

		FOR BHF USE					

LL1

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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: 0048421

Facility Name: SOUTHVIEW MANOR OPERATOR, LLC

Address: 3311 S. MICHIGAN AVE. CHICAGO 60616
Number City Zip Code

County: COOK

Telephone Number: (847) 674-5795 Fax # (847) 674-5794

HFS ID Number:

Date of Initial License for Current Owners: 11/01/06

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: BOB KAGDA Telephone Number: (847) 675-3585
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2011 to 12/31/2011 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)	AVRUM WEINFELD	
	(Title)	CEO	
Paid Preparer	(Signed)	(SEE ATTACHED ACCOUNTANTS' REPORT)	
		(Date)	
	(Print Name and Title)	BOB KAGDA VICE PRESIDENT	
	(Firm Name & Address)	KRUPNICK, BOKOR, KAGDA & BROOKS, LTD 3750 W DEVON, LINCOLNWOOD, IL 60712-1124	
	(Telephone)	(847) 675-3585 Fax # (847) 675-5777	
	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 SOUTHVIEW MANOR OPERATOR, LLC

0048421 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 _____

	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	<u>74</u>	Skilled (SNF)	<u>74</u>	<u>27,010</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>126</u>	Intermediate (ICF)	<u>126</u>	<u>45,990</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>200</u>	TOTALS	<u>200</u>	<u>73,000</u>	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	<u>2,309</u>	<u>196</u>	<u>5,169</u>	<u>7,674</u>	8
9	SNF/PED					9
10	ICF	<u>61,593</u>	<u>21</u>	<u>699</u>	<u>62,313</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>63,902</u>	<u>217</u>	<u>5,868</u>	<u>69,987</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.87%

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

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

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

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

☒

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 11/01/06

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

YES

☒

Date 11/01/06

NO

☐

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

YES

☒

NO

☐

If YES, enter number of beds certified 42 and days of care provided 5,075

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL

☒

MODIFIED

CASH*

☐

CASH*

☐

Is your fiscal year identical to your tax year?

YES

☒

NO

☐

Tax Year: 12/31/2011 Fiscal Year: 12/31/2011

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

Facility Name & ID Number **SOUTHVIEW MANOR OPERATOR, LLC** # **0048421** Report Period Beginning: **01/01/2011** Ending: **12/31/2011**
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	260,233	35,796	10,334	306,363		306,363		306,363			1
2	Food Purchase		390,127		390,127		390,127	(654)	389,473			2
3	Housekeeping	348,786	49,696		398,482		398,482		398,482			3
4	Laundry	59,242	23,104	4,938	87,284		87,284		87,284			4
5	Heat and Other Utilities			208,307	208,307		208,307		208,307			5
6	Maintenance	123,715	54,103	48,451	226,269		226,269	6,555	232,824			6
7	Other (specify):* SECURITY	180,787		27,846	208,633		208,633	80	208,713			7
8	TOTAL General Services	972,763	552,826	299,876	1,825,465		1,825,465	5,981	1,831,446			8
	B. Health Care and Programs											
9	Medical Director			400	400		400		400			9
10	Nursing and Medical Records	2,360,044	104,234	15,740	2,480,018		2,480,018		2,480,018			10
10a	Therapy	9,498		4,800	14,298		14,298		14,298			10a
11	Activities	131,519	32,364	325	164,208		164,208		164,208			11
12	Social Services	316,763		3,820	320,583		320,583		320,583			12
13	CNA Training											13
14	Program Transportation			19,801	19,801		19,801		19,801			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,817,824	136,598	44,886	2,999,308		2,999,308		2,999,308			16
	C. General Administration											
17	Administrative	127,808			127,808		127,808	135,082	262,890			17
18	Directors Fees											18
19	Professional Services			123,275	123,275		123,275	7,902	131,177			19
20	Dues, Fees, Subscriptions & Promotions			32,776	32,776		32,776	(6,094)	26,682			20
21	Clerical & General Office Expenses	227,922	26,815	135,877	390,614		390,614	(93,282)	297,332			21
22	Employee Benefits & Payroll Taxes			771,243	771,243		771,243		771,243			22
23	Inservice Training & Education			1,730	1,730		1,730	9	1,739			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			6,075	6,075		6,075	1,293	7,368			25
26	Insurance-Prop.Liab.Malpractice			99,735	99,735		99,735	1,266	101,001			26
27	Other (specify):*			309,356	309,356		309,356	(296,610)	12,746			27
28	TOTAL General Administration	355,730	26,815	1,480,067	1,862,612		1,862,612	(250,434)	1,612,178			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,146,317	716,239	1,824,829	6,687,385		6,687,385	(244,453)	6,442,932			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.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	10,334
	REPAIRS & MAINTENANCE	0
		0
		10,334
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	4,938
		0
		4,938
5	HEAT & OTHER UTILITIES	
	GAS HEAT	54,653
	ELECTRICITY	61,543
	WATER	64,041
	CABLE TV - LOBBY	28,070
		0
		208,307
6	MAINTENANCE	
	GROUNDS MAINTENANCE	4,765
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	21,095
	ELEVATOR MAINTENANCE & REPAIR	9,565
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	4,521
	FIRE SERVICE	8,505
		0
		0
		0
		0
		48,451
7	OTHER	
	SCAVENGER	27,846
	SECURITY SERVICE	0
		0
		0
		27,846
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	400
		400

