FOR BHF USE

LL1

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.

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

I. IDPH License ID Number: 0050450

Facility Name: SOUTHPOINT NURSING & REHABILITATION CENTER

Address: 1010 WEST 95TH STREET (Number) CHICAGO (City) 60643 (Zip Code)

County: COOK

Telephone Number: (773) 298-1177 **Fax #** (773) 298-1666

HFS ID Number:

Date of Initial License for Current Owners: 4/1/09

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: DANIEL S. GAAFAR **Telephone Number:** (317) 237-5500
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/11 to 12/31/11 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) MOISHE GUBIN
(Title) MANAGER

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) DANIEL S. GAAFAR, PARTNER
(Firm Name & Address) BRADLEY & ASSOCIATES, 201 S CAPITOL AVE, STE 910, INDIANAPOLIS, IN 46225
(Telephone) (317) 237-5500 Fax # (317) 237-5503

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001
Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

FOR BHF USE

LL1

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.

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

I. IDPH License ID Number: 0050450

Facility Name: Southpoint Nursing and Rehabilitation Center

Address: 1010 West 95th Street (Number) Chicago (City) 60643 (Zip Code)

County: Cook

Telephone Number: (773) 298-1177 **Fax #** (773) 298-1666

HFS ID Number: 364100431001

Date of Initial License for Current Owners: 4/1/09

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Daniel S. Gaafar **Telephone Number:** (317) 237-5500
Email Address: dang@bradleycpa.com

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2011 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) Moishe Gubin
(Title) Manager

Paid Preparer

(Signed) See Accountants' Compilation Report Attached (Date)
(Print Name and Title) Daniel S. Gaafar, Partner
(Firm Name & Address) Bradley Associates, 201 S. Capitol Ave, Suite 910 Indianapolis, IN 46225
(Telephone) (317) 237-5500 Fax # (317) 237-5503

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOUTHPOINT NURSING & REHABILITATION CENTER # 0050450 Report Period Beginning: 1/1/11 Ending: 12/31/11

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	228	Skilled (SNF)	228	83,220	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	228	TOTALS	228	83,220	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	59,996	1,817	5,657	67,470	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	59,996	1,817	5,657	67,470	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.07%

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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 4/1/09

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 4/1/09 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 228 and days of care provided 5,448

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/11 Fiscal Year: 12/31/11

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOUTHPOINT NURSING & REHABILITA # 0050450 Report Period Beginning: 1/1/11 Ending: 12/31/11

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	358,209	40,153	15,000	413,362		413,362	(6,906)	406,456			1
2	Food Purchase		334,167		334,167		334,167	(98)	334,069			2
3	Housekeeping	298,168	44,104		342,272		342,272		342,272			3
4	Laundry	43,289	28,350		71,639		71,639		71,639			4
5	Heat and Other Utilities			305,212	305,212		305,212	439	305,651			5
6	Maintenance	69,877	33,437	54,653	157,967		157,967	(3,489)	154,478			6
7	Other (specify):*											7
8	TOTAL General Services	769,543	480,211	374,865	1,624,619		1,624,619	(10,054)	1,614,565			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	3,436,035	585,724	33,767	4,055,526		4,055,526	14,102	4,069,628			10
10a	Therapy			626,732	626,732		626,732		626,732			10a
11	Activities	142,365	25,749		168,114		168,114		168,114			11
12	Social Services	61,392		6,539	67,931		67,931		67,931			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Pharmacy Consult.			10,410	10,410		10,410		10,410			15
16	TOTAL Health Care and Programs	3,639,792	611,473	701,448	4,952,713		4,952,713	14,102	4,966,815			16
	C. General Administration											
17	Administrative	100,880			100,880		100,880	(86)	100,794			17
18	Directors Fees											18
19	Professional Services			506,359	506,359		506,359	(263,492)	242,867			19
20	Dues, Fees, Subscriptions & Promotions			7,600	7,600		7,600		7,600			20
21	Clerical & General Office Expenses	192,666	94,251	24,950	311,867		311,867	157,226	469,093			21
22	Employee Benefits & Payroll Taxes			861,216	861,216		861,216	7,722	868,938			22
23	Inservice Training & Education											23
24	Travel and Seminar			12,027	12,027		12,027	(10,149)	1,878			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			311,748	311,748		311,748	20,146	331,894			26
27	Other (specify):*											27
28	TOTAL General Administration	293,546	94,251	1,723,900	2,111,697		2,111,697	(88,633)	2,023,064			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,702,881	1,185,935	2,800,213	8,689,029		8,689,029	(84,585)	8,604,444			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number SOUTHPOINT NURSING & REHABILITATION CENTEI #0050450 Report Period Beginning: 1/1/11 Ending: 12/31/11

