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: 0048421

Facility Name: SOUTHVIEW MANOR OPERATOR, LLC

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

County: COOK

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

HFS ID Number:

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

Type of Ownership:

	VOLUNTARY,NON-PROFIT	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: BOB KAGDA **Telephone Number:** (847) 675-3585
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2011 to 12/31/2011 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) AVRUM WEINFELD
(Title) CEO

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, VICE PRESIDENT
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD, 3750 W DEVON, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

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

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

III. STATISTICAL DATA

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

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

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

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 11/01/06

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/01/06 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 42 and days of care provided 5,075

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

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

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

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

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

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

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

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

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

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

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

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

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

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

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

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

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

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

GRAND TOTAL COLUMN 3 OTHER **1,824,829**

SOUTHVIEW MANOR OPERATOR, LLC
SCHEDULES
12/31/2011

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

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

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

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

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

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(8,103)	30		9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(654)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(4,680)	21		18
19	Entertainment		20		19
20	Contributions	(5,717)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(309,356)	27		24
25	Fund Raising, Advertising and Promotional	(3,267)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(93,137)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (424,914)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	174,810		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 174,810		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (250,104)		37

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

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

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

STATE OF ILLINOIS

SOUTHVIEW MANOR OPERATOR, LLC

ID# 0048421

Report Period Beginning: 01/01/2011

Ending: 12/31/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$	6	1
2	BANK CHARGES	(1,851)	21	2
3	STAFF DEVELOPMENT	(64,050)	21	3
4	MARKETING SALARIES	(26,071)	21	4
5	MARKETING AUTO LEASE	(1,165)	35	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
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30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(93,137)		49

STATE OF ILLINOIS

Summary A

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

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(654)	0	0	0	0	0	0	0	0	0	0	(654)	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	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	3,341	3,214	0	0	0	0	0	0	0	6,555	6
7	Other (specify):*	0	0	0	80	0	0	0	0	0	0	0	80	7
8	**TOTAL General Services**	(654)	0	3,341	3,294	0	0	0	0	0	0	0	5,981	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	122,489	3,100	9,493	0	0	0	0	0	0	0	135,082	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	103	535	7,264	0	0	0	0	0	0	0	7,902	19
20	Fees, Subscriptions & Promotions	(8,984)	0	0	2,890	0	0	0	0	0	0	0	(6,094)	20
21	Clerical & General Office Expenses	(96,652)	0	7,195	(3,825)	0	0	0	0	0	0	0	(93,282)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	9	0	0	0	0	0	0	0	9	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	194	1,099	0	0	0	0	0	0	0	1,293	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,060	206	0	0	0	0	0	0	0	1,266	26
27	Other (specify):*	(309,356)	0	7,779	4,967	0	0	0	0	0	0	0	(296,610)	27
28	**TOTAL General Administration**	(414,992)	122,592	19,863	22,103	0	0	0	0	0	0	0	(250,434)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(415,646)	122,592	23,204	25,397	0	0	0	0	0	0	0	(244,453)	29

STATE OF ILLINOIS

Summary B

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

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	(8,103)	0	0	127	0	0	0	0	0	0	0	(7,976)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	(1,165)	0	448	3,042	0	0	0	0	0	0	0	2,325	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(9,268)	0	448	3,169	0	0	0	0	0	0	0	(5,651)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(424,914)	122,592	23,652	28,566	0	0	0	0	0	0	0	(250,104)	45

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

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				6865 FIN. INC	LINCOLNWOOD	MANAGEMENT
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE		EMI ENTERPRISE	LINCOLNWOOD	MANAGEMENT
				EKS MGMT	LINCOLNWOOD	BOOKKEEPING
				IME REALTY	LINCOLNWOOD	HOME OFFICE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	17	MANAGEMNT FEES	$	6865 FINANCIAL INC		$	$	1
2	V	17	EMI ENTERPRISES				29,595	29,595	2
3	V	17	PHILIP ESFORMES INC				59,189	59,189	3
4	V	17	MICHAEL ROSEN				29,595	29,595	4
5	V	17	DANIEL WEISS				4,110	4,110	5
6	V	19	ACCOUNTING FEES				103	103	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$ 122,592	$ * 122,592	14

