FOR BHF USE

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2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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 Nursing & Rehabilitation Center

Address: 1010 West 95th Street (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 1/1/18 to 12/31/18 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) Paresh Vipani
(Title) CFO

Paid Preparer

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

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

Facility Name & ID Number Southpoint Nursing & Rehabilitation Center # 0050450 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	59,789	12	4,683	64,484	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	59,789	12	4,683	64,484	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.49%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve 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 2,008

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: 12/31/18 Fiscal Year: 12/31/18

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

Facility Name & ID Number Southpoint Nursing & Rehabilitation Center # 0050450 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	415,456	42,986	18,048	476,490		476,490		476,490			1
2	Food Purchase		336,927		336,927		336,927	1,866	338,793			2
3	Housekeeping	346,848	66,912		413,760		413,760	20	413,780			3
4	Laundry	113,467	52,505		165,972		165,972		165,972			4
5	Heat and Other Utilities			366,961	366,961		366,961	3,084	370,045			5
6	Maintenance	128,608	57,257	138,827	324,692		324,692	1,691	326,383			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,004,379	556,587	523,836	2,084,802		2,084,802	6,661	2,091,463			8
	B. Health Care and Programs											
9	Medical Director			55,400	55,400		55,400		55,400			9
10	Nursing and Medical Records	4,579,037	412,675	50,983	5,042,695		5,042,695	1,066	5,043,761			10
10a	Therapy			1,299,901	1,299,901		1,299,901		1,299,901			10a
11	Activities	170,253	21,321		191,574		191,574		191,574			11
12	Social Services	114,580		3,814	118,394		118,394		118,394			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* RX Consultant			17,946	17,946		17,946	(418)	17,528			15
16	**TOTAL Health Care and Programs**	4,863,870	433,996	1,428,044	6,725,910		6,725,910	648	6,726,558			16
	C. General Administration											
17	Administrative	134,251			134,251		134,251		134,251			17
18	Directors Fees											18
19	Professional Services			898,343	898,343		898,343	(459,504)	438,839			19
20	Dues, Fees, Subscriptions & Promotions			7,768	7,768		7,768	(89)	7,679			20
21	Clerical & General Office Expenses	193,390	76,306	296,838	566,534		566,534	166,883	733,417			21
22	Employee Benefits & Payroll Taxes			1,193,104	1,193,104		1,193,104	48,302	1,241,406			22
23	Inservice Training & Education											23
24	Travel and Seminar			14,192	14,192		14,192	(1,817)	12,375			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			1,062,458	1,062,458		1,062,458	126,846	1,189,304			26
27	Other (specify):*											27
28	**TOTAL General Administration**	327,641	76,306	3,472,703	3,876,650		3,876,650	(119,379)	3,757,271			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	6,195,890	1,066,889	5,424,583	12,687,362		12,687,362	(112,070)	12,575,292			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 Nursing & Rehabilitation Center #0050450 Report Period Beginning: 1/1/18 Ending: 12/31/18

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			55,700	55,700		55,700	363,358	419,058			30
31	Amortization of Pre-Op. & Org.			1,356	1,356		1,356	1,099,748	1,101,104			31
32	Interest			933,270	933,270		933,270	620,348	1,553,618			32
33	Real Estate Taxes							468,777	468,777			33
34	Rent-Facility & Grounds			2,640,000	2,640,000		2,640,000	(2,633,896)	6,104			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			3,630,326	3,630,326		3,630,326	(81,665)	3,548,661			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			15,493	15,493		15,493		15,493			38
39	Ancillary Service Centers		102,221		102,221		102,221	(2,027)	100,194			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			503,234	503,234		503,234		503,234			42
43	Other (specify):* Bad Debt Expense			181,686	181,686		181,686	(181,686)				43
44	TOTAL Special Cost Centers		102,221	700,413	802,634		802,634	(183,713)	618,921			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,195,890	1,169,110	9,755,322	17,120,322		17,120,322	(377,448)	16,742,874			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 Nursing & Rehabilitation Center # 0050450 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	199,258	30		9
10	Interest and Other Investment Income	(16,218)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(181,686)	43		24
25	Fund Raising, Advertising and Promotional	(17,059)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(6,174)	various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (21,879)		$	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)	(355,569)	various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (355,569)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (377,448)		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					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