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTAN XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	0
	PHARMACY CONSULTANT XVIII B 39-2	10,940
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	0
	DENTAL	4,800
		0
		15,740
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
	PSYCHIATRIC	4,800
		4,800
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	325
		0
		325
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	3,820
		3,820
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES

PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	19,801
		0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	0
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	13,602
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	109,673
		0
		123,275
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	3,267
	EMPLOYEE WANT ADS XIX F	0
	CONTRIBUTIONS VI 20 XIX F	500
	DUES & SUBSCRIPTIONS XIX F	14,472
	LICENSES & PERMITS XIX F	6,885
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	5,217
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	
	PATIENT BACKGROUND CHECKS XIX F	2,435
		32,776
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	1,851
	EQUIPMENT REPAIR & MAINTENANCE	12,025
	OUTSIDE CLERICAL SERVICES	35,000
	PENALTIES / OVERDRAFT CHARGES VI 18	4,680
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	18,271
	MESSENGER SERVICE	0
	STAFF DEVELOPMENT	64,050
		135,877

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	315,472
	UNEMPLOYMENT COMPENSATION XIX D	80,358
	WORKERS COMPENSATION INSURANC XIX D	98,900
	HOSPITALIZATION INSURANCE XIX D	265,752
	EMPLOYEE BENEFITS - OTHER XIX D	3,568
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	7,193
		0
		771,243
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	1,730
		1,730
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	6,075
		6,075
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	99,735
		99,735
27	OTHER	
	BAD DEBTS VI 24	309,356
		309,356

GRAND TOTAL COLUMN 3 OTHER

1,824,829

SOUTHVIEW MANOR OPERATOR, LLC
SCHEDULES
12/31/2011

EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22

TOTAL FOOD PURCHASE	390,127
LESS SALES TAX	<u>(654)</u>
NET FOOD	389,473
TOTAL PATIENT CENSUS	69,987
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	209,961
ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	209,961
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	209,961
NET FOOD	389,473
DIVIDE TOTAL MEALS/YEAR	<u>209,961</u>
COST PER MEAL	1.85
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	0
	=====

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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			29,676	29,676		29,676	(7,976)	21,700			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			13,250	13,250		13,250		13,250			32
33	Real Estate Taxes			307,120	307,120		307,120		307,120			33
34	Rent-Facility & Grounds			1,624,000	1,624,000		1,624,000		1,624,000			34
35	Rent-Equipment & Vehicles			59,264	59,264		59,264	2,325	61,589			35
36	Other (specify):*											36
37	TOTAL Ownership			2,033,310	2,033,310		2,033,310	(5,651)	2,027,659			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		192,230	517,223	709,453		709,453		709,453			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			109,500	109,500		109,500		109,500			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		192,230	626,723	818,953		818,953		818,953			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,146,317	908,469	4,484,862	9,539,648		9,539,648	(250,104)	9,289,544			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(8,103)	30		9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(654)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(4,680)	21		18
19	Entertainment		20		19
20	Contributions	(5,717)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(309,356)	27		24
25	Fund Raising, Advertising and Promotional	(3,267)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(93,137)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (424,914)		\$	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)	174,810		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 174,810		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (250,104)		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.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Report Period Beginning:
Ending:

ID# 0048421
01/01/2011
12/31/2011

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	DEFERRED MAINTENANCE	\$	6	1
2	BANK CHARGES	(1,851)	21	2
3	STAFF DEVELOPMENT	(64,050)	21	3
4	MARKETING SALARIES	(26,071)	21	4
5	MARKETING AUTO LEASE	(1,165)	35	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				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	(93,137)		49

Summary A

12/31/2011

[illegible]

Summary B

12/31/2011

[illegible]

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
				6865 FIN. INC	LINCOLNWOOD	MANAGEMENT
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE		EMI ENTERPRISE	LINCOLNWOOD	MANAGEMENT
				EKS MGMT	LINCOLNWOOD	BOOKKEEPING
				IME REALTY	LINCOLNWOOD	HOME OFFICE

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	17	MANAGEMNT FEES	\$	6865 FINANCIAL INC		\$		1
2	V	17	EMI ENTERPRISES				29,595	29,595	2
3	V	17	PHILIP ESFORMES INC				59,189	59,189	3
4	V	17	MICHAEL ROSEN				29,595	29,595	4
5	V	17	DANIEL WEISS				4,110	4,110	5
6	V	19	ACCOUNTING FEES				103	103	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$ 122,592	\$ * 122,592	14

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

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	17	MANAGEMENT FEE	\$ 29,595	EMI ENTERPRISES		\$	(29,595)	15
16	V	6	DRIVERS SALARIES				3,341	3,341	16
17	V	17	OFFICER SALARY				16,100	16,100	17
18	V	17	REGIONAL DIRECTOR				495	495	18
19	V	17	MGT CONSULTANT				16,100	16,100	19
20	V	19	ACCOUNTING FEES				535	535	20
21	V	21	OFFICE /CLERICAL				7,195	7,195	21
22	V	25	TRANSPORTATION				194	194	22
23	V	26	INSURANCE				1,060	1,060	23
24	V	27	EMPLOYEE BENEFITS				7,779	7,779	24
25	V	35	AUTO LEASE				448	448	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			\$ 29,595			\$ 53,247	\$ * 23,652	39

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

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	21	OUTSIDE CLERICAL	\$ 35,000	EKS MANAGEMENT INC		\$	(35,000)	15
16	V	6	PAINTERS SALARIES				3,214	3,214	16
17	V	7	SCAVENGER				80	80	17
18	V	17	CFO - SALARY				9,493	9,493	18
19	V	19	PROFESSIONAL FEES				7,264	7,264	19
20	V	20	WANT ADS / BACK GRD CKS				2,890	2,890	20
21	V	21	OFFICE / CLERICAL				31,175	31,175	21
22	V	23	SEMINARS				9	9	22
23	V	25	TRANSPORTATION				1,099	1,099	23
24	V	26	INSURANCE				206	206	24
25	V	27	EMPLOYEE BENEFITS				4,967	4,967	25
26	V	30	SL DEPRECIATION				127	127	26
27	V	35	EQUIPMENT RENT				3,042	3,042	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			\$ 35,000			\$ 63,566	\$ * 28,566	39

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

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								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

