01/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
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	95						5
6	Allocations - Extended Care Consulting, LLC	2009	57						6
7	Allocations - Extended Care Consulting, LLC	2010	556						7
8	Allocations - Extended Care Consulting, LLC	2011	200						8
9	Allocations - Extended Care Consulting, LLC	2012	66						9
10	Allocations - Extended Care Consulting, LLC	2014	913						10
11	Allocations - Extended Care Consulting, LLC	2016	1,095						11
12	Allocations - Extended Care Consulting, LLC	2017							12
13	Allocations - Extended Care Consulting, LLC	2018							13
14									14
15	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2002	15,781						15
16	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2002	13,036						16
17	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2003	15,363						17
18	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2005	763						18
19	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2009	138						19
20	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2014	1,322						20
21	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2015	217						21
22	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2016	858						22
23	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2017	1,488						23
24	Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2018	682						24
25									25
26	Allocations - Extended Care Consulting, LLC / Dyer Building	2007	4,942						26
27									27
28									28
29	Depreciation - Timber Point Healthcare Center, Inc.			21,094		21,094		287,758	29
30	Depreciation - Timber Point Associates, LLC			45,338		45,338		1,091,079	30
31	Depreciation - Extended Care Consulting, LLC			723		723		63,078	31
32	Depreciation - Extended Care Consulting, LLC / 2201 Main LLC			640		640		40,928	32
33	Depreciation - Extended Care Consulting, LLC / Dyer Building			110		110		1,259	33
34	TOTAL (lines 1 thru 33)		\$ 1,541,848	\$ 67,905		\$ 67,905	\$	\$ 1,484,102	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 166,701	\$	\$	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	See Supplemental	185,436						74
75	TOTALS	\$ 352,137	\$	\$	\$		\$	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	Bus		\$ 58,427	\$	\$	\$		\$	76
77	Facility	Van		23,698						77
78	Ext. Care Consult., LLC			524						78
79										79
80	TOTALS			\$ 82,649	\$	\$	\$		\$	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)	\$ 2,106,085	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 67,905	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 67,905	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)	\$ 1,484,102	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' PREPARATION REPORT

Timber Point Healthcare Center, Inc.
 Medicaid Cost Report
 01/01/18 - 12/31/18

Page 13 - Related Party Furniture and Equipment Allocations

Description	Acquisition Date	Grouping		Cost
Timber Point Associates, LLC	Prior	Furn. & Equipment		118,000
Extended Care Consulting, LLC	Prior	Furn. & Equipment		4,694
Extended Care Consulting, LLC	Current	Furn. & Equipment		-
Extended Care Consulting, LLC	Full	Furn. & Equipment		58,372
Extended Care Consulting, LLC	Full	Furn. & Equipment		4,370
				185,436

Facility Name & ID Number Timber Point Healthcare Center, Inc.

0043158

Report Period Beginning: 01/01/18

Ending: 12/31/18

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

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

12.	<u>/2019</u>	\$ _____
13.	<u>/2020</u>	\$ _____
14.	<u>/2021</u>	\$ _____

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

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

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

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

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

16. Rental Amount for movable equipment: \$ 11,396 Description: See Supplemental Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Facility</u>	<u>Ford Edge</u>	\$ _____	\$ <u>6,670</u>	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ <u>6,670</u>	21

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Timber Point Healthcare Center, Inc.
 Medicaid Cost Report
 01/01/18 - 12/31/18

Page 14 Supplemental Schedule

Description	Amount	Total
Building Rental		
Bruce 88 Storage	1,248	1,248
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
Total	<u>1,248</u>	<u>1,248</u>
Equipment Rental		
Digital Copy Systems	1,939	1,939
Flynn Sales & Services	6,300	6,300
Toshiba Financial Services	2,579	2,579
Ecolab	97	97
Other	204	204
		-
Extended Care Consulting, LLC	277	277
		-
		-
		-
		-
		-
		-
		-
		-
Total	<u>11,396</u>	<u>11,396</u>

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)							
			Units of Service	Cost	Units	Cost						
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	382,239	\$		\$	382,239	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				83,225				83,225	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				290,609				290,609	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39 - 02	# of prescripts					141,639			141,639	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					25,845				25,845	13
14	TOTAL			\$		\$	781,918	\$	141,639	\$	923,557	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.
 Medicaid Cost Report
 01/01/18 - 12/31/18

Page 16 Supplemental Schedule

Description	Salaries		Supplies		Other		Total
Laboratory					22,028		22,028
Radiology					2,166		2,166
Other					1,651		1,651
							-
							-
							-
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							-
Total					<u>25,845</u>		<u>25,845</u>