Southpoint Nursing & Rehabilitation Center

ID# 0050450

Report Period Beginning: 1/1/18

Ending: 12/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Misc Income	$ (176)	10	1
2	Misc Income	(1,140)	21	2
3	Vending Income	(2,120)	21	3
4	PAC Expense	(182)	20	4
5	RP Profit	(111)	10	5
6	RP Profit	(418)	15	6
7	RP Profit	(2,027)	39	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**	(6,174)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Southpoint Nursing & Rehabilitation Center # 0050450 Report Period Beginning: 1/1/18 Ending: 12/31/18

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	1,866	0	0	0	0	0	0	0	0	0	1,866	2
3	Housekeeping	0	20	0	0	0	0	0	0	0	0	0	20	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	3,084	0	0	0	0	0	0	0	0	0	3,084	5
6	Maintenance	0	1,691	0	0	0	0	0	0	0	0	0	1,691	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	6,661	0	0	0	0	0	0	0	0	0	6,661	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	(287)	1,353	0	0	0	0	0	0	0	0	0	1,066	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):*	(418)	0	0	0	0	0	0	0	0	0	0	(418)	15
16	TOTAL Health Care and Programs	(705)	1,353	0	0	0	0	0	0	0	0	0	648	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	(529,704)	70,200	0	0	0	0	0	0	0	0	(459,504)	19
20	Fees, Subscriptions & Promotions	(182)	93	0	0	0	0	0	0	0	0	0	(89)	20
21	Clerical & General Office Expenses	(20,319)	186,974	228	0	0	0	0	0	0	0	0	166,883	21
22	Employee Benefits & Payroll Taxes	0	48,302	0	0	0	0	0	0	0	0	0	48,302	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	(1,817)	0	0	0	0	0	0	0	0	0	(1,817)	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	1,645	125,201	0	0	0	0	0	0	0	0	126,846	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(20,501)	(294,507)	195,629	0	0	0	0	0	0	0	0	(119,379)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(21,206)	(286,493)	195,629	0	0	0	0	0	0	0	0	(112,070)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Southpoint Nursing & Rehabilitation Center # 0050450 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	199,258	0	164,100	0	0	0	0	0	0	0	0	363,358	30
31	Amortization of Pre-Op. & Org.	0	0	1,099,748	0	0	0	0	0	0	0	0	1,099,748	31
32	Interest	(16,218)	0	636,566	0	0	0	0	0	0	0	0	620,348	32
33	Real Estate Taxes	0	0	468,777	0	0	0	0	0	0	0	0	468,777	33
34	Rent-Facility & Grounds	0	0	(2,633,896)	0	0	0	0	0	0	0	0	(2,633,896)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	183,040	0	(264,705)	0	0	0	0	0	0	0	0	(81,665)	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	(2,027)	0	0	0	0	0	0	0	0	0	0	(2,027)	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):*	(181,686)	0	0	0	0	0	0	0	0	0	0	(181,686)	43
44	TOTAL Special Cost Centers	(183,713)	0	0	0	0	0	0	0	0	0	0	(183,713)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(21,879)	(286,493)	(69,076)	0	0	0	0	0	0	0	0	(377,448)	45

