FOR BHF USE

LL1

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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

I. IDPH License ID Number: 0050450

Facility Name: SOUTHPOINT NRSG & REHAB CTR

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

County: COOK

Telephone Number: 708 449-1900 **Fax #** 708 449-1500

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 1/1/15 to 12/31/15 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) Flora Reznik
(Title) CFO

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Daniel S. Gaafar, Partner
(Firm Name & Address) Bradley Associates, 201 S. Capitol Ave, Suite 700, Indianapolis, IN 46225
(Telephone) 317 237-5500 Fax # 317 235-5503

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**

Facility Name & ID Number SOUTHPOINT NRSG & REHAB CTR # 0050450 Report Period Beginning: 1/1/15 Ending: 12/31/15

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	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	60,862	585	5,046	66,493	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	60,862	585	5,046	66,493	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.90%

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 4,986

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: 12/31/15 Fiscal Year: 12/31/15

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

Facility Name & ID Number SOUTHPOINT NRSG & REHAB CTR # 0050450 Report Period Beginning: 1/1/15 Ending: 12/31/15

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	399,192		49,881	449,073		449,073	(1,567)	447,506			1
2	Food Purchase		322,476		322,476		322,476		322,476			2
3	Housekeeping	365,152	50,307		415,459		415,459		415,459			3
4	Laundry	78,966	46,522		125,488		125,488		125,488			4
5	Heat and Other Utilities			334,288	334,288		334,288	2,298	336,586			5
6	Maintenance	74,744	40,551	108,666	223,961		223,961	1,581	225,542			6
7	Other (specify):*											7
8	TOTAL General Services	918,054	459,856	492,835	1,870,745		1,870,745	2,312	1,873,057			8
	B. Health Care and Programs											
9	Medical Director			14,800	14,800		14,800		14,800			9
10	Nursing and Medical Records	4,420,994	477,242	(18,702)	4,879,534		4,879,534	2,430	4,881,964			10
10a	Therapy			913,446	913,446		913,446		913,446			10a
11	Activities	136,167	22,527		158,694		158,694		158,694			11
12	Social Services	84,218		3,450	87,668		87,668		87,668			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Pharmacy Consult			19,602	19,602		19,602		19,602			15
16	TOTAL Health Care and Programs	4,641,379	499,769	932,596	6,073,744		6,073,744	2,430	6,076,174			16
	C. General Administration											
17	Administrative	104,232			104,232		104,232		104,232			17
18	Directors Fees											18
19	Professional Services			774,408	774,408		774,408	(316,037)	458,371			19
20	Dues, Fees, Subscriptions & Promotions			14,998	14,998		14,998		14,998			20
21	Clerical & General Office Expenses	149,507	38,405	13,731	201,643		201,643	(136,137)	65,506			21
22	Employee Benefits & Payroll Taxes			1,222,672	1,222,672		1,222,672	31,181	1,253,853			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,221	3,221		3,221	1,937	5,158			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			1,161,781	1,161,781		1,161,781	133,091	1,294,872			26
27	Other (specify):*											27
28	TOTAL General Administration	253,739	38,405	3,190,811	3,482,955		3,482,955	(285,965)	3,196,990			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,813,172	998,030	4,616,242	11,427,444		11,427,444	(281,223)	11,146,221			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number SOUTHPOINT NRSG & REHAB CTR #0050450 Report Period Beginning: 1/1/15 Ending: 12/31/15

