FOR BHF USE

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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

I. IDPH License ID Number: 0043158

Facility Name: Timber Point Healthcare Ctr

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

County: Adams

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

HFS ID Number:

Date of Initial License for Current Owners: 1998

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Joshua S. Banach **Telephone Number:** (847) 628-8784
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 1/1/20 to 12/31/20 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) Denise A Leonard, CPA, Partner
(Firm Name & Address) Plante & Moran PLLC, 1111 Superior Ave, Suite 1250 Cleveland, OH 44114
(Telephone) (216) 274-6514 Fax # (248) 233-7349

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

Facility Name & ID Number Timber Point Healthcare Ctr # 0043158 Report Period Beginning: 1/1/20 Ending: 12/31/20

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	110	Skilled (SNF)	110	40,260	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	110	TOTALS	110	40,260	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	17,413	1,797	6,222	25,432	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,413	1,797	6,222	25,432	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.17%

D. How many bed reserve days during this year were paid by the Department?
None (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)
None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 5,555

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/20 Fiscal Year: 12/31/20

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

Facility Name & ID Number Timber Point Healthcare Ctr # 0043158 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	157,276	30,609	9,647	197,532		197,532	83	197,615			1
2	Food Purchase		154,670		154,670		154,670	61	154,731			2
3	Housekeeping	130,817	27,046	916	158,779		158,779	727	159,506			3
4	Laundry	37,122	19,730		56,852		56,852		56,852			4
5	Heat and Other Utilities			123,630	123,630		123,630	(10,265)	113,365			5
6	Maintenance	121,860	73,416	15,701	210,977		210,977	9,403	220,380			6
7	Other (specify):*			17,340	17,340		17,340	2,189	19,529			7
8	**TOTAL General Services**	447,075	305,471	167,234	919,780		919,780	2,198	921,978			8
	B. Health Care and Programs											
9	Medical Director			1,423	1,423		1,423		1,423			9
10	Nursing and Medical Records	1,647,894	173,919	12,883	1,834,696		1,834,696	(41)	1,834,655			10
10a	Therapy	30,128		731,686	761,814		761,814		761,814			10a
11	Activities	76,724	3,451		80,175		80,175		80,175			11
12	Social Services	131,101	57		131,158		131,158		131,158			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,885,847	177,427	745,992	2,809,266		2,809,266	(41)	2,809,225			16
	C. General Administration											
17	Administrative	180,340			180,340		180,340	10,407	190,747			17
18	Directors Fees											18
19	Professional Services			211,458	211,458		211,458	(126,744)	84,714			19
20	Dues, Fees, Subscriptions & Promotions			35,630	35,630		35,630	(6,428)	29,202			20
21	Clerical & General Office Expenses	88,328	52,032	13,183	153,543		153,543	45,665	199,208			21
22	Employee Benefits & Payroll Taxes			419,908	419,908		419,908		419,908			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,493	3,493		3,493	221	3,714			24
25	Other Admin. Staff Transportation			25,467	25,467		25,467	417	25,884			25
26	Insurance-Prop.Liab.Malpractice			161,347	161,347		161,347	893	162,240			26
27	Other (specify):*			24,207	24,207		24,207	(8,891)	15,316			27
28	**TOTAL General Administration**	268,668	52,032	894,693	1,215,393		1,215,393	(84,460)	1,130,933			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,601,590	534,930	1,807,919	4,944,439		4,944,439	(82,303)	4,862,136			29

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

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

Facility Name & ID Number Timber Point Healthcare Ctr #0043158 Report Period Beginning: 1/1/20 Ending: 12/31/20

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			16,044	16,044		16,044	34,732	50,776			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			20,108	20,108		20,108	197,733	217,841			32
33	Real Estate Taxes			29,489	29,489		29,489	2,787	32,276			33
34	Rent-Facility & Grounds			196,087	196,087		196,087	(194,839)	1,248			34
35	Rent-Equipment & Vehicles			26,374	26,374		26,374	152	26,526			35
36	Other (specify):*			1,877	1,877		1,877	(1,877)				36
37	**TOTAL Ownership**			289,979	289,979		289,979	38,688	328,667			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			231,298	231,298		231,298		231,298			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			194,093	194,093		194,093		194,093			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			425,391	425,391		425,391		425,391			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,601,590	534,930	2,523,289	5,659,809		5,659,809	(43,615)	5,616,194			45

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

Facility Name & ID Number Timber Point Healthcare Ctr # 0043158 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	(11,061)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	15,906	30		9
10	Interest and Other Investment Income	(2,114)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,877)	36		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	(1,185)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(23,022)	27		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	(49,367)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (72,720)		$	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)	29,105		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 29,105		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (43,615)		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