Facility Name & ID Number Southpoint Nursing & Rehabilitation Center # 0050450 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	Mgmt Co
GELP	29.615%	Belhaven Nursing & Rehab Center	Chicago	Southpoint Realty		Property Co
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	$	Infinity Healthcare Management		$	$	1
2	V	2	Food Purchase		Infinity Healthcare Management		1,866	1,866	2
3	V	3	Housekeeping		Infinity Healthcare Management		20	20	3
4	V	5	Utilities		Infinity Healthcare Management		3,084	3,084	4
5	V	6	Maintenance		Infinity Healthcare Management		1,691	1,691	5
6	V	10	Nursing	55,930	Infinity Healthcare Management		57,283	1,353	6
7	V	11	Activities		Infinity Healthcare Management				7
8	V	19	Professional Fees	532,317	Infinity Healthcare Management		2,613	(529,704)	8
9	V	20	Dues, Fees, Subs & Promotions	88	Infinity Healthcare Management		181	93	9
10	V	21	Clerical & Office Expense	132,623	Infinity Healthcare Management		319,597	186,974	10
11	V	22	Employee Benefits	348	Infinity Healthcare Management		48,650	48,302	11
12	V	24	Travel & Seminar	7,603	Infinity Healthcare Management		5,786	(1,817)	12
13	V	26	Insurance		Infinity Healthcare Management		1,645	1,645	13
14	Total			$ 728,909			$ 442,416	$ * (286,493)	14

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

Facility Name & ID Number Southpoint Nursing & Rehabilitation Center # 0050450 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	30	Depreciation	$	Infinity Healthcare Management		$	$	15
16	V	32	Interest		Infinity Healthcare Management		5,333	5,333	16
17	V	34	Rent		Infinity Healthcare Management		6,104	6,104	17
18	V								18
19	V	19	Professional Fees		Southpoint Realty		70,200	70,200	19
20	V	21	Office Expense		Southpoint Realty		228	228	20
21	V	26	Insurance		Southpoint Realty		125,201	125,201	21
22	V	30	Depreciation		Southpoint Realty		164,100	164,100	22
23	V	31	Amortization		Southpoint Realty		1,099,748	1,099,748	23
24	V	32	Interest		Southpoint Realty		631,233	631,233	24
25	V	33	Property Tax		Southpoint Realty		468,777	468,777	25
26	V	34	Rent	2,640,000	Southpoint Realty			(2,640,000)	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			$ 2,570,924	$ * (69,076)	39

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

Facility Name & ID Number Southpoint Nursing & Rehabilitation Center # 0050450 Report Period Beginning: 1/1/18 Ending: 12/31/18

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			Parshore Estates Nursing & Rehac Ctr	Chicago				5
6			West Suburban Nursing & Rehab Center	Bloomingdale				6
7			Landmark of Des Plaines Rehab Center	Des Plaines				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 Nursing & Rehabilitation Center # 0050450 Report Period Beginning: 1/1/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Southpoint Nursing & Rehabilitation Center # 0050450 Report Period Beginning: 1/1/18 Ending: 12/31/18

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 Nursing & Rehabilitation Center # 0050450 Report Period Beginning: 1/1/18 Ending: 12/31/18

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	HUD Loan		X	Mortgage	$75,249.00	6/1/14	$ 17,332,100	$ 16,204,824	6/1/49	3.8600	$ 631,233	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Capital One		X	Working Capital	None	8/31/14	26,000,000	10,520,288	8/31/19	3.9800	181,869	6
7	Infinity Funding	X		Working Capital	various	various	various		various	various	756,734	7
8												8
9	TOTAL Facility Related				$75,249.00		$ 43,332,100	$ 26,725,112			$ 1,569,836	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 43,332,100	$ 26,725,112			$ 1,569,836	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 108,592 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 Nursing & Rehabilitation Center # 0050450 Report Period Beginning: 1/1/18 Ending: 12/31/18

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	476,984	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.)	$	534,513	2
3. Under or (over) accrual (line 2 minus line 1).	$	57,529	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	$	411,248	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.	$	468,777	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2013	383,483	8
2014	391,269	9
2015	455,122	10
2016	497,403	11
2017	534,513	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Southpoint Nursing & Rehabilitation Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0050450