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

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

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	17	MANAGEMENT FEE	$ 29,595	EMI ENTERPRISES		$	$ (29,595)	15
16	V	6	DRIVERS SALARIES				3,341	3,341	16
17	V	17	OFFICER SALARY				16,100	16,100	17
18	V	17	REGIONAL DIRECTOR				495	495	18
19	V	17	MGT CONSULTANT				16,100	16,100	19
20	V	19	ACCOUNTING FEES				535	535	20
21	V	21	OFFICE /CLERICAL				7,195	7,195	21
22	V	25	TRANSPORTATION				194	194	22
23	V	26	INSURANCE				1,060	1,060	23
24	V	27	EMPLOYEE BENEFITS				7,779	7,779	24
25	V	35	AUTO LEASE				448	448	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 29,595			$ 53,247	$ * 23,652	39

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

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

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	21	OUTSIDE CLERICAL	$ 35,000	EKS MANAGEMENT INC		$	$ (35,000)	15
16	V	6	PAINTERS SALARIES				3,214	3,214	16
17	V	7	SCAVENGER				80	80	17
18	V	17	CFO - SALARY				9,493	9,493	18
19	V	19	PROFESSIONAL FEES				7,264	7,264	19
20	V	20	WANT ADS / BACK GRD CKS				2,890	2,890	20
21	V	21	OFFICE / CLERICAL				31,175	31,175	21
22	V	23	SEMINARS				9	9	22
23	V	25	TRANSPORTATION				1,099	1,099	23
24	V	26	INSURANCE				206	206	24
25	V	27	EMPLOYEE BENEFITS				4,967	4,967	25
26	V	30	SL DEPRECIATION				127	127	26
27	V	35	EQUIPMENT RENT				3,042	3,042	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 35,000			$ 63,566	$ * 28,566	39

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

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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

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

VII. RELATED PARTIES (continued)

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

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

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

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

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

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	EMI ENTERPRISES	PATIENT DAYS	510,807	10	$ 216,000	$	69,987	$ 29,595	1
2	17	PHILIP ESFORMES INC	PATIENT DAYS	510,807	10	432,000		69,987	59,189	2
3	17	MICHAEL ROSEN	PATIENT DAYS	510,807	10	216,000		69,987	29,595	3
4	17	DANIEL WEISS	PATIENT DAYS	510,807	10	30,000		69,987	4,110	4
5	19	ACCOUNTING FEES	PATIENT DAYS	510,807	10	750		69,987	103	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 894,750	$		$ 122,592	25

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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	6	DRIVERS SALARIES	PATIENT DAYS	847,662	14	$ 40,460	$ 40,460	69,987	$ 3,341	1
2	17	OFFICER SALARY	PATIENT DAYS	847,662	14	195,000	195,000	69,987	16,100	2
3	17	REGIONAL DIRECTOR	PATIENT DAYS	847,662	14	6,000	6,000	69,987	495	3
4	17	MGT CONSULTANT	PATIENT DAYS	847,662	14	195,000		69,987	16,100	4
5	19	ACCOUNTING FEES	PATIENT DAYS	847,662	14	6,480		69,987	535	5
6	21	OFFICE /CLERICAL	PATIENT DAYS	847,662	14	87,144	58,016	69,987	7,195	6
7	25	TRANSPORTATION	PATIENT DAYS	847,662	14	2,349		69,987	194	7
8	26	INSURANCE	PATIENT DAYS	847,662	14	12,837		69,987	1,060	8
9	27	EMPLOYEE BENEFITS	PATIENT DAYS	847,662	14	94,218		69,987	7,779	9
10	35	AUTO LEASE	PATIENT DAYS	847,662	14	5,423		69,987	448	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 644,911	$ 299,476		$ 53,247	25

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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	6	PAINTERS SALARIES	PATIENT DAYS	847,662	14	$ 38,929	$ 38,929	69,987	$ 3,214	1
2	7	SCAVENGER	PATIENT DAYS	847,662	14	971		69,987	80	2
3	17	CFO - SALARY	PATIENT DAYS	847,662	14	114,971	114,971	69,987	9,493	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	847,662	14	87,982	76,534	69,987	7,264	4
5	20	WANT ADS / BACK GRD CKS	PATIENT DAYS	847,662	14	35,000		69,987	2,890	5
6	21	OFFICE / CLERICAL	PATIENT DAYS	847,662	14	377,586	282,348	69,987	31,175	6
7	23	SEMINARS	PATIENT DAYS	847,662	14	115		69,987	9	7
8	25	TRANSPORTATION	PATIENT DAYS	847,662	14	13,315		69,987	1,099	8
9	26	INSURANCE	PATIENT DAYS	847,662	14	2,501		69,987	206	9
10	27	EMPLOYEE BENEFITS	PATIENT DAYS	847,662	14	60,163		69,987	4,967	10
11	30	SL DEPRECIATION	PATIENT DAYS	847,662	14	1,536		69,987	127	11
12	35	EQUIPMENT RENT	PATIENT DAYS	847,662	14	36,848		69,987	3,042	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 769,917	$ 512,782		$ 63,566	25

