

		FOR BHF USE					

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

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

I. IDPH License ID Number: <u>0050450</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>SOUTHPOINT NRSG & REHAB CTR</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/12</u> to <u>12/31/12</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>1010 W 95TH ST</u> <u>CHICAGO</u> <u>60643</u>																									
Number City Zip Code																									
County: <u>COOK</u>																									
Telephone Number: <u>(773) 298-1177</u> Fax # <u>(773) 298-1666</u>																									
HFS ID Number: _____		<table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Type or Print Name) <u>Alan Sorscher</u></td></tr><tr><td>(Title) <u>CFO</u></td></tr><tr><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	Paid Preparer	(Type or Print Name) <u>Alan Sorscher</u>	(Title) <u>CFO</u>	(Signed) _____	(Date) _____														
Officer or Administrator of Provider	(Signed) _____																								
	(Date) _____																								
Paid Preparer	(Type or Print Name) <u>Alan Sorscher</u>																								
	(Title) <u>CFO</u>																								
	(Signed) _____																								
	(Date) _____																								
Date of Initial License for Current Owners: <u>4/1/09</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td>_____</td></tr><tr><td></td><td>☐ Other _____</td><td>_____</td></tr></table>		☐ 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 _____	_____
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	☒ Limited Liability Co.	_____																							
	☐ Trust	_____																							
	☐ Other _____	_____																							
In the event there are further questions about this report, please contact:		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																							
Name: <u>Alan Sorscher</u> Telephone Number: <u>(708) 449-1900</u>																									
Email Address: _____																									

Facility Name & ID Number SOUTHPOINT NRSG & REHAB CTR# 0050450 Report Period Beginning: 1/1/12 Ending: 12/31/12

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>228</u>	Skilled (SNF)	<u>228</u>	<u>83,448</u>	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	<u>228</u>	TOTALS	<u>228</u>	<u>83,448</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>64,416</u>	<u>787</u>	<u>6,578</u>	<u>71,781</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>64,416</u>	<u>787</u>	<u>6,578</u>	<u>71,781</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 86.02%

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?

YESG. 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 4/1/09

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

YES ☒Date 4/1/09NO ☐

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

YES ☒NO ☐If YES, enter number
of beds certified 228 and days of care provided 6,334Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/12Fiscal Year: 12/31/12

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

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	424,862	46,690	15,000	486,552		486,552	(4,769)	481,783			1
2	Food Purchase		345,202		345,202		345,202	(1,682)	343,520			2
3	Housekeeping	310,581	51,405		361,986		361,986		361,986			3
4	Laundry	88,859	64,520		153,379		153,379		153,379			4
5	Heat and Other Utilities			288,605	288,605		288,605	654	289,259			5
6	Maintenance	82,416	43,363	85,554	211,333		211,333	(15,584)	195,749			6
7	Other (specify):*											7
8	TOTAL General Services	906,718	551,180	389,159	1,847,057		1,847,057	(21,381)	1,825,676			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	3,679,348	657,354	35,736	4,372,438		4,372,438	15,154	4,387,592			10
10a	Therapy			751,575	751,575		751,575		751,575			10a
11	Activities	139,477	14,913		154,390		154,390		154,390			11
12	Social Services	81,680		1,880	83,560		83,560		83,560			12
13	CNA Training											13
14	Program Transportation			1,928	1,928		1,928		1,928			14
15	Other (specify):* Pharmacy Consultant			19,536	19,536		19,536		19,536			15
16	TOTAL Health Care and Programs	3,900,505	672,267	834,655	5,407,427		5,407,427	15,154	5,422,581			16
	C. General Administration											
17	Administrative	115,437			115,437		115,437		115,437			17
18	Directors Fees											18
19	Professional Services			310,685	310,685		310,685	(257,405)	53,280			19
20	Dues, Fees, Subscriptions & Promotions			16,566	16,566		16,566		16,566			20
21	Clerical & General Office Expenses	278,438	100,450	33,717	412,605		412,605	30,401	443,006			21
22	Employee Benefits & Payroll Taxes			1,172,798	1,172,798		1,172,798	72,502	1,245,300			22
23	Inservice Training & Education											23
24	Travel and Seminar			18,024	18,024		18,024	268	18,292			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			412,500	412,500		412,500	19,344	431,844			26
27	Other (specify):*											27
28	TOTAL General Administration	393,875	100,450	1,964,290	2,458,615		2,458,615	(134,890)	2,323,725			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,201,098	1,323,897	3,188,104	9,713,099		9,713,099	(141,117)	9,571,982			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 (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			143,964	143,964		143,964	184,433	328,397			30
31	Amortization of Pre-Op. & Org.							1,099,752	1,099,752			31
32	Interest			300,492	300,492		300,492	1,174,197	1,474,689			32
33	Real Estate Taxes							411,611	411,611			33
34	Rent-Facility & Grounds			2,640,000	2,640,000		2,640,000	(2,633,146)	6,854			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Replacement Tax			2,230	2,230		2,230		2,230			36
37	TOTAL Ownership			3,086,686	3,086,686		3,086,686	236,847	3,323,533			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		282,966		282,966		282,966		282,966			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			807,782	807,782		807,782		807,782			42
43	Other (specify):* Bad Debt			1,385,000	1,385,000		1,385,000		1,385,000			43
44	TOTAL Special Cost Centers		282,966	2,192,782	2,475,748		2,475,748		2,475,748			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,201,098	1,606,863	8,467,572	15,275,533		15,275,533	95,730	15,371,263			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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(51,259)	30		9
10	Interest and Other Investment Income	(105)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(787)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(26,319)	21		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(873)	21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (79,343)		\$	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)	175,073	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 175,073		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 95,730		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		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