CONTACT PERSON REGARDING THIS REPORT Daniel S. Gaafar

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

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	25-05-423-001-0000	Nursing Facility	$ 2,631.42	$ 2,631.42
2.	25-05-423-002-0000	Nursing Facility	$ 2,993.41	$ 2,993.41
3.	25-05-423-003-0000	Nursing Facility	$ 3,485.75	$ 3,485.75
4.	25-05-423-004-0000	Nursing Facility	$ 3,742.07	$ 3,742.07
5.	25-05-423-005-0000	Nursing Facility	$ 14,278.33	$ 14,278.33
6.	25-05-423-006-0000	Nursing Facility	$ 65,725.73	$ 65,725.73
7.	25-05-423-007-0000	Nursing Facility	$ 79,119.73	$ 79,119.73
8.	25-05-423-008-0000	Nursing Facility	$ 200,779.60	$ 200,779.60
9.	25-05-423-009-0000	Nursing Facility	$ 161,756.74	$ 161,756.74
10.			$	$
		TOTALS	$ 534,512.78	$ 534,512.78

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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

Facility Name & ID Number Southpoint Nursing & Rehabilitation Center # 0050450 Report Period Beginning: 1/1/18 Ending: 12/31/18

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

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

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [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: 16
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	Land	85,244	2010	$ 500,000	1
2					2
3	TOTALS	85,244		$ 500,000	3

Facility Name & ID Number Southpoint Nursing & Rehabilitation Center # 0050450 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	$ 164,106	39	$ 164,103	$ (3)	$ 1,367,510	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Signs for Facility			2009	4,765	122	39	122		1,241	9
10	Signs for Facility			2009	4,765	122	39	122		1,221	10
11	New Flooring 1st and 2nd Floor			2009	40,859	1,048	39	1,048		10,131	11
12	New Flooring			2009	20,000	513	39	513		5,046	12
13	New Flooring			2009	20,000	513	39	513		4,960	13
14	TV Cabling			2009	1,500	38	39	38		378	14
15	Patch to the Field or Wall Flashings			2010	2,975	76	39	76		686	15
16	Patch to the Field or Wall Flashings			2010	2,975	76	39	76		686	16
17	Water Service Maint. And Insulation			2010	1,540	39	39	39		354	17
18	Leak Testing			2010	1,350	35	39	35		313	18
19	Misc. Construction Items Reclass from Repairs			2010	6,684	171	39	171		1,541	19
20	Water Heater Controller Replacement			2011	1,298	33	39	33		916	20
21	Removal of Closets, Eliminate Lights, Storage Room, etc.			2011	2,432	62	39	62		160	21
22	Cabinet Removal and Drywall Work			2011	3,960	102	39	102		265	22
23	Replacement Floors and Carpets			2011	2,480	64	39	64		497	23
24	Tile Work			2011	4,467	115	39	115		510	24
25	Pump - Harris Equip			2011	788	20	39	20		918	25
26	Removal of Old Carpet and Installation of New Carpet			2011	1,500	38	39	38		306	26
27	Installation of Cove Base in Office Areas			2011	246	6	39	6		49	27
28	Door Frame, Door Repairs, Hinge Replacement			2011	1,113	29	39	29		230	28
29	Patio Door Repairs, Hinge Replacement, Wall Work			2011	687	18	39	18		142	29
30	National Retrofitting Lights			2011	39,416	1,011	39	1,011		8,089	30
31	Heavy Duty Carpet and Spray Adhesive			2011	520	13	39	13		105	31
32	Reapaired and Sealcoated/Striped Driveway			2011	2,100	54	39	54		431	32
33	Kohlman Chutes			2011	1,549	40	39	40		319	33
34	New Power Supply			2012	4,038	104	39	104		727	34
35	Roof Repair and maintenance			2012	2,000	51	39	51		358	35
36	Kitchen Ceiling Tiles			2012	1,129	29	39	29		203	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Southpoint Nursing & Rehabilitation Center # 0050450 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	$	$ 469	37
38	Repair and replacement of pump and motor	2012	1,581	41	39	41		286	38
39	Capret Installation	2012	1,011	26	39	26		182	39
40	Concrete for patio	2012	1,850	47	39	47		330	40
41	Regrouting in Kitchen	2012	1,200	31	39	31		216	41
42	Compressor	2012	20,599	528	39	528		3,692	42
43	Crain Service operator	2012	700	18	39	18		126	43
44	Painting in kitchen	2012	1,900	49	39	49		342	44
45	Painting in dining room	2012	3,000	77	39	77		539	45
46	Installation of door	2012	2,751	71	39	71		496	46
47	Install drywall type sidewall heads	2013	2,318	59	39	59		325	47
48	paint / sand 1st floor	2013	3,090	79	39	79		435	48
49	Tpered ISO - re-roof	2013	9,785	251	39	251		1,380	49
50	Chller compressor	2013	42,500	1,090	39	1,090		5,995	50
51	install sidewalk	2013	2,950	76	39	76		417	51
52	sildwalk from slabs	2013	2,560	66	39	66		362	52
53	Replace door	2013	2,150	55	39	55		303	53
54	Cook blower - dishwasher	2013	2,092	54	39	54		296	54
55	Asphalt lot	2013	8,500	218	39	218		1,201	55
56	Handrails - 1st floor	2013	1,689	43	39	43		237	56
57	Flooring - 1st floor	2013	1,520	39	39	39		214	57
58	Exhaust Fans Throughout Building	2014	3,935	101	39	101		505	58
59	Repair Drywall and Paint Patient Room	2014	1,600	41	39	41		205	59
60	Install New Fire System	2014	6,688	171	39	171		855	60
61	Install New Sprinkler System	2014	8,715	223	39	223		1,115	61
62	Repair Leaks and Cooling Change Over	2014	5,854	150	39	150		750	62
63	Condenser & Welding Supplies	2014	3,932	101	39	101		505	63
64	Remove & Replace Ramp	2014	17,500	449	39	449		2,245	64
65	Repair Concrete and Remove Debris	2014	750	19	39	19		95	65
66	Replace Filter Dryer Cores	2014	1,916	49	39	49		245	66
67	Add Freon to Condenser and Change Core	2014	3,662	94	39	94		470	67
68	Repair Model # PL130B	2014	1,538	39	39	39		195	68
69	Repair Pump Assembly	2014	1,795	46	39	46		230	69
70	TOTAL (lines 4 thru 69)		$ 6,751,379	$ 173,116		$ 173,113	$ (3)	$ 1,433,550	70