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			29,047	29,047		29,047	279,449	308,496			30
31	Amortization of Pre-Op. & Org.			1,351	1,351		1,351	1,099,752	1,101,103			31
32	Interest			214,786	214,786		214,786	656,572	871,358			32
33	Real Estate Taxes							428,365	428,365			33
34	Rent-Facility & Grounds			2,640,000	2,640,000		2,640,000	(2,634,241)	5,759			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* **Replacement tax**			1,911	1,911		1,911	(1,911)				36
37	**TOTAL Ownership**			2,887,095	2,887,095		2,887,095	(172,014)	2,715,081			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			21,740	21,740		21,740		21,740			38
39	Ancillary Service Centers		276,566		276,566		276,566		276,566			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			500,168	500,168		500,168		500,168			42
43	Other (specify):* **Bad Debt**			510,000	510,000		510,000	(510,000)				43
44	**TOTAL Special Cost Centers**		276,566	1,031,908	1,308,474		1,308,474	(510,000)	798,474			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,813,172	1,274,596	8,535,245	15,623,013		15,623,013	(963,237)	14,659,776			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 SOUTHPOINT NRSG & REHAB CTR # 0050450 Report Period Beginning: 1/1/15 Ending: 12/31/15

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 Reference	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	43,925	30		9
10	Interest and Other Investment Income	(4,391)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(15)	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	(292,745)	21		18
19	Entertainment				19
20	Contributions	(100)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(510,000)	43		24
25	Fund Raising, Advertising and Promotional	(4,046)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,911)	36		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(15,191)	21		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (784,474)		$	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)	(178,763)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (178,763)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (963,237)		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 **Page 5A**

SOUTHPOINT NRSG & REHAB CTR

ID# **0050450**

Report Period Beginning: **1/1/15**

Ending: **12/31/15**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous Income	$ (15,191)	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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**	(15,191)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SOUTHPOINT NRSG & REHAB CTR # 0050450 **Report Period Beginning:** 1/1/15 **Ending:** 12/31/15

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(15)	(1,552)	0	0	0	0	0	0	0	0	0	(1,567)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	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	2,298	0	0	0	0	0	0	0	0	0	2,298	5
6	Maintenance	0	1,581	0	0	0	0	0	0	0	0	0	1,581	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(15)	2,327	0	0	0	0	0	0	0	0	0	2,312	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	2,430	0	0	0	0	0	0	0	0	0	2,430	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	2,430	0	0	0	0	0	0	0	0	0	2,430	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(331,454)	15,417	0	0	0	0	0	0	0	0	(316,037)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(312,082)	175,945	0	0	0	0	0	0	0	0	0	(136,137)	21
22	Employee Benefits & Payroll Taxes	0	31,181	0	0	0	0	0	0	0	0	0	31,181	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,937	0	0	0	0	0	0	0	0	0	1,937	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	2,710	130,381	0	0	0	0	0	0	0	0	133,091	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(312,082)	(119,681)	145,798	0	0	0	0	0	0	0	0	(285,965)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(312,097)	(114,924)	145,798	0	0	0	0	0	0	0	0	(281,223)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SOUTHPOINT NRSG & REHAB CTR # 0050450 **Report Period Beginning:** 1/1/15 **Ending:** 12/31/15

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	43,925	0	235,524	0	0	0	0	0	0	0	0	279,449	30
31	Amortization of Pre-Op. & Org.	0	0	1,099,752	0	0	0	0	0	0	0	0	1,099,752	31
32	Interest	(4,391)	0	660,963	0	0	0	0	0	0	0	0	656,572	32
33	Real Estate Taxes	0	428,365	0	0	0	0	0	0	0	0	0	428,365	33
34	Rent-Facility & Grounds	0	5,759	(2,640,000)	0	0	0	0	0	0	0	0	(2,634,241)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(1,911)	0	0	0	0	0	0	0	0	0	0	(1,911)	36
37	TOTAL Ownership	37,623	434,124	(643,761)	0	0	0	0	0	0	0	0	(172,014)	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):*	(510,000)	0	0	0	0	0	0	0	0	0	0	(510,000)	43
44	TOTAL Special Cost Centers	(510,000)	0	0	0	0	0	0	0	0	0	0	(510,000)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(784,474)	319,200	(497,963)	0	0	0	0	0	0	0	0	(963,237)	45

Facility Name & ID Number SOUTHPOINT NRSG & REHAB CTR # 0050450 Report Period Beginning: 1/1/15 Ending: 12/31/15