Facility Name & ID Number **Timber Point Healthcare Center, Inc.**

0043158

Report Period Beginning: **01/01/18**

Ending: **12/31/18**

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/18**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 48,347	\$ 57,294	1
2	Cash-Patient Deposits	16,114	16,114	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>1,063,925</u>)	1,286,707	1,286,707	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	33,774	33,774	6
7	Other Prepaid Expenses	1,161	1,161	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Supplemental Schedule</u>			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,386,103	\$ 1,395,050	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	208,111	347,852	15
16	Equipment, at Historical Cost	227,504	369,202	16
17	Accumulated Depreciation (book methods)	(287,758)	(1,378,837)	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): <u>See Supplemental Schedule</u>	13,748	13,748	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 161,605	\$ 589,965	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,547,708	\$ 1,985,015	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 657,540	\$ 657,540	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	16,114	16,114	28
29	Short-Term Notes Payable	1,534,548	1,534,548	29
30	Accrued Salaries Payable	170,405	170,405	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,530	7,530	31
32	Accrued Real Estate Taxes(Sch.IX-B)		29,968	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Supplemental Schedule</u>	1,894,426	2,980,491	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,280,563	\$ 5,396,596	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	6,342	6,342	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Supplemental Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 6,342	\$ 6,342	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,286,905	\$ 5,402,938	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,739,197)	\$ (3,417,923)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,547,708	\$ 1,985,015	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

Timber Point Healthcare Center, Inc.
 Medicaid Cost Report
 01/01/18 - 12/31/18

Page 17 Supplemental Schedule

Description	Operating	Building	Total
Line 9 - Other Current Assets			
			-
			-
			-
			-
Sub-Total	<u>-</u>	<u>-</u>	<u>-</u>
Line 23 - Long Term Assets			
Financing Fees (Net of Amortization)	321		321
Construction in Progress	13,427		13,427
			-
			-
Sub-Total	<u>13,748</u>	<u>-</u>	<u>13,748</u>
Line 36 - Other Current Liability			
Due to Affiliated Entities	1,894,426	1,086,065	2,980,491
			-
			-
			-
Sub-Total	<u>1,894,426</u>	<u>1,086,065</u>	<u>2,980,491</u>
Line 43 - Long term Liabilities			
			-
			-
			-
			-
Sub-Total	<u>-</u>	<u>-</u>	<u>-</u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,815,820)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,815,820)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	76,623	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)	\$ 76,623	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)	\$ (2,739,197)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

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

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,924,453	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,924,453	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	240,395	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 240,395	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	14,967	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 14,967	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	9,477	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 9,477	26
E. Other Revenue (specify).****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	207,892	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 207,892	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,397,184	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	907,918	31
32	Health Care	1,876,431	32
33	General Administration	2,029,254	33
B. Capital Expense			
34	Ownership	345,206	34
C. Ancillary Expense			
35	Special Cost Centers	944,164	35
36	Provider Participation Fee	217,588	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,320,561	40
41	Income before Income Taxes (line 30 minus line 40)**	76,623	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 76,623	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 3,431,851	44
45	Private Pay - Net Inpatient Revenue	358,268	45
46	Medicare - Net Inpatient Revenue	1,782,838	46
47	Other-(specify) <u>Insurance - Net Inpatient Revenue</u>	308,295	47
48	Other-(specify) <u>Hospice - Net Inpatient Revenue</u>	43,201	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,924,453	49

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Timber Point Healthcare Center, Inc.
Medicaid Cost Report
01/01/18 - 12/31/18

Page 19 Supplemental Schedule

Description	Amount	Total
Patient Transportation	2,442	2,442
Insurance Settlement (Excess Repairs)	205,450	205,450
		-
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		-
		-
Total	<u>207,892</u>	<u>207,892</u>

Facility Name & ID Number Timber Point Healthcare Center, Inc.

0043158

Report Period Beginning:

01/01/18

Ending:

12/31/18

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,867	2,122	\$ 83,468	\$ 39.33	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,407	14,465	436,888	30.20	3
4	Licensed Practical Nurses	12,928	13,983	296,430	21.20	4
5	CNAs & Orderlies	41,443	43,512	573,355	13.18	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,929	2,054	25,470	12.40	8
9	Activity Director	1,822	2,049	29,597	14.44	9
10	Activity Assistants	4,121	4,514	46,454	10.29	10
11	Social Service Workers	2,883	3,224	65,648	20.36	11
12	Dietician					12
13	Food Service Supervisor	590	607	9,238	15.22	13
14	Head Cook	7,046	7,555	76,108	10.07	14
15	Cook Helpers/Assistants	6,263	7,044	68,419	9.71	15
16	Dishwashers					16
17	Maintenance Workers	4,515	4,895	77,685	15.87	17
18	Housekeepers	11,913	13,152	134,497	10.23	18
19	Laundry	4,681	5,127	48,047	9.37	19
20	Administrator	1,885	2,126	128,364	60.38	20
21	Assistant Administrator					21
22	Other Administrative	484	484	46,549	96.18	22
23	Office Manager					23
24	Clerical	6,171	6,760	181,169	26.80	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	2,045	2,242	34,488	15.38	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	6,693	7,441	142,309	19.12	33
34	TOTAL (lines 1 - 33)	132,686	143,356	\$ 2,504,183 *	\$ 17.47	34