STATE OF ILLINOIS
SOUTHPOINT NRSG & REHAB CTR

Report Period Beginning: ID# 0050450
Ending: 1/1/12
12/31/12

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Misc. Revenue	\$ (873)	21	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
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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	(873)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SOUTHPOINT NRSG & REHAB CTR # 0050450 Report Period Beginning: 1/1/12 Ending: 12/31/12
SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	(4,769)	0	0	0	0	0	0	0	0	0	(4,769)	1
2	Food Purchase	0	(1,682)	0	0	0	0	0	0	0	0	0	(1,682)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	654	0	0	0	0	0	0	0	0	0	654	5
6	Maintenance	0	(15,584)	0	0	0	0	0	0	0	0	0	(15,584)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	(21,381)	0	0	0	0	0	0	0	0	0	(21,381)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	15,154	0	0	0	0	0	0	0	0	0	15,154	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	15,154	0	0	0	0	0	0	0	0	0	15,154	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(262,913)	5,508	0	0	0	0	0	0	0	0	(257,405)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(27,979)	58,380	0	0	0	0	0	0	0	0	0	30,401	21
22	Employee Benefits & Payroll Taxes	0	72,502	0	0	0	0	0	0	0	0	0	72,502	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	268	0	0	0	0	0	0	0	0	0	268	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	444	18,900	0	0	0	0	0	0	0	0	19,344	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(27,979)	(131,319)	24,408	0	0	0	0	0	0	0	0	(134,890)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(27,979)	(137,546)	24,408	0	0	0	0	0	0	0	0	(141,117)	29

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(51,259)	168	235,524	0	0	0	0	0	0	0	0	184,433	30
31	Amortization of Pre-Op. & Org.	0	0	1,099,752	0	0	0	0	0	0	0	0	1,099,752	31
32	Interest	(105)	0	1,174,302	0	0	0	0	0	0	0	0	1,174,197	32
33	Real Estate Taxes	0	0	411,611	0	0	0	0	0	0	0	0	411,611	33
34	Rent-Facility & Grounds	0	6,854	(2,640,000)	0	0	0	0	0	0	0	0	(2,633,146)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(51,364)	7,022	281,189	0	0	0	0	0	0	0	0	236,847	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(79,343)	(130,524)	305,597	0	0	0	0	0	0	0	0	95,730	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Michael Blisko	30%			Infinity Healthcare	Hillside IL	Management Co
Moishe Gubin	30%					
A&F General Realty	9%					
M. Loeb	31%					