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			71,293	71,293		71,293	241,829	313,122			30
31	Amortization of Pre-Op. & Org.			301	301		301	1,099,748	1,100,049			31
32	Interest			68,832	68,832		68,832	1,187,737	1,256,569			32
33	Real Estate Taxes							413,250	413,250			33
34	Rent-Facility & Grounds			2,640,000	2,640,000		2,640,000	(2,627,258)	12,742			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			2,780,426	2,780,426		2,780,426	315,306	3,095,732			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		263,151		263,151		263,151		263,151			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			124,830	124,830		124,830		124,830			42
43	Other (specify):*							5,015	5,015			43
44	TOTAL Special Cost Centers		263,151	124,830	387,981		387,981	5,015	392,996			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,702,881	1,449,086	5,705,469	11,857,436		11,857,436	235,736	12,093,172			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOUTHPOINT NURSING & REHABILITATION CENT # 0050450 Report Period Beginning: 1/1/11 Ending: 12/31/11

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	6,296	30		9
10	Interest and Other Investment Income	5,358	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(45)	1		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(9,777)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(24,633)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (22,801)		$	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)	258,537	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 258,537		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 235,736		37

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

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

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

SOUTHPOINT NURSING & REHABILITATION CENTER

ID# 0050450

Report Period Beginning: 1/1/11

Ending: 12/31/11

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	AUTO ALLOWANCE/COMMUTING	$ (10,650)	24	1
2	VENDING INCOME	(3,484)	6	2
3	MISC. REV. - DIETARY/FOOD REBATES	(1,561)	1	3
4	MISC. REV. - MEDICAL RECORDS	(3,039)	10	4
5	MISC. REV. - JURY DUTY	(86)	17	5
6	MISC. REV. - OFFICE EXPENSES	(5,813)	21	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**	(24,633)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SOUTHPOINT NURSING & REHABILITATION CENTEI **#** 0050450 **Report Period Beginning:** 1/1/11 **Ending:** 12/31/11

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	(1,606)	(5,300)	0	0	0	0	0	0	0	0	0	(6,906)	1
2	Food Purchase	0	(98)	0	0	0	0	0	0	0	0	0	(98)	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	439	0	0	0	0	0	0	0	0	0	439	5
6	Maintenance	(3,484)	(5)	0	0	0	0	0	0	0	0	0	(3,489)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(5,090)	(4,964)	0	0	0	0	0	0	0	0	0	(10,054)	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	(3,039)	17,141	0	0	0	0	0	0	0	0	0	14,102	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**	(3,039)	17,141	0	0	0	0	0	0	0	0	0	14,102	16
	C. General Administration													
17	Administrative	(86)	0	0	0	0	0	0	0	0	0	0	(86)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(263,492)	0	0	0	0	0	0	0	0	0	(263,492)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(15,590)	172,816	0	0	0	0	0	0	0	0	0	157,226	21
22	Employee Benefits & Payroll Taxes	0	7,722	0	0	0	0	0	0	0	0	0	7,722	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(10,650)	501	0	0	0	0	0	0	0	0	0	(10,149)	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	437	19,709	0	0	0	0	0	0	0	0	20,146	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(26,326)	(82,016)	19,709	0	0	0	0	0	0	0	0	(88,633)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(34,455)	(69,839)	19,709	0	0	0	0	0	0	0	0	(84,585)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SOUTHPOINT NURSING & REHABILITATION CENTE # 0050450 **Report Period Beginning:** 1/1/11 **Ending:** 12/31/11