Timber Point Healthcare Ctr

ID# 0043158

Report Period Beginning: 1/1/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Timber Point Assoc.-Bank Charges/Admin Fees	$ (512)	21	1
2	Patient Clothing	(41)	10	2
3	Bank Charges	(4,277)	21	3
4	Collections Expense	(1,377)	21	4
5	PAC Dues	(7,783)	20	5
6	Capitalized R&M	(4,187)	06	6
7	PPP Consulting	(1,800)	19	7
8	Non-Allowable Expense	(29,390)	21	8
9		0		9
10		0		10
11		0		11
12		0		12
13		0		13
14		0		14
15		0		15
16		0		16
17		0		17
18		0		18
19		0		19
20		0		20
21		0		21
22		0		22
23		0		23
24		0		24
25		0		25
26		0		26
27		0		27
28		0		28
29		0		29
30		0		30
31		0		31
32		0		32
33		0		33
34		0		34
35		0		35
36		0		36
37		0		37
38		0		38
39		0		39
40		0		40
41		0		41
42		0		42
43		0		43
44		0		44
45		0		45
46		0		46
47		0		47
48		0		48
49	**Total**	(49,367)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Timber Point Healthcare Ctr # 0043158 Report Period Beginning: 1/1/20 Ending: 12/31/20

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

	Operating Expenses	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)	
	A. General Services													
1	Dietary	0	0	83	0	0	0	0	0	0	0	0	83	1
2	Food Purchase	0	0	61	0	0	0	0	0	0	0	0	61	2
3	Housekeeping	0	0	727	0	0	0	0	0	0	0	0	727	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	796	0	0	0	0	0	0	0	0	796	5
6	Maintenance	(4,187)	0	1,585	12,005	0	0	0	0	0	0	0	9,403	6
7	Other (specify):*	0	0	0	2,189	0	0	0	0	0	0	0	2,189	7
8	**TOTAL General Services**	(4,187)	0	3,251	14,194	0	0	0	0	0	0	0	13,259	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	(41)	0	0	0	0	0	0	0	0	0	0	(41)	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**	(41)	0	0	0	0	0	0	0	0	0	0	(41)	16
	C. General Administration													
17	Administrative	0	0	0	10,407	0	0	0	0	0	0	0	10,407	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,800)	0	(124,944)	0	0	0	0	0	0	0	0	(126,744)	19
20	Fees, Subscriptions & Promotions	(7,783)	0	1,355	0	0	0	0	0	0	0	0	(6,428)	20
21	Clerical & General Office Expenses	(35,556)	512	7,135	73,574	0	0	0	0	0	0	0	45,665	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	221	0	0	0	0	0	0	0	0	221	24
25	Other Admin. Staff Transportation	0	0	417	0	0	0	0	0	0	0	0	417	25
26	Insurance-Prop.Liab.Malpractice	0	0	893	0	0	0	0	0	0	0	0	893	26
27	Other (specify):*	0	0	0	15,316	0	0	0	0	0	0	0	15,316	27
28	**TOTAL General Administration**	(45,139)	512	(114,924)	99,297	0	0	0	0	0	0	0	(60,254)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(49,367)	512	(111,672)	113,491	0	0	0	0	0	0	0	(47,037)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Timber Point Healthcare Ctr # 0043158 Report Period Beginning: 1/1/20 Ending: 12/31/20

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

	Capital Expense D. Ownership	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)	
30	Depreciation	15,906	17,425	1,401	0	0	0	0	0	0	0	0	34,732	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	194,839	5,008	0	0	0	0	0	0	0	0	199,847	32
33	Real Estate Taxes	0	0	2,787	0	0	0	0	0	0	0	0	2,787	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	152	0	0	0	0	0	0	0	0	152	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	15,906	17,425	9,348	0	0	0	0	0	0	0	0	42,679	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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(33,461)	17,937	(102,324)	113,491	0	0	0	0	0	0	0	(4,357)	45

Facility Name & ID Number Timber Point Healthcare Ctr # 0043158 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	33	Real Estate Taxes	30,132	Timber Point Associates LLC	100.00%	30,132		2
3	V	21	A&G Fees and Charges		Timber Point Associates LLC	100.00%	512	512	3
4	V	30	Depreciation		Timber Point Associates LLC	100.00%	17,425	17,425	4
5	V	32	Interest		Timber Point Associates LLC	100.00%	194,839	194,839	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 224,971			$ 242,908	$ * 17,937	14

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

Facility Name & ID Number Timber Point Healthcare Ctr # 0043158 Report Period Beginning: 1/1/20 Ending: 12/31/20