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	29.615	Ambassador Nursing & Rehab Center	Chicago	Infinity Healthcare	Hillside	Management Co.
GELP	29.615	Belhaven Nursing & Rehab Center	Chicago			
A&F General Realty	10.070	City View Multicare Center	Cicero			
Atied Associates	30.000	Continental Nursing & Rehab Center	Chicago			
Ted Lerman	00.700	Forest View Rehab & Nursing Center	Itasca			
		Lakeview Nursing & Rehab Center	Chicago			
		Midway Neurological & Rehab Center	Bridgeview			

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	$ 11,175	Infinity Healthcare Management		$ 9,623	$ (1,552)	1
2	V	10	Nursing Wages	43,103	Infinity Healthcare Management		45,533	2,430	2
3	V	21	Office Wages		Infinity Healthcare Management		187,804	187,804	3
4	V	5	Utilities		Infinity Healthcare Management		2,298	2,298	4
5	V	6	Maintenance		Infinity Healthcare Management		1,581	1,581	5
6	V	19	Professional Services	332,443	Infinity Healthcare Management		989	(331,454)	6
7	V	21	Office Expense	28,117	Infinity Healthcare Management		16,258	(11,859)	7
8	V	22	Employee Benefit	3,457	Infinity Healthcare Management		34,638	31,181	8
9	V	24	Auto/Travel Expense	594	Infinity Healthcare Management		2,531	1,937	9
10	V	26	Insurance		Infinity Healthcare Management		2,710	2,710	10
11	V	33	Property Tax		Infinity Healthcare Management		3,985	3,985	11
12	V	34	Rent		Infinity Healthcare Management		5,759	5,759	12
13	V	33	Property Tax		Southpoint Realty		424,380	424,380	13
14	Total			$ 418,889			$ 738,089	$ * 319,200	14

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

Facility Name & ID Number SOUTHPOINT NRSG & REHAB CTR # 0050450 Report Period Beginning: 1/1/15 Ending: 12/31/15

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	Insurance	$	Southpoint Realty		$ 130,381	$ 130,381	15
16	V	32	Interest		Southpoint Realty		660,963	660,963	16
17	V	31	Amortization		Southpoint Realty		1,099,752	1,099,752	17
18	V	19	Professional Fees		Southpoint Realty		15,417	15,417	18
19	V	30	Depreciation		Southpoint Realty		235,524	235,524	19
20	V	34	Rent	2,640,000	Southpoint Realty			(2,640,000)	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 2,640,000			$ 2,142,037	$ * (497,963)	39

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

Facility Name & ID Number SOUTHPOINT NRSG & REHAB CTR # 0050450 Report Period Beginning: 1/1/15 Ending: 12/31/15

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			Momence Meadows Nursing & Rehab Ctr	Momence				1
2			Niles Nursing & Rehab Center	Niles				2
3			Oak Lawn Respiratory & Rehab Center	Oak Lawn				3
4			Parker Nursing & Rehab Center	Streator				4
5			Parkshore Estates Nursing & Rehab Ctr	Chicago				5
6			West Suburban Nursing & Rehab Center	Bloomingdale				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 SOUTHPOINT NRSG & REHAB CTR # 0050450 Report Period Beginning: 1/1/15 Ending: 12/31/15

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 NRSG & REHAB CTR # 0050450 Report Period Beginning: 1/1/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number SOUTHPOINT NRSG & REHAB CTR # 0050450 Report Period Beginning: 1/1/15 Ending: 12/31/15

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	HUD loan		X	mortgage	$75,294.00	6/1/14	$ 17,332,100	$ 16,991,199	6/1/49	3.8600	$ 660,963	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Capital One		X	working capital	none	8/31/14	26,000,000	1,772,824	8/31/18	various	145,320	6
7	Infinity Funding	X		working capital	various	various	847,450	847,450	various	various	69,466	7
8												8
9	TOTAL Facility Related				$75,294.00		$ 44,179,550	$ 19,611,473			$ 875,749	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 44,179,550	$ 19,611,473			$ 875,749	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 112,829 Line # 26