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	1	DIETARY	\$ 15,000	INFINITY HEALTHCARE MANAGEMENT		\$ 10,231	\$ (4,769)	1
2	V	2	FOOD	1,682	INFINITY HEALTHCARE MANAGEMENT			(1,682)	2
3	V	6	MAINTENANCE	19,712	INFINITY HEALTHCARE MANAGEMENT		4,128	(15,584)	3
4	V	10	NURSING	25,200	INFINITY HEALTHCARE MANAGEMENT		40,354	15,154	4
5	V	19	PROFESSIONAL SVC	264,000	INFINITY HEALTHCARE MANAGEMENT		1,087	(262,913)	5
6	V	21	OFFICE	33,605	INFINITY HEALTHCARE MANAGEMENT		91,879	58,274	6
7	V	22	EMPLOYEE BENEFITS	4,225	INFINITY HEALTHCARE MANAGEMENT		76,727	72,502	7
8	V	5	UTILITIES		INFINITY HEALTHCARE MANAGEMENT		654	654	8
9	V	26	LIABILITY INSURANCE		INFINITY HEALTHCARE MANAGEMENT		444	444	9
10	V	34	RENT		INFINITY HEALTHCARE MANAGEMENT		6,854	6,854	10
11	V	30	DEPRECIATION		INFINITY HEALTHCARE MANAGEMENT		168	168	11
12	V	24	TRAVEL		INFINITY HEALTHCARE MANAGEMENT		268	268	12
13	V	21	OFFICE		SOUTHPOINT REALTY LLC		106	106	13
14	Total			\$ 363,424			\$ 232,900	\$ * (130,524)	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	30	Depreciation	\$	Southpoint Realty LLC		\$ 235,524	\$ 235,524	15
16	V	31	Amortization		Southpoint Realty LLC		1,099,752	1,099,752	16
17	V	32	Interest	2,293	Southpoint Realty LLC		1,176,595	1,174,302	17
18	V	33	Property Taxes		Southpoint Realty LLC		411,611	411,611	18
19	V	34	Rent	2,640,000	Southpoint Realty LLC			(2,640,000)	19
20	V	19	PROFESSIONAL SVS		Southpoint Realty LLC		5,508	5,508	20
21	V	26	PROPERTY INSURANCE		Southpoint Realty LLC		18,900	18,900	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			\$ 2,642,293			\$ 2,947,890	\$ * 305,597	39

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

Facility Name & ID Number SOUTHPOINT NRSG & REHAB CTR # 0050450 Report Period Beginning: 1/1/12 Ending: 12/31/12

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		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 SOUTHPOINT NRSG & REHAB CTR # 0050450 Report Period Beginning: 1/1/12 Ending: 12/31/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

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	Cole Taylor Bank		x	Capital Financing	\$60,000.00	9/1/10	\$ 15,000,000	\$ 13,178,013	6/1/13	6.0000	\$ 687,776	1	
2	Eric Rothner		x	Capital Financing	Interst Only	8/1/10	4,900,000	4,900,000	8/1/15	6.0000	343,000	2	
3	New York Boys Management	x		Capital Financing	Interst Only	9/1/10	2,300,000	2,100,000	9/1/20	10.0000	148,112	3	
4												4	
5												5	
	Working Capital												
6	Cole Taylor Bank		x	Working Capital	None	9/1/10	3,000,000	2,415,000	9/1/13	5.0000	262,455	6	
7	Infinity Funding	x		Working Capital	None	Various	350,000	350,000	Various	Various	38,037	7	
8												8	
9	TOTAL Facility Related				\$60,000.00		\$ 25,550,000	\$ 22,943,013			\$ 1,479,380	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 25,550,000	\$ 22,943,013			\$ 1,479,380	15	

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

* 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

[illegible]

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.**

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SOUTHPOINT NRSG & REHAB CTR COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0050450

CONTACT PERSON REGARDING THIS REPORT Alan Sorscher

TELEPHONE (708) 449-1900 FAX #: ()

A. Summary of Real Estate Tax Cost

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

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	<u>25-05-423-001-0000</u>	<u>NURSING HOME</u>	\$ <u>1,984.58</u>	\$ <u>1,984.58</u>
2.	<u>25-05-423-002-0000</u>	<u>NURSING HOME</u>	\$ <u>2,257.71</u>	\$ <u>2,257.71</u>
3.	<u>25-05-423-003-0000</u>	<u>NURSING HOME</u>	\$ <u>2,630.94</u>	\$ <u>2,630.94</u>
4.	<u>25-05-423-004-0000</u>	<u>NURSING HOME</u>	\$ <u>2,822.39</u>	\$ <u>2,822.39</u>
5.	<u>25-05-423-005-0000</u>	<u>NURSING HOME</u>	\$ <u>10,943.35</u>	\$ <u>10,943.35</u>
6.	<u>25-05-423-006-0000</u>	<u>NURSING HOME</u>	\$ <u>50,621.58</u>	\$ <u>50,621.58</u>
7.	<u>25-05-423-007-0000</u>	<u>NURSING HOME</u>	\$ <u>60,946.83</u>	\$ <u>60,946.83</u>
8.	<u>25-05-423-008-0000</u>	<u>NURSING HOME</u>	\$ <u>154,783.73</u>	\$ <u>154,783.73</u>
9.	<u>25-05-423-009-0000</u>	<u>NURSING HOME</u>	\$ <u>124,602.50</u>	\$ <u>124,602.50</u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
		TOTALS	\$ <u><u>411,593.61</u></u>	\$ <u><u>411,593.61</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 90,255