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 REHABIL	BEECHER	Ex. Care Consulting	Evanston, IL	Home Office	1
2	Jakob Bakst	33.33%	BURBANK REHABILITATION CENTER	BURBANK	Ex. Care Clinical	Evanston, IL	Administrative	2
3	Eric Rothner	33.34%	CHATEAU NURSING AND REHABILITATIO	WILLOWBROOK	2201 Main Street	Evanston, IL	Bldg. Company	3
4			COUNTRYSIDE NURSING AND REHABILITA	DOLTON	CCS VEBA	Evanston, IL	Health Insurance	4
5			GRASMERE PLACE, LLC	CHICAGO	Vent Lease	Evanston, IL	Vent. Rental	5
6			ESTATES OF HIDDEN LAKE	ST. LOUIS, MO	Max RX, LLC	Des Plaines, IL	Pharmacy	6
7			LAKEWOOD NURSING & REHABILITATION	PLAINFIELD	Timber Point Assoc LL	Camp Point, IL	Bldg. Company	7
8			LEMONT NURSING AND REHABILITATION	LEMONT				8
9			MAJOR HOSPITAL DYER	DYER, IN				9
10			MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN				10
11			MAJOR HOSPITAL LINCOLNSHIRE	MERRIVILLE, IN				11
12			MAJOR HOSPITAL MUNSTER	MUNSTER, IN				12
13			MAJOR HOSPITAL SEBOS	HOBART, IN				13
14			MAJOR HOSPITAL SPRING MILL HEALTH C	MERRIVILLE, IN				14
15			MCKINLEY HEALTH CARE CENTER	CANTON, OH				15
16			PRAIRIE MANOR NURSING & REHABILITA	CHICAGO HEIGHTS				16
17			PRAIRIE VILLAGE HEALTHCARE CENTER,	JACKSONVILLE				17
18			RAINBOW BEACH QOC, L.L.C.	CHICAGO				18
19			RUSHVILLE NURSING & REHABILITATION	RUSHVILLE				19
20			SHEFFIELD MANOR	DYER, IN				20
21			SOUTH HOLLAND MANOR HEALTH & REH	SOUTH HOLLAND				21
22			SOUTH SUBURBAN REHABILITATION CEN	HOMEWOOD				22
23			ST. JAMES WELLNESS REHAB VILLAS	CRETE				23
24			THE ESTATES OF HYDE PARK	CHICAGO				24
25			WESTMONT MANOR HEALTH & REHAB CE	WESTMONT				25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Timber Point Healthcare Ctr # 0043158 Report Period Beginning: 1/1/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$	Extended Care Consulting LLC	100.00%	$ 83	$ 83	15
16	V	02	Food		Extended Care Consulting LLC	100.00%	61	61	16
17	V	03	Housekeeping		Extended Care Consulting LLC	100.00%	727	727	17
18	V	05	Utilities		Extended Care Consulting LLC	100.00%	796	796	18
19	V	06	Maintenance		Extended Care Consulting LLC	100.00%	1,585	1,585	19
20	V	17	Administrative		Extended Care Consulting LLC	100.00%	0		20
21	V	19	Professional Fees		Extended Care Consulting LLC	100.00%	3,240	3,240	21
22	V	20	Dues and Subscriptions		Extended Care Consulting LLC	100.00%	1,355	1,355	22
23	V	21	Office and Clerical		Extended Care Consulting LLC	100.00%	7,135	7,135	23
24	V	24	Seminar and Travel		Extended Care Consulting LLC	100.00%	221	221	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting LLC	100.00%	417	417	25
26	V	26	Insurance		Extended Care Consulting LLC	100.00%	893	893	26
27	V	30	Depreciation		Extended Care Consulting LLC	100.00%	1,401	1,401	27
28	V	32	Interest		Extended Care Consulting LLC	100.00%	5,008	5,008	28
29	V	33	Real Estate Taxes		Extended Care Consulting LLC	100.00%	2,787	2,787	29
30	V	34	Rent - Building		Extended Care Consulting LLC	100.00%	0		30
31	V	35	Rent - Equipment		Extended Care Consulting LLC	100.00%	152	152	31
32	V								32
33	V	19	Consulting Fees	128,184	Extended Care Consulting LLC	100.00%		(128,184)	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 128,184			$ 25,860	$ * (102,324)	39