* 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 SOUTHPOINT NRSG & REHAB CTR # 0050450 **Report Period Beginning:** 1/1/15 **Ending:** 12/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 509,699	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.)		$ 391,269	2
3. Under or (over) accrual (line 2 minus line 1).		$ (118,430)	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 544,884	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.		$ 426,454	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	413,242	8
	2011	411,594	9
	2012	378,305	10
	2013	383,483	11
	2014	391,269	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SOUTHPOINT NRSG & REHAB CTR COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0050450

CONTACT PERSON REGARDING THIS REPORT 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 2014 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 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	25-05-423-001-0000	NURSING HOME	$ 2,239.49	$ 2,239.49
2.	25-05-423-002-0000	NURSING HOME	$ 2,547.84	$ 2,547.84
3.	25-05-423-003-0000	NURSING HOME	$ 2,953.18	$ 2,953.18
4.	25-05-423-004-0000	NURSING HOME	$ 3,185.09	$ 3,185.09
5.	25-05-423-005-0000	NURSING HOME	$ 10,839.26	$ 10,839.26
6.	25-05-423-006-0000	NURSING HOME	$ 48,032.92	$ 48,032.92
7.	25-05-423-007-0000	NURSING HOME	$ 57,753.56	$ 57,753.56
8.	25-05-423-008-0000	NURSING HOME	$ 145,643.25	$ 145,643.25
9.	25-05-423-009-0000	NURSING HOME	$ 118,074.07	$ 118,074.07
10.			$	$
		TOTALS	$ 391,268.66	$ 391,268.66

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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 NRSG & REHAB CTR # 0050450 Report Period Beginning: 1/1/15 Ending: 12/31/15

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. [ ] (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).

None

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

1. Total Amount Incurred: 16,534,084
2. Number of Years Over Which it is Being Amortized: 15
3. Current Period Amortization: 1,101,103
4. Dates Incurred: 4/1/09

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		85,244	2010	$ 500,000	1
2					2
3	TOTALS	85,244		$ 500,000	3

Facility Name & ID Number SOUTHPOINT NRSG & REHAB CTR # 0050450 Report Period Beginning: 1/1/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	228		2010		$ 6,400,000	$ 164,100	39	$ 164,100	$	$ 875,204	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Signs for Facility			2009	4,765	122	39	122		874	9
10	Signs for Facility			2009	4,765	122	39	122		854	10
11	New Flooring 1st and 2nd Floor			2009	40,859	1,048	39	1,048		6,986	11
12	New Flooring			2009	20,000	513	39	513		3,506	12
13	New Flooring			2009	20,000	513	39	513		3,420	13
14	TV Cabling			2009	1,500	38	39	38		263	14
15	Patch to the Field or Wall Flashings			2010	2,975	76	39	76		457	15
16	Patch to the Field or Wall Flashings			2010	2,975	76	39	76		457	16
17	Water Service Maint. And Insulation			2010	1,540	39	39	39		236	17
18	Leak Testing			2010	1,350	35	39	35		208	18
19	Misc. Construction Items Reclass from Repairs			2010	6,684	171	39	171		1,029	19
20	Water Heater Controller Replacement			2011	1,298	33	39	33		610	20
21	Removal of Closets, Eliminate Lights, Storage Room, etc.			2011	2,432	62	39	62		100	21
22	Cabinet Removal and Drywall Work			2011	3,960	102	39	102		166	22
23	Replacement Floors and Carpets			2011	2,480	64	39	64		311	23
24	Tile Work			2011	4,467	115	39	115		318	24
25	Pump - Harris Equip			2011	788	20	39	20		573	25
26	Removal of Old Carpet and Installation of New Carpet			2011	1,500	38	39	38		192	26
27	Installation of Cove Base in Office Areas			2011	246	6	39	6		31	27
28	Door Frame, Door Repairs, Hinge Replacement			2011	1,113	29	39	29		143	28
29	Patio Door Repairs, Hinge Replacement, Wall Work			2011	687	18	39	18		88	29
30	National Retrofitting Lights			2011	39,416	1,011	39	1,011		5,055	30
31	Heavy Duty Carpet and Spray Adhesive			2011	520	13	39	13		66	31
32	Reapaired and Sealcoated/Striped Driveway			2011	2,100	54	39	54		269	32
33	Kohlman Chutes			2011	1,549	40	39	40		199	33
34	New Power Supply			2012	4,038	104	39	104		415	34
35	Roof Repair and maintenance			2012	2,000	51	39	51		205	35
36	Kitchen Ceiling Tiles			2012	1,129	29	39	29		116	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 NRSG & REHAB CTR # 0050450 Report Period Beginning: 1/1/15 Ending: 12/31/15