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	6,296	0	235,533	0	0	0	0	0	0	0	0	241,829	30
31	Amortization of Pre-Op. & Org.	0	0	1,099,748	0	0	0	0	0	0	0	0	1,099,748	31
32	Interest	5,358	0	1,182,379	0	0	0	0	0	0	0	0	1,187,737	32
33	Real Estate Taxes	0	0	413,250	0	0	0	0	0	0	0	0	413,250	33
34	Rent-Facility & Grounds	0	12,742	(2,640,000)	0	0	0	0	0	0	0	0	(2,627,258)	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	11,654	12,742	290,910	0	0	0	0	0	0	0	0	315,306	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	5,015	0	0	0	0	0	0	0	0	5,015	43
44	TOTAL Special Cost Centers	0	0	5,015	0	0	0	0	0	0	0	0	5,015	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(22,801)	(57,097)	315,634	0	0	0	0	0	0	0	0	235,736	45

Facility Name & ID Number SOUTHPOINT NURSING & REHABILITATION CENTER # 0050450 Report Period Beginning: 1/1/11 Ending: 12/31/11

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	29.965%			Infinity Healthcare	Hillside, IL	Management Co.
Moishe Gubin	29.965%					
A&F General Realty	10.070%					
Atied Associates	30.000%					

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	DIETARY	$ 15,000	INFINITY HEALTHCARE MANAGEMENT		$ 9,700	$ (5,300)	1
2	V	2	FOOD	98	INFINITY HEALTHCARE MANAGEMENT			(98)	2
3	V	5	UTILITIES	73	INFINITY HEALTHCARE MANAGEMENT		512	439	3
4	V	6	MAINTENANCE	800	INFINITY HEALTHCARE MANAGEMENT		795	(5)	4
5	V	10	NURSING	25,200	INFINITY HEALTHCARE MANAGEMENT		42,341	17,141	5
6	V	19	PROFESSIONAL SVCS	264,000	INFINITY HEALTHCARE MANAGEMENT		258	(263,742)	6
7	V	21	OFFICE	32,283	INFINITY HEALTHCARE MANAGEMENT		204,948	172,665	7
8	V	22	EMPLOYEE BENEFITS	1,980	INFINITY HEALTHCARE MANAGEMENT		9,702	7,722	8
9	V	24	TRAVEL/SEMINAR		INFINITY HEALTHCARE MANAGEMENT		501	501	9
10	V	26	LIABILITY INSURANCE		INFINITY HEALTHCARE MANAGEMENT		437	437	10
11	V	34	RENT		INFINITY HEALTHCARE MANAGEMENT		12,742	12,742	11
12	V	19	PROF SVCS - FILING FEES		SOUTHPOINT REALTY, LLC		250	250	12
13	V	21	BANK CHARGES		SOUTHPOINT REALTY, LLC		151	151	13
14	Total			$ 339,434			$ 282,337	$ * (57,097)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOUTHPOINT NURSING & REHABILITATION CENTER # 0050450 Report Period Beginning: 1/1/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	26	PROPERTY INSURANCE	$	SOUTHPOINT REALTY, LLC		$ 19,709	$ 19,709	15
16	V	30	DEPRECIATION		SOUTHPOINT REALTY, LLC		235,533	235,533	16
17	V	31	AMORTIZATION		SOUTHPOINT REALTY, LLC		1,099,748	1,099,748	17
18	V	32	INTEREST		SOUTHPOINT REALTY, LLC		1,182,379	1,182,379	18
19	V	33	PROPERTY TAXES		SOUTHPOINT REALTY, LLC		413,250	413,250	19
20	V	34	RENT	2,640,000	SOUTHPOINT REALTY, LLC			(2,640,000)	20
21	V	43	OTHER - REPLACEMENT TAX				5,015	5,015	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			$ 2,640,000			$ 2,955,634	$ * 315,634	39

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

Facility Name & ID Number SOUTHPOINT NURSING & REHABILITA # 0050450 Report Period Beginning: 1/1/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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

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

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOUTHPOINT NURSING & REHABILITA # 0050450 Report Period Beginning: 1/1/11 Ending: 12/31/11