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

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

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

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

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 279,834	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 292,017	2
3. Under or (over) accrual (line 2 minus line 1).		$ 12,183	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 294,937	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 307,120	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	243,413	8
	2007	240,814	9
	2008	243,230	10
	2009	279,835	11
	2010	292,017	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2009 TAX BILL.

	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 SOUTHVIEW MANOR OPERATOR, LLC COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0048421

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

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

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

Enter the tax index number and real estate tax assessed for 2010 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	17-34-116-003-0000	NURSING HOME	$ 101,331.70	$ 101,331.70
2.	17-34-116-004-0000	NURSING HOME	$ 57,652.76	$ 57,652.76
3.	17-34-116-005-0000	NURSING HOME	$ 43,678.75	$ 43,678.75
4.	17-34-116-006-0000	NURSING HOME	$ 43,678.75	$ 43,678.75
5.	17-34-116-007-0000	NURSING HOME	$ 43,678.75	$ 43,678.75
6.	17-34-116-008-0000	NURSING HOME	$ 1,996.12	$ 1,996.12
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 292,016.83	$ 292,016.83

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 SOUTHVIEW MANOR OPERATOR, LLC # 0048421 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 91,960 B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

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

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

XI. OWNERSHIP COSTS (continued)

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

	1 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					$	$		$	$	$	4
5											5
6											6
7	RELATED PARTY HOME OFFICE				46,019						7
8											8
	Improvement Type**										
9	ELEVATOR REPAIR			2007	19,816	721	27.5	721		3,395	9
10	TELEPHONE SYSTEM			2007	13,100	476	27.5	476		2,360	10
11	WATER HEATER			2007	32,500	1,182	27.5	1,182		5,565	11
12											12
13	ROOF REPAIR			2008	14,800	538	27.5	538		1,861	13
14	60 TON CHILLER			2008	71,075	2,585	27.5	2,585		8,939	14
15	PUMP GASKETS, OIL TANK COOLERS			2008	9,115	331	27.5	331		1,062	15
16	OIL COOLERS, PUMP SEALS			2008	19,285	702	27.5	702		2,252	16
17	AWNING			2008	3,000	109	27.5	109		350	17
18	FENCE			2008	3,960	264	15	264		924	18
19											19
20	DRPAERIES			2009	26,336	2,528	5	5,267	2,739	13,168	20
21											21
22	ELEVATOR REPAIR			2010	8,820	321	27.5	321		495	22
23	PLUMBING			2010	4,800	175	27.5	175		241	23
24											24
25	DOORS			2011	3,800	109	27.5	109		109	25
26	MODERNIZATION OF ELEVATOR			2011	147,325	2,009	27.5	2,009		2,009	26
27	CHILLER			2011	3,845	64	27.5	64		64	27
28	FIRE SERCURITY SYSTEM			2011	22,920	104	27.5	104		104	28
29											29
30											30
31	PARKING LOT - LANDLORD GRANITE			2010	19,880						31
32	BEDROOM VINYL WINDOWS - LANDLORD GRANITE			2010	85,985						32
33	FLAT ROOF RESURFACING - LANDLORD GRANITE			2010	29,000						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 SOUTHVIEW MANOR OPERATOR, LLC # 0048421 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 585,381	$ 12,218		$ 14,957	$ 2,739	$ 42,898	70

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

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 60,531	$ 6,214	$ 6,054	$ (160)	10 YRS	$ 17,350	71
72	Current Year Purchases	11,244	11,244	562	(10,682)	10YRS	562	72
73	Fully Depreciated Assets							73
74	REALATED PARTY		127	127				74
75	TOTALS	$ 71,775	$ 17,585	$ 6,743	$ (10,842)		$ 17,912	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

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

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: GRANITE SOUTHVIEW LLC
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		200	11/01/06	$ 1,624,000	5.5	5	3
4	Additions							4
5								5
6								6
7	TOTAL		200		$ 1,624,000 **			7

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

9. Option to Buy: [ ] YES [ ] NO Terms: *

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	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO
16. Rental Amount for movable equipment: $ 32,155 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$ 27,109	17
18	SEE SCHEDULE ATTACHED				18
19					19
20					20
21	TOTAL		$	$ 27,109	21

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

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

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

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.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

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.