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

Facility Name & ID Number Timber Point Healthcare Ctr # 0043158 Report Period Beginning: 1/1/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance Salaries	$	Extended Care Consulting LLC	100.00%	$ 12,005	$ 12,005	15
16	V	06	Maintenance (Direct)		Extended Care Consulting LLC	100.00%			16
17	V	07	Emp. Ben. - Gen. Serv.		Extended Care Consulting LLC	100.00%	2,189	2,189	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting LLC	100.00%			18
19	V	12	Admission (Direct)		Extended Care Consulting LLC	100.00%			19
20	V	15	Emp. Ben. - Nursing (Direct)		Extended Care Consulting LLC	100.00%			20
21	V	17	Administrative Salaries		Extended Care Consulting LLC	100.00%	10,407	10,407	21
22	V	21	Office and Clerical Salaries		Extended Care Consulting LLC	100.00%	73,574	73,574	22
23	V	21	Office and Clerical (Direct)		Extended Care Consulting LLC	100.00%			23
24	V	27	Emp. Ben. - Gen. Admin.		Extended Care Consulting LLC	100.00%	15,316	15,316	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting LLC	100.00%			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			$			$ 113,491	$ * 113,491	39

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

Facility Name & ID Number Timber Point Healthcare Ctr # 0043158 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	$ 160,765	CCS VEBA	100.00%	$ 160,765	$	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			$ 160,765			$ 160,765	$ *	39

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

Facility Name & ID Number Timber Point Healthcare Ctr # 0043158 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Adam Vales	Relative	Clerical	0.00	See Supplemental	0.80	2.00%	Alloc. Salary	$ 1,429	22-7	1
2	Sherwin Ray	Owner	Administrative	33.33%	See Supplemental	5.50	13.75%	Salary	27,504	17-1	2
3	Jakob Bakst	Owner	Administrative	33.33%	See Supplemental	6.00	15.00%	Salary	22,500	17-1	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 51,433		13

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

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

Facility Name & ID Number Timber Point Healthcare Ctr # 0043158 Report Period Beginning: 1/1/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

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

Facility Name & ID Number Timber Point Healthcare Ctr # 0043158 Report Period Beginning: 1/1/20 Ending: 12/31/20

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
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 491-9565

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Resident Days	1,219,947	36	$ 3,992	$	25,432	$ 83	1
2	02	Food	Resident Days	1,219,947	36	2,910		25,432	61	2
3	03	Housekeeping	Resident Days	1,219,947	36	34,856		25,432	727	3
4	05	Utilities	Resident Days	1,219,947	36	38,173		25,432	796	4
5	06	Maintenance	Resident Days	1,219,947	36	76,040		25,432	1,585	5
6	17	Administrative	Resident Days	1,219,947	36			25,432		6
7	19	Professional Fees	Resident Days	1,219,947	36	155,408		25,432	3,240	7
8	20	Dues and Subscriptions	Resident Days	1,219,947	36	64,998		25,432	1,355	8
9	21	Office and Clerical	Resident Days	1,219,947	36	342,251		25,432	7,135	9
10	24	Seminar and Travel	Resident Days	1,219,947	36	10,602		25,432	221	10
11	25	Other Staff Admin. Trans.	Resident Days	1,219,947	36	19,988		25,432	417	11
12	26	Insurance	Resident Days	1,219,947	36	42,836		25,432	893	12
13	30	Depreciation	Resident Days	1,219,947	36	67,209		25,432	1,401	13
14	32	Interest	Resident Days	1,219,947	36	240,208		25,432	5,008	14
15	33	Real Estate Taxes	Resident Days	1,219,947	36	133,701		25,432	2,787	15
16	34	Rent - Building	Resident Days	1,219,947	36			25,432		16
17	35	Rent - Equipment	Resident Days	1,219,947	36	7,304		25,432	152	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,240,476	$		$ 25,861	25

Facility Name & ID Number Timber Point Healthcare Ctr # 0043158 Report Period Beginning: 1/1/20 Ending: 12/31/20

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
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 491-9565

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	06	Maintenance Salaries	Resident Days	1,219,947	36	$ 575,856	$ 575,856	25,432	$ 12,005	1
2	06	Maintenance (Direct)								2
3	07	Emp. Ben. - Gen. Serv.	Resident Days	1,219,947	36	105,021		25,432	2,189	3
4	07	Emp. Ben. - Gen. Serv. (Direct)								4
5	12	Admission (Direct)								5
6	15	Emp. Ben. - Nursing (Direct)								6
7	17	Administrative Salaries	Resident Days	1,219,947	36	499,202	499,202	25,432	10,407	7
8	21	Office and Clerical Salaries	Resident Days	1,219,947	36	3,529,267	3,529,267	25,432	73,574	8
9	21	Office and Clerical (Direct)								9
10	27	Emp. Ben. - Gen. Admin.	Resident Days	1,219,947	36	734,685		25,432	15,316	10
11	27	Emp. Ben. - Gen. Admin. (Direct)								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					$ 5,444,030	$ 4,604,325		$ 113,491	25

Facility Name & ID Number Timber Point Healthcare Ctr # 0043158 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	8,032,049		$ 8,032,049	$	160,765	$ 160,765	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					$ 8,032,049	$		$ 160,765	25