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Cole Taylor Bank		X	Capital Financing	$60,000.00	9/1/10	$ 15,000,000	$ 15,000,000	9/1/13	5.5000	$ 836,458	1
2	Eric Rothner		X	Capital Financing	Interest Only	8/1/10	4,940,000	4,900,000	8/1/15	7.0000	345,921	2
3	New York Boys Management	X		Capital Financing	$25,824.00	9/1/10	2,300,000	2,100,000	9/1/20	10.0000		3
4												4
5												5
	Working Capital											
6	Cole Taylor Bank		X	Working Capital	None	12/11/09	2,000,000	2,000,000	5/15/12	5.5000	68,832	6
7												7
8												8
9	**TOTAL Facility Related**				$85,824.00		$ 24,240,000	$ 24,000,000			$ 1,251,211	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	**TOTAL Non-Facility Related**						$	$			$	14
15	**TOTALS (line 9+line14)**						$ 24,240,000	$ 24,000,000			$ 1,251,211	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.)**

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number SOUTHPOINT NURSING & REHABILITATION CENTER # 0050450 Report Period Beginning: 1/1/11 Ending: 12/31/11

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.**	$ 327,889	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.)		$ 413,242	2
3. Under or (over) accrual (line 2 minus line 1).		$ 85,353	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 327,897	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.		$ 413,250	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2006		8
2007		9
2008	341,328	10
2009	395,969	11
2010	413,242	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SOUTHPOINT NURSING & REHABILITATION CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0050450

CONTACT PERSON REGARDING THIS REPORT DANIEL S. GAAFAR

TELEPHONE (317) 237-5500 FAX #: (317) 237-5503

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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	25-05-423-001-0000	NURSING HOME	$ 1,992.51	$ 1,992.51
2.	25-05-423-002-0000	NURSING HOME	$ 2,266.78	$ 2,266.78
3.	25-05-423-003-0000	NURSING HOME	$ 2,641.46	$ 2,641.46
4.	25-05-423-004-0000	NURSING HOME	$ 2,833.71	$ 2,833.71
5.	25-05-423-005-0000	NURSING HOME	$ 10,987.15	$ 10,987.15
6.	25-05-423-006-0000	NURSING HOME	$ 50,824.26	$ 50,824.26
7.	25-05-423-007-0000	NURSING HOME	$ 61,190.88	$ 61,190.88
8.	25-05-423-008-0000	NURSING HOME	$ 155,403.54	$ 155,403.54
9.	25-05-423-009-0000	NURSING HOME	$ 125,101.43	$ 125,101.43
10.			$	$
		TOTALS	$ 413,241.72	$ 413,241.72

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 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.

Facility Name & ID Number SOUTHPOINT NURSING & REHABILITATION CENTER # 0050450 Report Period Beginning: 1/1/11 Ending: 12/31/11

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 [X] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (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 [X] NO
If so, please complete the following:

1. Total Amount Incurred: 4,516
2. Number of Years Over Which it is Being Amortized: 15 years
3. Current Period Amortization: 301
4. Dates Incurred: Prior to 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1		85,244	2010	$ 500,000	1
2					2
3	TOTALS	85,244		$ 500,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOUTHPOINT NURSING & REHABILITATION CENTER # 0050450 Report Period Beginning: 1/1/11 Ending: 12/31/11