B. General Construction Type: Exterior BRICK

Frame MASONRY/STEEL

Number of Stories 3

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).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred: 20,273

2. Number of Years Over Which it is Being Amortized: 15

3. Current Period Amortization: 2,702

4. Dates Incurred: 4/1/09

Nature of Costs: Organizational 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		85,244	2010	\$ 500,000	1
2					2
3	TOTALS	85,244		\$ 500,000	3

Facility Name & ID Number SOUTHPOINT NRS&G & REHAB CTR

0050450

Report Period Beginning:

1/1/12

Ending:

12/31/12

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	228		2010		\$ 6,400,000	\$ 164,100	39	\$ 164,103	\$ 3	\$ 382,904	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Signs for Facility			2009	4,765	122	39	122	(0)	458	9
10	Signs for Facility			2009	4,765	122	39	122	(0)	458	10
11	New Flooring 1st and 2nd Floor			2009	40,859	1,048	39	1,048	(0)	3,929	11
12	New Flooring			2009	20,000	513	39	513	(0)	1,923	12
13	New Flooring			2009	20,000	513	39	513	(0)	1,923	13
14	TV Cabling			2009	1,500	38	39	38	(0)	144	14
15	Patch to the Field or Wall Flashings			2010	2,975	76	39	76	(0)	248	15
16	Patch to the Field or Wall Flashings			2010	2,975	76	39	76	(0)	248	16
17	Water Service Maint. And Insulation			2010	1,540	39	39	39	(0)	128	17
18	Leak Testing			2010	1,350	35	39	35	(0)	112	18
19	Misc. Construction Items Reclass from Repairs			2010	6,684	171	39	171	(0)	557	19
20	Water Heater Controller Replacement			2011	1,298	33	39	33	(0)	66	20
21	Removal of Closets, Eliminate Lights, Storage Room, etc.			2011	2,432	62	39	62	(0)	124	21
22	Cabinet Removal and Drywall Work			2011	3,960	102	39	102	(0)	203	22
23	Replacement Floors and Carpets			2011	2,480	64	39	64	(0)	128	23
24	Tile Work			2011	4,467	115	39	115	(0)	230	24
25	Pump - Harris Equip			2011	788	20	39	20	(0)	40	25
26	Removal of Old Carpet and Installation of New Carpet			2011	1,500	38	39	38	(0)	76	26
27	Installation of Cove Base in Office Areas			2011	246	6	39	6	(0)	12	27
28	Door Frame, Door Repairs, Hinge Replacement			2011	1,113	29	39	29	(0)	58	28
29	Patio Door Repairs, Hinge Replacement, Wall Work			2011	687	18	39	18	(0)	36	29
30	National Retrofitting Lights			2011	39,416	1,011	39	1,011	(0)	2,022	30
31	Heavy Duty Carpet and Spray Adhesive			2011	520	13	39	13	(0)	26	31
32	Repaired and Sealcoated/Striped Driveway			2011	2,100	54	39	54	(0)	108	32
33	Kohlman Chutes			2011	1,549	40	39	40	(0)	80	33
34	New Power Supply			2012	4,038	103	39	26	(77)	103	34
35	Roof Repair and maintenance			2012	2,000	51	39	51	0	51	35
36	Kitchen ceiling tiles			2012	1,129	29	39	22	(7)	29	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		2012	\$ 2,612	\$ 67	39	\$ 45	\$ (22)	\$ 67	37
38	Repair and replacement of pump and motor	2012	1,581	41	39	14	(27)	41	38
39	Capret Installation	2012	1,011	26	39	19	(7)	26	39
40	Concrete for patio	2012	1,850	47	39	32	(15)	47	40
41	Regrouting in Kitchen	2012	1,200	31	39	21	(10)	31	41
42	Compressor	2012	20,599	528	39	264	(264)	528	42
43	Crain Service operator	2012	700	18	39	9	(9)	18	43
44	Painting in kitchen	2012	1,900	49	39	16	(33)	49	44
45	Painting in dining room	2012	3,000	77	39	13	(64)	77	45
46	Installation of door	2012	2,751	71	39	12	(59)	71	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)		\$ 6,614,340	\$ 169,603		\$ 169,003	\$ (600)	\$ 397,379	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	\$701,780	\$102,385	\$140,357	\$37,972	5 years	\$323,859	71	
72	Current Year Purchases	107,507	107,507	11,781	(95,726)	5 years	107,507	72	
73	Fully Depreciated Assets	36,274		7,256	7,256		36,274	73	
74								74	
75	TOTALS	\$845,561	\$209,892	\$159,394	\$(50,498)		\$467,640	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)				\$7,959,901	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)				\$379,495	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)				\$328,397	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)				\$(51,097)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)				\$865,019	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: 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								6
7	TOTAL				\$			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: \$
- Description:
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning
Ending