Facility Name & ID Number Timber Point Healthcare Ctr # 0043158 Report Period Beginning: 1/1/20 Ending: 12/31/20

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			$	$ 947,409			$ 194,839	1
2												2
3												3
4												4
5												5
	Working Capital											
6	HFG, LLC		X	Line of Credit							19,892	6
7	Shareholder Loan		X	Working Capital				1,500,000				7
8	Allocated From ECC		X								5,008	8
9	TOTAL Facility Related						$	$ 2,447,409			$ 219,739	9
	B. Non-Facility Related*											
10	Interest Income		X								(2,114)	10
11	LTC Rx- Misc Interest		X								216	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,898)	14
15	TOTALS (line 9+line14)						$	$ 2,447,409			$ 217,841	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None 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.)

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

Facility Name & ID Number Timber Point Healthcare Ctr # 0043158 Report Period Beginning: 1/1/20 Ending: 12/31/20

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 31,204	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.)		$ 32,385	2
3. Under or (over) accrual (line 2 minus line 1).		$ 1,181	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 31,087	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.)		$ 8	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.		$ 32,276	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	26,932	8
	2016	28,059	9
	2017	28,540	10
	2018	29,106	11
	2019	29,606	12

Beginning Accrual Adjusted
2020 Accrual: $29,606 X 1.05 = $31,087
Allocated From ECC: $2,787

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Timber Point Healthcare Ctr COUNTY Adams

FACILITY IDPH LICENSE NUMBER 0043158

CONTACT PERSON REGARDING THIS REPORT Joshua S. Banach

TELEPHONE (847) 628-8784 FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2019 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 2019.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	03-0-0932-001-00	Long Term Care Facility	$ 29,606.40	$ 29,606.40
2.	Allocated From Extended Care	Home Office Allocation	$ 197,162.69	$ 2,787.24
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 226,769.09	$ 32,393.64

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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 Ctr # 0043158 Report Period Beginning: 1/1/20 Ending: 12/31/20

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).

None

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	Allocated From ECC			11,592	2
3	TOTALS			$ 129,592	3

Facility Name & ID Number Timber Point Healthcare Ctr # 0043158 Report Period Beginning: 1/1/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	110		1998		$ 1,120,000	$	40	$ 28,000	$ 28,000	$ 644,000	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10	Facility Improvements										10
11	Various			2001	18,442		20	922	922	18,442	11
12	Various			2003	7,919		20	396	396	7,127	12
13	Various			2004	24,419		20	1,221	1,221	20,756	13
14	Various			2005	12,730		20	637	637	10,184	14
15	Various			2006	18,831		20	942	942	14,123	15
16	Various			2007	6,583		20	329	329	4,608	16
17	Various			2008	22,650		20	1,133	1,133	14,723	17
18	Various			2010	7,216		20	361	361	3,969	18
19	Various			2011	7,314		20	366	366	3,657	19
20	Kitchen Roof Top Unit- Replacement			2012	4,938		20	247	247	2,222	20
21	Flooring- Nurses Station			2012	6,461		20	323	323	2,907	21
22	Plumbing- PVC Piping From Basement To Outside Facility			2012	3,975		20	199	199	1,789	22
23	Driveway Repairs East Entrance- Tear, gravel, regrade			2013	12,925		20	646	646	5,170	23
24	Flooring- Front Lobby			2013	6,185		20	309	309	2,474	24
25	Flooring- Hallways/Common Areas			2014	3,116		20	156	156	1,091	25
26	Water Heater			2014	4,979		20	249	249	1,743	26
27	Flooring- Hallways/Common Areas			2014	5,955		20	298	298	2,084	27
28	Flooring- Hallways/Common Areas			2015	19,907		20	995	995	5,972	28
29	Sewer and Plumbing			2015	5,790		20	290	290	1,737	29
30	Flooring- Hallways/Common Areas/Rooms			2016	4,883		20	244	244	1,221	30
31	Flooring- Hallways/Common Areas/Rooms			2017	5,890		20	295	295	1,178	31
32	Flooring- Hallways/Common Areas/Rooms			2017	4,686		20	234	234	937	32
33	Installation of 132 Sprinkler heads- Throughout Facility			2020	3,157		20	158	158	158	33
34	Front Hall AC Repairs- Thermostat and Capacitor			2020	4,187		20	209	209	209	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