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	$ 164,103	39	$ 164,103	$	$ 218,804	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Signs for Facility			2009	4,765	122	39	122		336	9
10	Signs for Facility			2009	4,765	122	39	122		336	10
11	New Flooring 1st and 2nd Floor			2009	40,859	1,048	39	1,048		2,881	11
12	New Flooring			2009	20,000	513	39	513		1,410	12
13	New Flooring			2009	20,000	513	39	513		1,410	13
14	TV Cabling			2009	1,500	38	39	38		106	14
15	Patch to the Field or Wall Flashings			2010	2,975	76	39	76		172	15
16	Patch to the Field or Wall Flashings			2010	2,975	76	39	76		172	16
17	Water Service Maint. And Insulation			2010	1,540	39	39	39		89	17
18	Leak Testing			2010	1,350	35	39	35		78	18
19	Misc. Construction Items Reclass from Repairs			2010	6,684	171	39	171		386	19
20	Water Heater Controller Replacement			2011	1,298	33	39	25	(8)	33	20
21	Removal of Closets, Eliminate Lights, Storage Room, etc.			2011	2,432	62	39	57	(5)	62	21
22	Cabinet Removal and Drywall Work			2011	3,960	102	39	51	(51)	102	22
23	Replacement Floors and Carpets			2011	2,480	64	39	16	(48)	64	23
24	Tile Work			2011	4,467	115	39	29	(86)	115	24
25	Pump - Harris Equip			2011	788	20	39	20		20	25
26	Removal of Old Carpet and Installation of New Carpet			2011	1,500	38	39	38		38	26
27	Installation of Cove Base in Office Areas			2011	246	6	39	6		6	27
28	Door Frame, Door Repairs, Hinge Replacement			2011	1,113	29	39	24	(5)	29	28
29	Patio Door Repairs, Hinge Replacement, Wall Work			2011	687	18	39	12	(6)	18	29
30	National Retrofitting Lights			2011	39,416	1,011	39	758	(253)	1,011	30
31	Heavy Duty Carpet and Spray Adhesive			2011	520	13	39	10	(3)	13	31
32	Reapaired and Sealcoated/Striped Driveway			2011	2,100	54	39	31	(23)	54	32
33	Kohlman Chutes			2011	1,549	40	39	13	(27)	40	33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number SOUTHPOINT NURSING & REHABILITATION CENTER # 0050450 Report Period Beginning: 1/1/11 Ending: 12/31/11

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)		$ 6,569,969	$ 168,461		$ 167,946	$ (515)	$ 227,784	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number SOUTHPOINT NURSING & REHABILITATION C# 0050450 Report Period Beginning: 1/1/11 Ending: 12/31/11

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	$ 102,091	$ 140,356	$ 38,265	5 YEARS	$ 254,279	71
72	Current Year Purchases	36,274	36,274	4,820	(31,454)	5 YEARS	4,820	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 738,054	$ 138,365	$ 145,176	$ 6,811		$ 259,099	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 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 7,808,023	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 306,826	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 313,122	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 6,296	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 486,883	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.

Facility Name & ID Number SOUTHPOINT NURSING & REHABILITATION CENTEI # 0050450 Report Period Beginning: 1/1/11 Ending: 12/31/11

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NOT APPLICABLE
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

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	$

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOUTHPOINT NURSING & REHABILITATION CENTER # 0050450 Report Period Beginning: 1/1/11 Ending: 12/31/11

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOUTHPOINT NURSING & REHABILITATION CENTER # 0050450 Report Period Beginning: 1/1/11 Ending: 12/31/11

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

	1	2	3	4	5	6	7	8	
	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	$		$ 252,192	$		$ 252,192	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs			121,366			121,366	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3	hrs			253,174			253,174	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				251,596		251,596	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					11,555		11,555	13
14	TOTAL			$		$ 626,732	$ 263,151		$ 889,883	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOUTHPOINT NURSING & REHABILITATION CENTEF # 0050450 Report Period Beginning: 1/1/11 Ending: 12/31/11

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/11 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (56,836)	$ 942,881	1
2	Cash-Patient Deposits	(4,936)	(4,936)	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	4,668,244	4,673,970	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	125,003	125,003	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)**	$ 4,731,475	$ 5,736,918	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	169,967	169,967	15
16	Equipment, at Historical Cost	238,055	738,055	16
17	Accumulated Depreciation (book methods)	(160,934)	(486,882)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	4,516	4,516	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(1,652)	(1,652)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe **NET GOODWILL**		15,029,883	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 249,952	$ 22,353,887	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,981,427	$ 28,090,805	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,185,357	$ 2,185,357	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	472,374	472,374	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				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,657,731	$ 3,074,746	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,000,000	24,000,000	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)**	$ 2,000,000	$ 24,000,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,657,731	$ 27,074,746	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 323,696	$ 1,016,059	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,981,427	$ 28,090,805	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number SOUTHPOINT NURSING & REHABILITATION CENTER # 0050450 Report Period Beginning: 1/1/11 Ending: 12/31/11