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

Facility Name & ID Number Southpoint Nursing & Rehabilitation Center # 0050450 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	$ 173,116		$ 173,113	$ (3)	$ 1,433,550	1
2	Deliver & Install Washers	2014	9,000	231	39	231		1,155	2
3	Trap Two Valve Cover	2014	2,925	75	39	75		375	3
4	3rd Floor Elevator and Wanderer System	2015	2,842	73	39	73		292	4
5	Add Exterior Lighting	2015	4,114	105	39	105		420	5
6	Paint 9 Resident Rooms	2015	5,495	141	39	141		564	6
7	Heating/Cooling Expansion Tank	2015	8,500	218	39	218		872	7
8	Paint 10 Resident Rooms	2015	6,240	160	39	160		640	8
9	Repair and Repave Parking Lot	2015	35,000	897	39	897		3,588	9
10	Paint 2nd and 3rd Floor Activity Rooms	2015	2,974	76	39	76		304	10
11	Install Fire Alarm System	2015	6,726	172	39	172		688	11
12	Main Entrance Door	2016	2,995	77	39	77		231	12
13	New Compressor for Freezer	2016	5,700	146	39	146		438	13
14	Sprinkler pip replacement	2016	3,578	92	39	92		276	14
15	Repair & Configure Fire Pump Controller	2016	3,375	87	39	87		261	15
16	Redo Ceiling in Oxygen Room	2016	3,284	84	39	84		252	16
17	Laundry Room Exhaust Fan	2016	3,377	87	39	87		261	17
18	Rooftop Exhaust Fan	2016	3,865	99	39	99		297	18
19	Replace Laundry Room Motor Starter	2016	3,550	91	39	91		273	19
20	Replace 2 Norton Electromechanical Closers	2016	3,894	100	39	100		300	20
21	2 Fire Dampers in Oxygen Room	2016	3,175	81	39	81		243	21
22	Lobby Renovations	2016	3,384	87	39	87		261	22
23	New Door	2016	1,459	37	39	37		111	23
24	Paint Therapy Room	2017	3,072	79	39	79		118	24
25	Kitchen Air Handler Coil Replacement	2017	13,225	339	39	339		509	25
26	225 Ton Carrier Chiller	2017	172,000	4,410	39	4,410		6,615	26
27	Front Entrance Interior Door	2017	4,298	110	39	110		165	27
28	2 Top Latches on Fire Door	2017	3,041	78	39	78		117	28
29	Repairs to Rear Door	2017	2,708	69	39	69		104	29
30	Repair & Rebuild Pump	2017	4,299	110	39	110		165	30
31	Dining Room Pedestrian Door	2017	3,663	94	39	94		141	31
32	Paint Rooms 127,125,104,100,103,101,105 & Exam Room	2017	4,663	120	39	120		180	32
33	Custom Made Blinds	2017	2,965	76	39	76		114	33
34	TOTAL (lines 1 thru 33)		$ 7,090,764	$ 181,817		$ 181,814	$ (3)	$ 1,453,880	34