Facility Name & ID Number Timber Point Healthcare Ctr # 0043158 Report Period Beginning: 1/1/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38	Timber Point Associates, LLC (Building Partnership)								38
39	Various	1998	15,322		20			15,322	39
40	Various	1999	10,509		20			10,509	40
41	Various	2000	2,585		20			2,585	41
42	Various	2000	12,177		20			12,177	42
43	Various	2001	99,148		20	4,957	4,957	99,148	43
44									44
45									45
46									46
47									47
48	Financial Statement Depreciation- Timber Point Associates			17,425			(17,425)		48
49	Financial Statement Depreciation- Timber Point Healthcare Center			16,044			(16,044)		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)		$ 1,482,879	$ 33,469		$ 44,114	$ 10,645	$ 912,222	70

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

Facility Name & ID Number Timber Point Healthcare Ctr # 0043158 Report Period Beginning: 1/1/20 Ending: 12/31/20

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		$ 1,482,879	$ 33,469		$ 44,114	$ 10,645	$ 912,222	1
2									2
3	Related Party Allocations								3
4									4
5									5
6	Dyer Building Allocation	2007	5,003	111	40	111		1,496	6
7	Allocated From ECC/2201 Main	2002	15,975	410	40	410		7,492	7
8									8
9									9
10	Allocated From ECC	2007	96	5	20	5		67	10
11	Allocated From ECC	2009	57	3	20	3		35	11
12	Allocated From ECC	2010	562	28	20	28		309	12
13	Allocated From ECC	2011	202	10	20	10		101	13
14	Allocated From ECC	2012	67	3	20	3		30	14
15	Allocated From ECC	2014	925	46	20	46		324	15
16	Allocated From ECC	2016	1,109	55	20	55		277	16
17									17
18	Allocated From ECC/2201 Main	2002	13,196		20			13,196	18
19	Allocated From ECC/2201 Main	2003	15,551		20			15,551	19
20	Allocated From ECC/2201 Main	2005	773		20			773	20
21	Allocated From ECC/2201 Main	2009	139	7	20	7		84	21
22	Allocated From ECC/2201 Main	2014	1,338	67	20	67		468	22
23	Allocated From ECC/2201 Main	2015	220	11	20	11		142	23
24	Allocated From ECC/2201 Main	2016	868	43	20	43		217	24
25	Allocated From ECC/2201 Main	2017	1,506	75	20	75		301	25
26	Allocated From ECC/2201 Main	2018	690	35	20	35		104	26
27	Allocated From ECC/2201 Main	2019	260	13	20	13		26	27
28	Allocated From ECC/2201 Main	2020	70	3	20	3		3	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,541,486	$ 34,394		$ 45,039	$ 10,645	$ 953,218	34

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

Facility Name & ID Number Timber Point Healthcare Ctr # 0043158 Report Period Beginning: 1/1/20 Ending: 12/31/20

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 12B, Carried Forward		$ 1,541,486	$ 34,394		$ 45,039	$ 10,645	$ 953,218	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									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,541,486	$ 34,394		$ 45,039	$ 10,645	$ 953,218	34

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

Facility Name & ID Number Timber Point Healthcare Ctr # 0043158 Report Period Beginning: 1/1/20 Ending: 12/31/20

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 12C, Carried Forward		$ 1,541,486	$ 34,394		$ 45,039	$ 10,645	$ 953,218	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									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,541,486	$ 34,394		$ 45,039	$ 10,645	$ 953,218	34

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

Facility Name & ID Number Timber Point Healthcare Ctr # 0043158 Report Period Beginning: 1/1/20 Ending: 12/31/20

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 12D, Carried Forward		$ 1,541,486	$ 34,394		$ 45,039	$ 10,645	$ 953,218	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									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,541,486	$ 34,394		$ 45,039	$ 10,645	$ 953,218	34

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

Facility Name & ID Number Timber Point Healthcare Ctr # 0043158 Report Period Beginning: 1/1/20 Ending: 12/31/20

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 12E, Carried Forward		$ 1,541,486	$ 34,394		$ 45,039	$ 10,645	$ 953,218	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									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,541,486	$ 34,394		$ 45,039	$ 10,645	$ 953,218	34

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

Facility Name & ID Number Timber Point Healthcare Ctr # 0043158 Report Period Beginning: 1/1/20 Ending: 12/31/20

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 12F, Carried Forward		$ 1,541,486	$ 34,394		$ 45,039	$ 10,645	$ 953,218	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									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,541,486	$ 34,394		$ 45,039	$ 10,645	$ 953,218	34

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

Facility Name & ID Number Timber Point Healthcare Ctr # 0043158 Report Period Beginning: 1/1/20 Ending: 12/31/20

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 12G, Carried Forward		$ 1,541,486	$ 34,394		$ 45,039	$ 10,645	$ 953,218	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									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,541,486	$ 34,394		$ 45,039	$ 10,645	$ 953,218	34