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	Ceiling tiles	2012	$ 2,612	$ 67	39	$ 67	$	$ 268	37
38	Repair and replacement of pump and motor	2012	1,581	41	39	41		163	38
39	Capret Installation	2012	1,011	26	39	26		104	39
40	Concrete for patio	2012	1,850	47	39	47		189	40
41	Regrouting in Kitchen	2012	1,200	31	39	31		123	41
42	Compressor	2012	20,599	528	39	528		2,114	42
43	Crain Service operator	2012	700	18	39	18		72	43
44	Painting in kitchen	2012	1,900	49	39	49		195	44
45	Painting in dining room	2012	3,000	77	39	77		308	45
46	Installation of door	2012	2,751	71	39	71		283	46
47	Install drywall type sidewall heads	2013	2,318	59	39	59		148	47
48	paint / sand 1st floor	2013	3,090	79	39	79		198	48
49	Tpered ISO - re-roof	2013	9,785	251	39	251		627	49
50	Chller compressor	2013	42,500	1,090	39	1,090		2,726	50
51	install sidewalk	2013	2,950	76	39	76		189	51
52	sildwalk from slabs	2013	2,560	66	39	66		164	52
53	Replace door	2013	2,150	55	39	55		138	53
54	Cook blower - dishwasher	2013	2,092	54	39	54		134	54
55	Asphalt lot	2013	8,500	218	39	218		545	55
56	Handrails - 1st floor	2013	1,689	43	39	43		108	56
57	Flooring - 1st floor	2013	1,520	39	39	39		97	57
58	Exhaust Fans Throughout Building	2014	3,935	101	39	101		202	58
59	Repair Drywall and Paint Patient Room	2014	1,600	41	39	41		82	59
60	Install New Fire System	2014	6,688	171	39	171		342	60
61	Install New Sprinkler System	2014	8,715	223	39	223		446	61
62	Repair Leaks and Cooling Change Over	2014	5,854	150	39	150		300	62
63	Condenser & Welding Supplies	2014	3,932	101	39	101		202	63
64	Remove & Replace Ramp	2014	17,500	449	39	449		899	64
65	Repair Concrete and Remove Debris	2014	750	19	39	19		38	65
66	Replace Filter Dryer Cores	2014	1,916	49	39	49		98	66
67	Add Freon to Condenser and Change Core	2014	3,662	94	39	94		188	67
68	Repair Model # PL130B	2014	1,538	39	39	39		78	68
69	Repair Pump Assembly	2014	1,795	46	39	46		92	69
70	TOTAL (lines 4 thru 69)		$ 6,751,379	$ 173,110		$ 173,110	$	$ 914,211	70