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (140,496)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (140,496)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	464,192	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)**	$ 464,192	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)**	$ 323,696	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOUTHPOINT NURSING & REHABILITATION # 0050450 Report Period Beginning: 1/1/11 Ending: 12/31/11

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 11,424,146	1
2	Discounts and Allowances for all Levels	(918,387)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,505,759	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,225,954	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,225,954	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	246,016	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	21,246	19
20	Radiology and X-Ray	2,626	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 269,888	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	(5,358)	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ (5,358)	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING INCOME	3,484	28
28a	MISC. INCOME	321,901	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 325,385	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,321,628	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,624,619	31
32	Health Care	4,952,713	32
33	General Administration	2,111,697	33
	B. Capital Expense		
34	Ownership	2,780,426	34
	C. Ancillary Expense		
35	Special Cost Centers	263,151	35
36	Provider Participation Fee	124,830	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,857,436	40
41	**Income before Income Taxes (line 30 minus line 40)****	464,192	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 464,192	43

* **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. SEE ACCOUNTANTS' COMPILATION REPORT**

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

Facility Name & ID Number SOUTHPOINT NURSING & REHABILITATION CENTE # 0050450 Report Period Beginning: 1/1/11 Ending: 12/31/11

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,950	2,199	$ 109,123	$ 49.62	1
2	Assistant Director of Nursing					2
3	Registered Nurses	16,350	17,607	542,212	30.80	3
4	Licensed Practical Nurses	52,458	56,418	1,402,700	24.86	4
5	CNAs & Orderlies	117,760	130,997	1,382,000	10.55	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	10,496	12,006	142,365	11.86	9
10	Activity Assistants					10
11	Social Service Workers	4,025	4,846	61,392	12.67	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	27,784	31,454	358,209	11.39	15
16	Dishwashers					16
17	Maintenance Workers	3,766	4,050	69,877	17.25	17
18	Housekeepers	25,208	28,080	298,168	10.62	18
19	Laundry	3,995	4,556	43,289	9.50	19
20	Administrator	2,147	2,179	100,880	46.30	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,044	8,563	192,666	22.50	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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	273,983	302,955	$ 4,702,881 *	$ 15.52	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	429	$ 15,000	1-3	35
36	Medical Director	MONTHLY	24,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	675	33,767	10-3	38
39	Pharmacist Consultant	208	10,410	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	187	6,539	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,499	$ 89,716		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number SOUTHPOINT NURSING & REHABILITATION (# 0050450 Report Period Beginning: 1/1/11 Ending: 12/31/11

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Ayodeji Adegoye	ADMIN	0%	$ 100,880
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 100,880

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	$ 9,251
Johnson, Goldberg, & Br…	ACCOUNTING	5,000
Neal Gerber Eisenberg	LEGAL	536
Lamont E Stallworth	LEGAL	625
Lewis Brisbois & Smith	LEGAL	1,114
Infinity Healthcare	PROFESSIONAL	264,000
Other Professional Fees	PROFESSIONAL	225,833
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 506,359

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 134,891
Unemployment Compensation Insurance	165,499
FICA Taxes	355,584
Employee Health Insurance	143,375
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Uniforms	5,069
Employee Expense	28,932
Pension Expense	35,588
TOTAL (agree to Schedule V, line 22, col.8)	$ 868,938

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)	
Patient Background Checks	
Illinois Dept. of Public Health	1,990
State of Illinois	25
Secretary of State	1,050
City of Chicago	4,020
NGS, Collab. HC, Dept. of Rev.	515
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,600

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Mileage	531
Seminar Expense	
Business Seminar(s)	599
Education	748
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,878

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOUTHPOINT NURSING & REHABILITATION CENT # 0050450 Report Period Beginning: 1/1/11 Ending: 12/31/11

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													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOUTHPOINT NURSING & REHABILITATION CENTER # 0050450 Report Period Beginning: 1/1/11 Ending: 12/31/11

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. $ **68,026** 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. $ **124,830**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **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.
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 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? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.