Facility Name & ID Number SOUTHVIEW MANOR OPERATOR, LLC # 0048421 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
1	ALLOCATION FR EMI ENTERPRISES:								\$		1
2	MORRIS ESFORMES	PRESIDENT	MGMT	32.67	SEE ATTACHED	6	7.50	SALARY	16,100	17-7	2
3	PHILIP ESFORMES	Adm. Consultant	Administrative	32.67		3	4.55	consult fee	16,100	17-7	3
4											4
5	ALLOCATION FR 6865 FIN.										5
6	PHILIP ESFORMES	Adm. Consultant	Administrative	32.67		3	4.55	consult fee	59,189	17-7	6
7	DANIEL WEISS	Adm. Consultant	Administrative	0.00		0	0.00	consult fee	4,110	17-7	7
8											8
9	ALLOCATION FR EKS MANAGEMENT:										9
10	AVRUM WEINFELD	CFO	FINANCIAL	2.00		3	4.61	SALARY	9,493	17-7	10
11	FLORA WEISS	O/S Consultant	BOOKKEPPING	0.00		0.5	0.89	consult fee	1,404	21-7	11
12											12
13								TOTAL	\$ 106,396		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 SOUTHVIEW MANOR OPERATOR, LLC # 0048421 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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 6865 FINANCIAL INC
Street Address 6865 N. LINCOLN AVE
City / State / Zip Code LINCOLNWOOD, IL. 60712
Phone Number (847) 674-5795
Fax Number (847) 674-5794

	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	17	EMI ENTERPRISES	PATIENT DAYS	510,807	10	\$ 216,000	\$ 69,987	\$ 29,595	1
	2	17	PHILIP ESFORMES INC	PATIENT DAYS	510,807	10	432,000	69,987	59,189	2
	3	17	MICHAEL ROSEN	PATIENT DAYS	510,807	10	216,000	69,987	29,595	3
	4	17	DANIEL WEISS	PATIENT DAYS	510,807	10	30,000	69,987	4,110	4
	5	19	ACCOUNTING FEES	PATIENT DAYS	510,807	10	750	69,987	103	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				\$ 894,750	\$		\$ 122,592	25

Facility Name & ID Number SOUTHVIEW MANOR OPERATOR, LLC # 0048421 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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 EMI ENTERPRISES INC
Street Address 6865 N. LINCOLN AVE
City / State / Zip Code LINCOLNWOOD,IL. ,60712
Phone Number (847)674-5795
Fax Number (847)674-5794

	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	DRIVERS SALARIES	PATIENT DAYS	847,662	14	\$ 40,460	\$ 40,460	69,987	\$ 3,341	1
2	17	OFFICER SALARY	PATIENT DAYS	847,662	14	195,000	195,000	69,987	16,100	2
3	17	REGIONAL DIRECTOR	PATIENT DAYS	847,662	14	6,000	6,000	69,987	495	3
4	17	MGT CONSULTANT	PATIENT DAYS	847,662	14	195,000		69,987	16,100	4
5	19	ACCOUNTING FEES	PATIENT DAYS	847,662	14	6,480		69,987	535	5
6	21	OFFICE /CLERICAL	PATIENT DAYS	847,662	14	87,144	58,016	69,987	7,195	6
7	25	TRANSPORTATION	PATIENT DAYS	847,662	14	2,349		69,987	194	7
8	26	INSURANCE	PATIENT DAYS	847,662	14	12,837		69,987	1,060	8
9	27	EMPLOYEE BENEFITS	PATIENT DAYS	847,662	14	94,218		69,987	7,779	9
10	35	AUTO LEASE	PATIENT DAYS	847,662	14	5,423		69,987	448	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					\$ 644,911	\$ 299,476		\$ 53,247	25

Facility Name & ID Number SOUTHVIEW MANOR OPERATOR, LLC # 0048421 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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 EKS MANAGEMENT INC
Street Address 6865 N. LINCOLN AVE
City / State / Zip Code LINCOLNWOOD,IL. ,60712
Phone Number (847)674-5795
Fax Number (847)674-5794

	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	PAINTERS SALARIES	PATIENT DAYS	847,662	14	\$ 38,929	\$ 38,929	69,987	\$ 3,214	1
2	7	SCAVENGER	PATIENT DAYS	847,662	14	971		69,987	80	2
3	17	CFO - SALARY	PATIENT DAYS	847,662	14	114,971	114,971	69,987	9,493	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	847,662	14	87,982	76,534	69,987	7,264	4
5	20	WANT ADS / BACK GRD CKS	PATIENT DAYS	847,662	14	35,000		69,987	2,890	5
6	21	OFFICE / CLERICAL	PATIENT DAYS	847,662	14	377,586	282,348	69,987	31,175	6
7	23	SEMINARS	PATIENT DAYS	847,662	14	115		69,987	9	7
8	25	TRANSPORTATION	PATIENT DAYS	847,662	14	13,315		69,987	1,099	8
9	26	INSURANCE	PATIENT DAYS	847,662	14	2,501		69,987	206	9
10	27	EMPLOYEE BENEFITS	PATIENT DAYS	847,662	14	60,163		69,987	4,967	10
11	30	SL DEPRECIATION	PATIENT DAYS	847,662	14	1,536		69,987	127	11
12	35	EQUIPMENT RENT	PATIENT DAYS	847,662	14	36,848		69,987	3,042	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					\$ 769,917	\$ 512,782		\$ 63,566	25