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$ 10,194	01 - 03	35
36	Medical Director	3,195	09 - 03	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	6,201	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	938	12 - 03	45
46	Other(specify) <u>See Supplemental</u>	15,018		46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 35,546		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

Timber Point Healthcare Center, Inc.
Medicaid Cost Report
01/01/18 - 12/31/18

Page 20 Supplemental Schedule

Description	CC Reference	Hours Worked	Hours Paid	Salary	Average Rate	Hours Paid	Contracted Cost
Nursing Home Employees							
Resident Escorts	10	577	610	5,334	8.74		
Ward Clerk	10	4,130	4,644	53,848	11.60		
Care Plan Coordinator	10	1,986	2,187	62,520	28.59		
Non-Allowable	43			20,607	-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
Total		<u>6,693</u>	<u>7,441</u>	<u>142,309</u>	<u>19.12</u>		

Contracted Services							
MDS Consultant	10						15,018
Total						<u>-</u>	<u>15,018</u>

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Andrea Lewis	Administrator	0	\$ 128,364	Workers' Compensation Insurance	\$ 69,352	IDPH License Fee	\$ 1,990	
Sherwin Ray	Administration	33.33	46,549	Unemployment Compensation Insurance	21,252	Advertising: Employee Recruitment	27,677	
				FICA Taxes	177,457	Health Care Worker Background Check	3,865	
				Employee Health Insurance	118,181	(Indicate # of checks performed)		
				Employee Meals		<u>Patient Background Checks</u>		
				Illinois Municipal Retirement Fund (IMRF)*		Licenses	1,703	
				Other Employee Benefits	12,984	Dues - Associations	17,895	
						Dues and Subscriptions	1,569	
						Advertising and Promotion	30,719	
						Extended Care Consulting, LLC	1,109	
						Less: Public Relations Expense	()	
						Non-allowable advertising	(30,719)	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1)				TOTAL (agree to Schedule V,			TOTAL (agree to Sch. V,	
(List each licensed administrator separately.)				line 22, col.8)			line 20, col. 8)	
\$ <u>174,913</u>				\$ <u>399,226</u>			\$ <u>55,808</u>	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description				Description	Line #	Amount	Description	Amount
							Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	2,780
							Extended Care Consulting, LLC	210
							Entertainment Expense	()
							(agree to Sch. V,	
TOTAL (agree to Schedule V, line 17, col. 3)				TOTAL			TOTAL (agree to Sch. V,	
(Attach a copy of any management service agreement)				\$ <u> </u>			line 24, col. 8)	
\$ <u> </u>				\$ <u> </u>			\$ <u>2,990</u>	
C. Professional Services								
Vendor/Payee	Type	Amount						
Extended Care Consulting, LLC	Home Office	\$ 114,000						
Plante & Moran, PLLC	Accounting	24,212						
Marcum, LLP	Accounting	1,568						
Personnel Planners, Inc.	Unemployment Consultant	1,980						
Ability Network	Data Processing / IT Cons.	8,702						
National Datacare Corporation	Data Processing / IT Cons.	2,608						
Propay	Data Processing / IT Cons.	16,117						
Matrixcare	Data Processing / IT Cons.	9,328						
Other	Data Processing / IT Cons.	1,715						
Mulch Shelist	Legal	84						
Neal, Gerber & Eisenberg, LLP	Legal	33						
See Supplemental Schedule		28,053						
TOTAL (agree to Schedule V, line 19, column 3)								
(For legal fee disclosure, see page 39 of instructions)								
\$ <u>208,400</u>								

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

Timber Point Healthcare Center, Inc.
 Medicaid Cost Report
 01/01/18 - 12/31/18

Page 21 Supplemental Schedule - Other Professional Fees

Vendor	Service Description		Amount		Total
Blymas	Other Professional		2,736		2,736
Other	Other Professional		3,594		3,594
Other	Non-Allowable		21,723		21,723
					-
					-
					-
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Total			<u>28,053</u>		<u>28,053</u>

Timber Point Healthcare Center, Inc.
 Medicaid Cost Report
 01/01/18 - 12/31/18

Page 21 Supplemental Schedule - Legal Invoice Detail

Vendor	Service Description	Invoice Date	Amount	Non-Allowable	Allowable
Mulch Shelst	Business Matters	02/01/18	84		84
Neal, Gerber & Eisenberg, LLP	Business Matters	12/14/18	33		33
					-
					-
					-
					-
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					-
Total			117	-	117

Facility Name & ID Number Timber Point Healthcare Center, Inc.# 0043158

Report Period Beginning:

01/01/18Ending: 12/31/18**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. ICLTC - \$17,895
- (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. \$ 11,086 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. \$ 217,588
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes 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? 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? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees

SEE ACCOUNTANTS' PREPARATION REPORT