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

Fiscal Year EndingAnnual Rent

12. /2013\$
13. /2014\$
14. /2015\$

* 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.

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

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

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)	\$			

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.

HFS 3745 (N-4-99)

IL478-2471

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	10A-3	hrs	\$		\$ 287,584	\$		\$ 287,584	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs			134,275			134,275	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3	hrs			329,716			329,716	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				269,836		269,836	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Lab/Radiology	39-2					13,130		13,130	13
14	TOTAL			\$		\$ 751,575	\$ 282,966		\$ 1,034,541	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.

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	\$ 137,351	\$ 348,087	1
2	Cash-Patient Deposits	(4,903)	(4,903)	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	3,868,873	3,868,873	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	193,920	193,920	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,195,241	\$ 4,405,977	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		500,000	13
14	Buildings, at Historical Cost		6,400,000	14
15	Leasehold Improvements, at Historical Cost	214,338	214,338	15
16	Equipment, at Historical Cost	345,562	845,562	16
17	Accumulated Depreciation (book methods)	(303,547)	(865,019)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	20,273	20,273	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(3,003)	(3,003)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify) Net Goodwil		13,930,131	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 273,623	\$ 21,042,282	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,468,864	\$ 25,448,259	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,317,723	\$ 1,317,723	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	647,336	647,336	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		417,015	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Working capital loan</u>	350,000	350,000	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,315,059	\$ 2,732,074	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,415,000	22,593,013	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)	\$ 2,415,000	\$ 22,593,013	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,730,059	\$ 25,325,088	46
47	TOTAL EQUITY(page 18, line 24)	\$ (261,195)	\$ 123,171	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,468,864	\$ 25,448,259	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 323,696	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 323,696	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(234,891)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock	(350,000)	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)	\$ (584,891)	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)	\$ (261,195)	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		2
I. Revenue	Amount		
A. Inpatient Care			
1Gross Revenue -- All Levels of Care	\$ 13,355,379	1	
2Discounts and Allowances for all Levels	1,357,982	2	
3SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 14,713,361	3	
B. Ancillary Revenue			
4Day Care		4	
5Other Care for Outpatients		5	
6Therapy	322,534	6	
7Oxygen		7	
8SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 322,534	8	
C. Other Operating Revenue			
9Payments for Education		9	
10Other Government Grants		10	
11CNA Training Reimbursements		11	
12Gift and Coffee Shop		12	
13Barber and Beauty Care		13	
14Non-Patient Meals		14	
15Telephone, Television and Radio		15	
16Rental of Facility Space		16	
17Sale of Drugs		17	
18Sale of Supplies to Non-Patients		18	
19Laboratory		19	
20Radiology and X-Ray		20	
21Other Medical Services		21	
22Laundry		22	
23SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23	
D. Non-Operating Revenue			
24Contributions		24	
25Interest and Other Investment Income***	105	25	
26SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 105	26	
E. Other Revenue (specify):****			
27Settlement Income (Insurance, Legal, Etc.)		27	
28Vending	3,769	28	
28aMiscellaneous	873	28a	
29SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,642	29	
30TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 15,040,642	30	

	1		2
II. Expenses	Amount		
A. Operating Expenses			
31General Services	1,847,057	31	
32Health Care	5,407,427	32	
33General Administration	2,458,615	33	
B. Capital Expense			
34Ownership	3,086,686	34	
C. Ancillary Expense			
35Special Cost Centers	1,667,966	35	
36Provider Participation Fee	807,782	36	
D. Other Expenses (specify):			
37		37	
38		38	
39		39	
40TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 15,275,533	40	
41Income before Income Taxes (line 30 minus line 40)**	(234,891)	41	
42Income Taxes		42	
43NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (234,891)	43	