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

Facility Name & ID Number SOUTHPOINT NRSG & REHAB CTR # 0050450 Report Period Beginning: 1/1/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 6,751,379	$ 173,110		$ 173,110	$	$ 914,211	1
2	Deliver & Install Washers	2014	9,000	231	39	231		462	2
3	Trap Two Valve Cover	2014	2,925	75	39	75		150	3
4	3rd Floor Elevator and Wanderer System	2015	2,842	73	39	73		73	4
5	Add Exterior Lighting	2015	4,114	105	39	105		105	5
6	Paint 9 Resident Rooms	2015	5,495	141	39	141		141	6
7	Heating/Cooling Expansion Tank	2015	8,500	218	39	218		218	7
8	Paint 10 Resident Rooms	2015	6,240	160	39	160		160	8
9	Repair and Repave Parking Lot	2015	35,000	897	39	897		897	9
10	Paint 2nd and 3rd Floor Activity Rooms	2015	2,974	76	39	76		76	10
11	Install Fire Alarm System	2015	6,726	172	39	172		172	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,835,195	$ 175,258		$ 175,258	$	$ 916,665	34

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

Facility Name & ID Number SOUTHPOINT NRSG & REHAB CTR # 0050450 Report Period Beginning: 1/1/15 Ending: 12/31/15

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	$ 978,552	$ 84,152	$ 126,914	$ 42,762	5	$ 852,058	71
72	Current Year Purchases	54,188	5,160	6,324	1,164	5	5,160	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,032,740	$ 89,312	$ 133,238	$ 43,926		$ 857,218	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)	$ 8,367,935	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 264,570	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 308,496	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 43,926	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,773,883	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 NRSG & REHAB CTR # 0050450 Report Period Beginning: 1/1/15 Ending: 12/31/15

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

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.	/2016	$
13.	/2017	$
14.	/2018	$

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.

Facility Name & ID Number SOUTHPOINT NRSG & REHAB CTR # 0050450 Report Period Beginning: 1/1/15 Ending: 12/31/15

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.

Facility Name & ID Number SOUTHPOINT NRSG & REHAB CTR # 0050450 Report Period Beginning: 1/1/15 Ending: 12/31/15

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A-3	hrs	$	5,664	$ 372,403	$	5,664	$ 372,403	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs		1,912	121,124		1,912	121,124	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3	hrs		6,921	396,420		6,921	396,420	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				253,115		253,115	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): X-Ray	39-2					11,558		11,558	12
13	Other (specify): Laboratory	39-2					11,893		11,893	13
14	TOTAL			$	14,497	$ 889,947	$ 276,566	14,497	$ 1,166,513	14

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

Facility Name & ID Number SOUTHPOINT NRSG & REHAB CTR # 0050450 Report Period Beginning: 1/1/15 Ending: 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/15 (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	$ (518,655)	$ 115,915	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	4,466,205	4,466,205	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	415,524	415,524	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):		282,192	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,363,074	$ 5,279,836	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	435,193	435,193	15
16	Equipment, at Historical Cost	532,740	1,032,740	16
17	Accumulated Depreciation (book methods)	(505,839)	(1,773,883)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	20,273	16,534,084	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(7,056)	(5,872,395)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):		355,382	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 475,311	$ 17,611,121	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,838,385	$ 22,890,957	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,936,779	$ 2,662,040	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	29,036	29,036	28
29	Short-Term Notes Payable		252,091	29
30	Accrued Salaries Payable	323,369	323,369	30
31	Accrued Taxes Payable (excluding real estate taxes)	60,229	60,229	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		54,655	33
34	Deferred Compensation	(1,709)	(1,709)	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Line of Credit	1,772,824	1,772,824	36
37	Due to Infinity	847,450	847,450	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,967,978	$ 5,999,985	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		16,739,108	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)**	$	$ 16,739,108	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,967,978	$ 22,739,093	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (129,593)	$ 151,864	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,838,385	$ 22,890,957	48

***(See instructions.)**

Facility Name & ID Number SOUTHPOINT NRSG & REHAB CTR # 0050450 Report Period Beginning: 1/1/15 Ending: 12/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 967,672	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 967,672	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(1,097,263)	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) **Minor Variance**	(2)	15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,097,265)	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)**	$ (129,593)	24	*

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

Facility Name & ID Number SOUTHPOINT NRSG & REHAB CTR # 0050450 Report Period Beginning: 1/1/15 Ending: 12/31/15