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

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	39-3	hrs	$		$ 271,129	$		$ 271,129	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			130			130	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			180,804			180,804	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				192,230		192,230	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): THERAPY, LAB					65,160			65,160	13
14	TOTAL			$		$ 517,223	$ 192,230		$ 709,453	14

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

STATE OF ILLINOIS

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

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2011 (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	$ 123,396	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (570,000))	3,773,040		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	122,932		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): real estate,ins.escrow	73,715		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,093,083	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	404,497		15
16	Equipment, at Historical Cost	71,775		16
17	Accumulated Depreciation (book methods)	(116,254)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	96,375		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): ADVANCE RENT	15,725		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 472,118	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,565,201	$	25

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

*(See instructions.)

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

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 893,227	1
2	Restatements (describe):		2
3	ROUNDING	2	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 893,229	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,196,588)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (2,196,588)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,303,359)	24 *

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

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

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

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

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

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

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

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

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

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	1,673	1,705	$ 68,244	$ 40.03	1
2	Assistant Director of Nursing	1,893	2,070	62,091	30.00	2
3	Registered Nurses	2,494	2,530	61,874	24.46	3
4	Licensed Practical Nurses	47,127	50,913	1,150,158	22.59	4
5	CNAs & Orderlies	80,109	86,002	845,896	9.84	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	787	809	9,498	11.74	8
9	Activity Director					9
10	Activity Assistants	12,393	13,272	131,519	9.91	10
11	Social Service Workers	18,019	19,021	316,763	16.65	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,843	24,542	260,233	10.60	15
16	Dishwashers					16
17	Maintenance Workers	7,636	8,260	123,715	14.98	17
18	Housekeepers	33,465	35,824	348,786	9.74	18
19	Laundry	5,408	6,019	59,242	9.84	19
20	Administrator	2,256	2,417	127,808	52.88	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	20,614	21,884	227,922	10.42	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,100	4,261	59,365	13.93	31
32	Other Health C: MDS	4,219	4,347	112,416	25.86	32
33	Other(specify) SECURITY	18,277	19,175	180,787	9.43	33
34	TOTAL (lines 1 - 33)	283,313	303,051	$ 4,146,317 *	$ 13.68	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 10,334	1-3	35
36	Medical Director	O	400	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	10,940	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	325	11-3	44
45	Social Service Consultant	E	3,820	12-3	45
46	Other(specify) PSYCHIATRIC	S	4,800	10-3	46
47	DENTAL		4,800	10-3	47
48					48
49	TOTAL (lines 35 - 48)		$ 35,419		49

C. CONTRACT NURSES

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

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
DEBBIE MASSEY	ADMINISTRATOR	0	$ 127,808
			0
			0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 127,808

B. Administrative - Other

Description	Amount
	$ 0
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
SEE SCHEDULE ATTACHED		123,275
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 123,275

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 98,900
Unemployment Compensation Insurance	80,358
FICA Taxes	315,472
Employee Health Insurance	265,752
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	3,568
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	0
CHICAGO HEAD TAX	7,193
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 771,243

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

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	0
Health Care Worker Background Check	0
(Indicate # of checks performed)	
Patient Background Checks 47	2,435
TRUST/FRANCHISE/CONTRIB/ETC	5,717
MARKETING/ADV/PROMO	3,267
LICENSES/DUES/SUBSCRIPTIONS	21,357
MGMT CO ALLOC	2,890
TRUST/FRANCHISE/CONTRIB/ETC	(5,717)
Less: Public Relations Expense	(0)
Non-allowable advertising	(3,267)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 26,682

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

**See instructions.

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

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	PAINT/DECORATING		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

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

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL LONG TERM CARE $14,297**

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

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ Line **10-2**

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

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **109,500**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name:

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

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.