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

Facility Name & ID Number Timber Point Healthcare Ctr # 0043158 Report Period Beginning: 1/1/20 Ending: 12/31/20

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 12H, Carried Forward		$ 1,541,486	$ 34,394		$ 45,039	$ 10,645	$ 953,218	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									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,541,486	$ 34,394		$ 45,039	$ 10,645	$ 953,218	34

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

Facility Name & ID Number Timber Point Healthcare Ctr # 0043158 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	$ 52,607	$	$ 5,261	$ 5,261	10	$ 26,304	71
72	Current Year Purchases					10		72
73	Fully Depreciated Assets	109,409				10	109,409	73
74	See Attached	209,963	475	475		10	209,554	74
75	TOTALS	$ 371,979	$ 475	$ 5,736	$ 5,261		$ 345,267	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	2014	$ 58,427	$	$	$	5	$ 58,427	76
77	Facility	Van	1998	23,698				5	23,698	77
78	Allocated From ECC		2014	531				5	531	78
79										79
80	TOTALS			$ 82,656	$	$	$		$ 82,656	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)	$ 2,125,713	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 34,869	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 50,775	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 15,906	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,381,140	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	Flooring & Cove Base	$ 18,154	92
93			93
94			94
95		$ 18,154	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.

Facility Name & ID Number Timber Point Healthcare Ctr # 0043158 Report Period Beginning: 1/1/20 Ending: 12/31/20

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								5
6	Storage Unit Rental				1,248			6
7	TOTAL				$ 1,248 **			7

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2021	$
13.	/2022	$
14.	/2023	$

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: $ 16,420 Description: $5,136 Copier/Printers; $7,700 Laudry Machines; $3,432 Other Rentals; $152 Allocated From ECC
(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/Truck	$ 842.17	$ 10,106	17
18	(Rental expense offset by credit for previously leased 2007 Chevy)				18
19					19
20					20
21	TOTAL		$ 842.17	$ 10,106	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.

Facility Name & ID Number Timber Point Healthcare Ctr # 0043158 Report Period Beginning: 1/1/20 Ending: 12/31/20

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.

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	V10A	hrs	$	4,679	$ 350,961	$	4,679	$ 350,961	1
2	Licensed Speech and Language Development Therapist	V10A	hrs		682	51,129		682	51,129	2
3	Licensed Recreational Therapist	V10A	hrs			0				3
4	Licensed Physical Therapist	V10A	hrs		4,395	329,596		4,395	329,596	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation	V39	hrs	30,128					30,128	8
9	Pharmacy	V39	# of prescrpts				181,601		181,601	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): LAB/RADIOLOGY	V39					49,591		49,591	12
13	Other (specify): BILLABLE SUPPLIES	V39								13
14	TOTAL			$ 30,128	9,756	$ 731,686	$ 231,192	9,756	$ 993,006	14

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

Facility Name & ID Number Timber Point Healthcare Ctr # 0043158 Report Period Beginning: 1/1/20 Ending: 12/31/20

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/20 (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	$ 21,827	$ 30,628	1
2	Cash-Patient Deposits	49,217	49,217	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,240,285	2,240,285	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	73,327	73,327	6
7	Other Prepaid Expenses	4,004	4,004	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	179,376	179,376	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,568,036	$ 2,576,837	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	305,427	305,427	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	211,268	351,009	15
16	Equipment, at Historical Cost	231,701	373,399	16
17	Accumulated Depreciation (book methods)	(322,007)	(1,420,101)	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 (spe See Attached	18,154	18,154	22
23	Other(specify): See Attached	192,825	192,825	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 637,368	$ 1,058,713	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,205,404	$ 3,635,550	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 912,830	$ 912,829	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	45,590	45,590	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	118,192	118,192	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,868	2,868	31
32	Accrued Real Estate Taxes(Sch.IX-B)		31,087	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached			36
37	See Attached	784,281	784,281	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,863,761	$ 1,894,847	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,500,000	1,500,000	39
40	Mortgage Payable		947,409	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached		138,406	43
44	See Attached	433,901	433,901	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,933,901	$ 3,019,716	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,797,662	$ 4,914,563	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (592,258)	$ (1,279,013)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,205,404	$ 3,635,550	48

***(See instructions.)**

Facility Name & ID Number Timber Point Healthcare Ctr # 0043158 Report Period Beginning: 1/1/20 Ending: 12/31/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,536,168)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,536,168)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,943,910	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)**	$ 1,943,910	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)**	$ (592,258)	24 *