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							\$					\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6	ALBANY BANK		X	WORKING CAPITAL	INTEREST	REVOLV		2,119,000	REVOL		13,250		6
7													7
8													8
9	TOTAL Facility Related						\$	2,119,000			\$	13,250	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$				\$		14
15	TOTALS (line 9+line14)						\$	2,119,000			\$	13,250	15

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

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

** 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

1. Real Estate Tax accrual used on 2010 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	279,834	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.)			\$	292,017	2
3. Under or (over) accrual (line 2 minus line 1).			\$	12,183	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	294,937	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	307,120	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006	243,413	8	
		2007	240,814	9	
		2008	243,230	10	
		2009	279,835	11	
		2010	292,017	12	
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL				13	FROM R. E. TAX STATEMENT FOR 2010 \$ 13
THE PAYMENT ON LINE 2 APPLIES TO THE 2009 TAX BILL.				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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>SOUTHVIEW MANOR OPERATOR, LLC</u>	COUNTY	<u>COOK</u>
---------------	--------------------------------------	--------	-------------

FACILITY IDPH LICENSE NUMBER 0048421

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2010 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 2010.

(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>17-34-116-003-0000</u>	<u>NURSING HOME</u>	\$ <u>101,331.70</u>	\$ <u>101,331.70</u>
2. <u>17-34-116-004-0000</u>	<u>NURSING HOME</u>	\$ <u>57,652.76</u>	\$ <u>57,652.76</u>
3. <u>17-34-116-005-0000</u>	<u>NURSING HOME</u>	\$ <u>43,678.75</u>	\$ <u>43,678.75</u>
4. <u>17-34-116-006-0000</u>	<u>NURSING HOME</u>	\$ <u>43,678.75</u>	\$ <u>43,678.75</u>
5. <u>17-34-116-007-0000</u>	<u>NURSING HOME</u>	\$ <u>43,678.75</u>	\$ <u>43,678.75</u>
6. <u>17-34-116-008-0000</u>	<u>NURSING HOME</u>	\$ <u>1,996.12</u>	\$ <u>1,996.12</u>
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u>292,016.83</u>	\$ <u>292,016.83</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?

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 91,960

B. General Construction Type: Exterior Frame Number of Stories

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).
N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number SOUTHVIEW MANOR OPERATOR, LLC

0048421

Report Period Beginning:

01/01/2011

Ending:

12/31/2011

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	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4					\$	\$		\$	\$	4
5										5
6										6
7		RELATED PARTY HOME OFFICE			46,019					7
8										8
	Improvement Type**									
9		ELEVATOR REPAIR	2007		19,816	721	27.5	721		3,395
10		TELEPHONE SYSTEM	2007		13,100	476	27.5	476		2,360
11		WATER HEATER	2007		32,500	1,182	27.5	1,182		5,565
12										12
13		ROOF REPAIR	2008		14,800	538	27.5	538		1,861
14		60 TON CHILLER	2008		71,075	2,585	27.5	2,585		8,939
15		PUMP GASKETS, OIL TANK COOLERS	2008		9,115	331	27.5	331		1,062
16		OIL COOLERS, PUMP SEALS	2008		19,285	702	27.5	702		2,252
17		AWNING	2008		3,000	109	27.5	109		350
18		FENCE	2008		3,960	264	15	264		924
19										19
20		DRPAERIES	2009		26,336	2,528	5	5,267	2,739	13,168
21										21
22		ELEVATOR REPAIR	2010		8,820	321	27.5	321		495
23		PLUMBING	2010		4,800	175	27.5	175		241
24										24
25		DOORS	2011		3,800	109	27.5	109		109
26		MODERNIZATION OF ELEVATOR	2011		147,325	2,009	27.5	2,009		2,009
27		CHILLER	2011		3,845	64	27.5	64		64
28		FIRE SERCURITY SYSTEM	2011		22,920	104	27.5	104		104
29										29
30										30
31		PARKING LOT - LANDLORD GRANITE	2010		19,880					
32		BEDROOM VINYL WINDOWS - LANDLORD GRANITE	2010		85,985					
33		FLAT ROOF RESURFACING - LANDLORD GRANITE	2010		29,000					
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