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 13,544,470	1
2	Discounts and Allowances for all Levels	(607)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 13,543,863	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	818,378	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 818,378	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	141,468	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,218	19
20	Radiology and X-Ray	400	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 144,086	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,232	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,232	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Miscellaneous Income	15,191	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 15,191	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 14,525,750	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,870,745	31
32	Health Care	6,073,744	32
33	General Administration	3,482,955	33
	B. Capital Expense		
34	Ownership	2,887,095	34
	C. Ancillary Expense		
35	Special Cost Centers	298,306	35
36	Provider Participation Fee	500,168	36
	D. Other Expenses (specify):		
37	Bad Debt	510,000	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 15,623,013	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,097,263)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,097,263)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 10,432,516	44
45	Private Pay - Net Inpatient Revenue	138,399	45
46	Medicare - Net Inpatient Revenue	1,480,362	46
47	Other-(specify)	1,492,586	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 13,543,863	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

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

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

Facility Name & ID Number SOUTHPOINT NRSG & REHAB CTR # 0050450 Report Period Beginning: 1/1/15 Ending: 12/31/15

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	1,934	2,084	$ 111,297	$ 53.41	1
2	Assistant Director of Nursing	8,425	9,257	300,865	32.50	2
3	Registered Nurses	24,510	28,414	874,064	30.76	3
4	Licensed Practical Nurses	47,723	54,682	1,345,881	24.61	4
5	CNAs & Orderlies	129,494	145,451	1,668,561	11.47	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	10,545	11,957	136,167	11.39	9
10	Activity Assistants					10
11	Social Service Workers	3,676	4,222	84,218	19.95	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	27,579	30,872	399,192	12.93	15
16	Dishwashers					16
17	Maintenance Workers	3,597	3,757	74,744	19.89	17
18	Housekeepers	26,522	30,335	365,152	12.04	18
19	Laundry	6,829	7,631	78,966	10.35	19
20	Administrator	1,949	1,995	104,232	52.25	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,158	14,071	209,657	14.90	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	3,594	3,991	60,176	15.08	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	308,535	348,719	$ 5,813,172 *	$ 16.67	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	319	$ 11,175	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	392	19,602	10-3	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	99	3,450	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	810	$ 34,227		49

C. CONTRACT NURSES

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

Facility Name & ID Number SOUTHPOINT NRSG & REHAB CTR # 0050450 Report Period Beginning: 1/1/15 Ending: 12/31/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
John Stare	Administrator		$ 104,232
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 104,232

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	$ 6,077
Johnson, Goldburg, & Brown	Accounting	2,500
Duane Morris LLP	Legal	2,795
Polsinelli PC	Legal	3,063
Meyer Magence	Legal	375
Myers Carden & Sax	Legal	39,150
Johnson & Bell	Legal	121,398
Lewis, Brisbois, Bisgaard, & Smith	Legal	236,571
Various	Legal	12,400
Infinity	Mgmt/Professional	350,079
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 774,408

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 180,570
Unemployment Compensation Insurance	266,070
FICA Taxes	437,890
Employee Health Insurance	282,984
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Uniform Expense	14,932
Pension Expense	65,386
Employee Expense	6,021
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,253,853

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	
IHCA	12,403
Department of Revenue	730
City of Chicago	1,450
Various	415
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,998

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
mileage	2,718
Seminar Expense	
seminars	2,440
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,158

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number SOUTHPOINT NRSG & REHAB CTR # 0050450 Report Period Beginning: 1/1/15 Ending: 12/31/15

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		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number SOUTHPOINT NRSG & REHAB CTR # 0050450 Report Period Beginning: 1/1/15 Ending: 12/31/15

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? **YES**
If YES, give association name and amount. **ILLINOIS COUNCIL 12,403**

(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. $ **63,280** 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. $ **500,168**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

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

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation. N/A
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **YES**
Attach invoices and a summary of services for all architect and appraisal fees.