III. Net Inpatient Revenue detailed by Payer Source			
44Medicaid - Net Inpatient Revenue	\$ 11,300,356	44	
45Private Pay - Net Inpatient Revenue	33,477	45	
46Medicare - Net Inpatient Revenue	3,276,187	46	
47Other-(specify) Insurance	103,341	47	
48Other-(specify)		48	
49TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 14,713,361	49	

* This must agree with page 4, line 45, column 4.
** Does this agree with taxable income (loss) per Federal Income Tax Return? yes 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.

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	1,960	2,080	\$ 113,725	\$ 54.68	1
2	Assistant Director of Nursing					2
3	Registered Nurses	20,389	21,493	690,027	32.10	3
4	Licensed Practical Nurses	48,791	52,304	1,435,993	27.45	4
5	CNAs & Orderlies	124,744	136,435	1,382,441	10.13	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	10,286	11,409	139,477	12.23	9
10	Activity Assistants					10
11	Social Service Workers	4,037	4,318	81,680	18.92	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	30,075	33,247	424,862	12.78	15
16	Dishwashers					16
17	Maintenance Workers	4,008	4,144	82,416	19.89	17
18	Housekeepers	24,637	27,495	310,581	11.30	18
19	Laundry	8,438	8,989	88,859	9.89	19
20	Administrator	1,888	2,080	115,437	55.50	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,178	13,127	278,438	21.21	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	3,915	4,320	57,162	13.23	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	295,346	321,441	\$ 5,201,098 *	\$ 16.18	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	429	\$ 15,000	11-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	715	35,736	10-3	38
39	Pharmacist Consultant	391	19,536	15-3	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	54	1,880	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,588	\$ 72,152		49

C. CONTRACT NURSES

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

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID Number SOUTHPOINT NRSG & REHAB CTR# 0050450Report Period Beginning: 1/1/12Ending: 12/31/12Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Ayodeji Adegoye	Admin		\$ 115,437
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 115,437

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
Bradley & Associates	Accounting	\$ 8,158
Johnson,Goldberg & Brown	Accounting	2,500
Swanson, Martin	Legal	6,288
Lewis Brisbois	Legal	271,862
Scott & Kraus	Legal	10,055
Other Porfessional	Legal	11,823
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)		\$ 310,685

D. Employee Benefits and Payroll Taxes

Description	Amount	
Workers' Compensation Insurance	\$ 236,561	
Unemployment Compensation Insurance	256,104	
FICA Taxes	388,184	
Employee Health Insurance	188,489	
Employee Meals		
Illinois Municipal Retirement Fund (IMRF)*		
Uniforms	7,239	
Employee Expense	30,142	
Pension	66,079	
Infinity - Employee Benefits	72,502	
TOTAL (agree to Schedule V, line 22, col.8)		\$ 1,245,300

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

Description	Line #	Amount
		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount	
IDPH License Fee	\$	
Advertising: Employee Recruitment		
Health Care Worker Background Check (Indicate # of checks performed)		
CLIA Lab	513	
IDPH	3,980	
Il Council	8,299	
Dept of Bldgs	2,128	
ACHCA	518	
City of Chgo	1,128	
Less: Public Relations Expense	()	
Non-allowable advertising	()	
Yellow page advertising	()	
TOTAL (agree to Sch. V, line 20, col. 8)		\$ 16,566

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Mileage	15,612
Seminar Expense	
Seminars	2,209
Education	203
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 18,024

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
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9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

XX. GENERAL INFORMATION:

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

NO
- (2) Are there any dues to nursing home associations included on the cost report?

NO

If YES, give association name and amount.

n/a
- (3) Did the nursing home make political contributions or payments to a political action organization?

NO

If YES, have these costs been properly adjusted out of the cost report?

N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

NO

If YES, what is the capacity?

N/A
- (5) Have you properly capitalized all major repairs and equipment purchases?

YES

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

5 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 71,626

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.

\$ 807,782

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.

\$ N/A
- (16) Travel and Transportation

a. Are there costs included for out-of-state travel?

NO

If YES, attach a complete explanation.

N/A

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?

0%

d. Have vehicle usage logs been maintained?

N/A

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

N/A

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

N/A

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) 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.