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									38
39									39
40									40
41									41
42									42
43									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)		\$ 585,381	\$ 12,218		\$ 14,957	\$ 2,739	\$ 42,898	70

**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	\$60,531	\$6,214	\$6,054	\$(160)	10 YRS	\$17,350	71
72	Current Year Purchases	11,244	11,244	562	(10,682)	10YRS	562	72
73	Fully Depreciated Assets							73
74	REALATED PARTY		127	127				74
75	TOTALS	\$71,775	\$17,585	\$6,743	\$(10,842)		\$17,912	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$657,156	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$29,803	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$21,700	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(8,103)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$60,810	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:GRANITE SOUTHVIEW LLC
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:		200	11/01/06	\$ 1,624,000	5.5	5	3
4	Additions							4
5								5
6								6
7	TOTAL		200		\$ 1,624,000			7

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

9. Option to Buy:☐ YES☐ NO
- Terms:
- *

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: \$ 32,155
- Description:SEE SCHEDULE ATTACHED
- (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			\$	\$ 27,109	17
18	SEE SCHEDULE ATTACHED				18
19					19
20					20
21	TOTAL		\$	\$ 27,109	21

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.	/2012	\$
13.	/2013	\$
14.	/2014	\$

* 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.

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

☒ 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

☐

☐

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

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)	\$			

- (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.

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	

- (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.)

12345678										
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 271,129	\$		\$ 271,129	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			130			130	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			180,804			180,804	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				192,230		192,230	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): THERAPY, LAB					65,160			65,160	13
14	TOTAL			\$		\$ 517,223	\$ 192,230		\$ 709,453	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.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 123,396	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (570,000))	3,773,040		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	122,932		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): real estate,ins.escrow	73,715		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,093,083	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	404,497		15
16	Equipment, at Historical Cost	71,775		16
17	Accumulated Depreciation (book methods)	(116,254)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	96,375		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): ADVANCE RENT	15,725		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 472,118	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,565,201	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 499,172	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	4,961,952		29
30	Accrued Salaries Payable	90,975		30
31	Accrued Taxes Payable (excluding real estate taxes)	21,524		31
32	Accrued Real Estate Taxes(Sch.IX-B)	294,937		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,868,560	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,868,560	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,303,359)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,565,201	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 893,227	1
2	Restatements (describe):		2
3	ROUNDING	2	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 893,229	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,196,588)	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)	\$ (2,196,588)	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)	\$ (1,303,359)	24 *

* This must agree with page 17, line 47.

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			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 7,244,265	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,244,265	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	72,725	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 72,725	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,316,990	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,825,465	31
32	Health Care	2,999,308	32
33	General Administration	1,862,612	33
	B. Capital Expense		
34	Ownership	2,033,310	34
	C. Ancillary Expense		
35	Special Cost Centers	709,453	35
36	Provider Participation Fee	109,500	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES	(26,070)	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,513,578	40
41	Income before Income Taxes (line 30 minus line 40)**	(2,196,588)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (2,196,588)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.
TAX RETURN PREPARED ON CASH BASIS