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

Facility Name & ID Number Timber Point Healthcare Ctr # 0043158 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	$ 6,927,223	1
2	Discounts and Allowances for all Levels	(2,692,419)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,234,804	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,188,547	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,188,547	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	430,466	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	27,111	19
20	Radiology and X-Ray	30,437	20
21	Other Medical Services	9,257	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 497,271	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,114	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,114	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a		680,983	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 680,983	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,603,719	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	919,780	31
32	Health Care	2,809,266	32
33	General Administration	1,215,393	33
	B. Capital Expense		
34	Ownership	289,979	34
	C. Ancillary Expense		
35	Special Cost Centers	231,298	35
36	Provider Participation Fee	194,093	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,659,809	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,943,910	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,943,910	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,007,418	44
45	Private Pay - Net Inpatient Revenue	320,975	45
46	Medicare - Net Inpatient Revenue	1,090,534	46
47	Other-(specify) ALL OTHER SNF/SCF IP REVENUE	97,940	47
48	Other-(specify) C/A ANCILLARY ACCOUNTS	(282,063)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,234,804	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete 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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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	1,878	2,063	$ 84,446	$ 40.93	1
2	Assistant Director of Nursing					2
3	Registered Nurses	19,602	21,238	709,058	33.39	3
4	Licensed Practical Nurses	9,519	10,172	234,140	23.02	4
5	CNAs & Orderlies	38,367	39,499	604,700	15.31	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,897	2,121	30,128	14.20	8
9	Activity Director	1,772	1,948	28,307	14.53	9
10	Activity Assistants	3,905	4,382	48,417	11.05	10
11	Social Service Workers	4,125	4,520	109,558	24.24	11
12	Dietician					12
13	Food Service Supervisor	1,006	1,079	22,091	20.47	13
14	Head Cook	11,805	12,578	135,185	10.75	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	6,796	7,507	121,860	16.23	17
18	Housekeepers	11,794	13,043	130,817	10.03	18
19	Laundry	3,234	3,634	37,122	10.22	19
20	Administrator	2,852	3,025	180,340	59.62	20
21	Assistant Administrator					21
22	Other Administrative	3,158	3,364	88,328	26.26	22
23	Office Manager					23
24	Clerical					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	957	1,040	15,550	14.95	31
32	Other Health Care(specify)	1,574	1,766	21,543	12.20	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	124,241	132,979	$ 2,601,590 *	$ 19.56	34

* 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	153	$ 9,647	V01-03	35
36	Medical Director	Monthly Fees	1,423	V09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly Fees	5,467	V10-03	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				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	153	$ 16,537		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

Facility Name & ID Number Timber Point Healthcare Ctr # 0043158 Report Period Beginning: 1/1/20 Ending: 12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Andrea Lewis	Administrator	0.00%	$ 130,336
Sherwin Ray	Administrative	33.33%	27,504
Jakob Bakst	Administrative	33.33%	22,500
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 180,340

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
Propay Payroll Services	Payroll Processing	$ 13,966
See Attached	Legal Services	3,637
Touch Support	Customer Satisfaction	457
National Datacare Corporation	Resident Funds Processing	3,013
Ability Network	Data Processing/Billing	10,865
Matrix Care	Data Processing/Software	14,452
Plante Moran	Accounting Services	24,000
Personnel Planners	Unemployment Consulting	1,380
DIAWA	LOC Consulting	3,404
IIT/Sourcetech	IT Consulting Services	660
Ron Cournaya	Cost Reporting	3,120
See Supplemental Page 21		132,503
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 211,458

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 105,928
Unemployment Compensation Insurance	10,386
FICA Taxes	187,577
Employee Health Insurance	98,571
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	280
Other Employee Welfare	14,166
Holiday Expense	3,000
TOTAL (agree to Schedule V, line 22, col.8)	$ 419,908

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 829
Advertising: Employee Recruitment	13,780
Health Care Worker Background Check	2,605
(Indicate # of checks performed 200)	
Patient Background Checks	
Dues & Subscriptions	8,655
Licenses & Fees	1,978
Allocated From ECC	1,355
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 29,202

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,493
Allocated From ECC	221
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,714

**See instructions.

Facility Name & ID Number Timber Point Healthcare Ctr # 0043158 Report Period Beginning: 1/1/20 Ending: 12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

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
Sher LLP	PPP Consulting (Adj)	$ 1,800
Benefit Service Group	Employee Benefits Consulting	327
Resolute Healthcare	Healthcare Consulting	2,192
Extended Care Consulting	Consulting Services	128,184
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 132,503

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	$

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

**See instructions.

Facility Name & ID Number Timber Point Healthcare Ctr # 0043158 Report Period Beginning: 1/1/20 Ending: 12/31/20

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. **Healthcare Council of IL $15,565**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(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. $ **11,627** Line **10-2**

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

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **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. $ **194,093**
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? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **Ln 14**
d. Have vehicle usage logs been maintained? **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 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.