*** 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.

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	1,673	1,705	\$ 68,244	\$ 40.03	1
2	Assistant Director of Nursing	1,893	2,070	62,091	30.00	2
3	Registered Nurses	2,494	2,530	61,874	24.46	3
4	Licensed Practical Nurses	47,127	50,913	1,150,158	22.59	4
5	CNAs & Orderlies	80,109	86,002	845,896	9.84	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	787	809	9,498	11.74	8
9	Activity Director					9
10	Activity Assistants	12,393	13,272	131,519	9.91	10
11	Social Service Workers	18,019	19,021	316,763	16.65	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,843	24,542	260,233	10.60	15
16	Dishwashers					16
17	Maintenance Workers	7,636	8,260	123,715	14.98	17
18	Housekeepers	33,465	35,824	348,786	9.74	18
19	Laundry	5,408	6,019	59,242	9.84	19
20	Administrator	2,256	2,417	127,808	52.88	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	20,614	21,884	227,922	10.42	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	4,100	4,261	59,365	13.93	31
32	Other Health Care <u>MDS</u>	4,219	4,347	112,416	25.86	32
33	Other(specify) <u>SECURITY</u>	18,277	19,175	180,787	9.43	33
34	TOTAL (lines 1 - 33)	283,313	303,051	\$ 4,146,317 *	\$ 13.68	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	M	\$ 10,334	1-3	35
36	Medical Director	O	400	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	10,940	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	325	11-3	44
45	Social Service Consultant	E	3,820	12-3	45
46	Other(specify) <u>PSYCHIATRIC</u>	S	4,800	10-3	46
47	<u>DENTAL</u>		4,800	10-3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 35,419		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)		\$		53

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
DEBBIE MASSEY	ADMINISTRATOR	0	\$ 127,808	Workers' Compensation Insurance	\$	98,900	IDPH License Fee	\$
			0	Unemployment Compensation Insurance		80,358	Advertising: Employee Recruitment	0
			0	FICA Taxes		315,472	Health Care Worker Background Check	0
				Employee Health Insurance		265,752	(Indicate # of checks performed)	
				Employee Meals		0	Patient Background Checks	47 2,435
				Illinois Municipal Retirement Fund (IMRF)*			TRUST/FRANCHISE/CONTRIB/ETC	5,717
				EMPLOYEE BENEFITS - OTHER		3,568	MARKETING/ADV/PROMO	3,267
				EMPLOYEE PHYSICAL EXAMS		0	LICENSES/DUES/SUBSCRIPTIONS	21,357
				PENSION/PROFIT SHARING PLANS		0	MGMT CO ALLOC	2,890
TOTAL (agree to Schedule V, line 17, col. 1)				CHICAGO HEAD TAX		7,193	TRUST/FRANCHISE/CONTRIB/ETC	(5,717)
(List each licensed administrator separately.)				INSURANCE - EXECUTIVE LIFE		0	Less: Public Relations Expense	(0)
B. Administrative - Other				INSURANCE - EXECUTIVE LIFE VI 21		0	Non-allowable advertising	(3,267)
Description			Amount				Yellow page advertising	(0)
			\$ 0					
TOTAL (agree to Schedule V, line 17, col. 3)				TOTAL (agree to Schedule V,	\$	771,243		
(Attach a copy of any management service agreement)				line 22, col.8)				
C. Professional Services				E. Schedule of Non-Cash Compensation Paid			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
								0
							Seminar Expense	
								0
SEE SCHEDULE ATTACHED			123,275				Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V,	
(If total legal fees exceed \$5,000, attach copy of invoices.)							line 24, col. 8)	\$
			\$ 123,275					

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?

YES
- (2)

Are there any dues to nursing home associations included on the cost report?

YES

If YES, give association name and amount.

IL COUNCIL LONG TERM CARE \$14,297
- (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?
- (5)

Have you properly capitalized all major repairs and equipment purchases?

YES

What was the average life used for new equipment added during this period?

10 YR
- (6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$

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.
- (9)

Are you presently operating under a sublease agreement?

YES

NO
- (10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$

109,500

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?

N/A

Indicate the amount.

\$
- (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.

\$

c. What percent of all travel expense relates to transportation of nurses and patients?

5%

d. Have vehicle usage logs been maintained?

NO

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

NO

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

YES

g. Does the facility transport residents to and from day training?

NO

Indicate the amount of income earned from providing such transportation during this reporting period.

\$

N/A
- (17)

Has an audit been performed by an independent certified public accounting firm?

NO

Firm Name:
- (18)

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

YES
- (19)

If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report?

YES

Attach invoices and a summary of services for all architect and appraisal fees.