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

Facility Name & ID Number Southpoint Nursing & Rehabilitation Center # 0050450 Report Period Beginning: 1/1/18 Ending: 12/31/18

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 12B, Carried Forward		$ 7,090,764	$ 181,817		$ 181,814	$ (3)	$ 1,453,880	1
2	Fire-Rated Access Panels and Sub Floor for Oxygen Room	2017	3,531	91	39	91		136	2
3	Replace Main Exhaust for Three Water Boilers	2017	4,445	114	39	114		171	3
4	New Doors for Rooms 126,223,224,231,208,206 Oxygen Room & K	2017	2,918	75	39	75		112	4
5	Replace Sidewalk in Back of Building,Replace a Section of Drivew	2017	2,500	64	39	64		96	5
6	Surveillance cameras for 1st-3rd floor & basement	2018	2,760	35	39	35		35	6
7	Paint lobby, 1st and 2nd floor main dining rooms	2018	3,627	46	39	46		46	7
8	New sewage ejector pump (1st payment)	2018	5,743	74	39	74		74	8
9	New contactor and overloads for ejector pump	2018	2,045	26	39	26		26	9
10	New sewage ejector pump (2nd payment)	2018	6,248	80	39	80		80	10
11	Installation of rental pump for ejector system	2018	1,719	22	39	22		22	11
12	Laundry exhaust fan	2018	4,650	60	39	60		60	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)		$ 7,130,949	$ 182,504		$ 182,501	$ (3)	$ 1,454,738	34

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

Facility Name & ID Number Southpoint Nursing & Rehabilitation Center # 0050450 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	$ 671,121	$ 34,069	$ 134,224	$ 100,155	5	$ 587,950	71
72	Current Year Purchases	33,112	3,227	6,622	3,395	5	3,227	72
73	Fully Depreciated Assets	478,552		95,710	95,710	5	478,552	73
74								74
75	TOTALS	$ 1,182,785	$ 37,296	$ 236,557	$ 199,261		$ 1,069,729	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)	$ 8,813,734	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 219,800	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 419,058	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 199,258	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,524,467	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Southpoint Nursing & Rehabilitation Center # 0050450 Report Period Beginning: 1/1/18 Ending: 12/31/18

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.	/2019	$
13.	/2020	$
14.	/2021	$

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 Nursing & Rehabilitation Center # 0050450 Report Period Beginning: 1/1/18 Ending: 12/31/18

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 Nursing & Rehabilitation Center # 0050450 Report Period Beginning: 1/1/18 Ending: 12/31/18

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-3	hrs	$	9,952	$ 602,922	$	9,952	$ 602,922	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		2,443	170,109		2,443	170,109	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		8,219	526,870		8,219	526,870	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				95,566		95,566	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): X-Ray	39-2					6,655		6,655	12
13	Other (specify): Laboratory	39-2					0			13
14	TOTAL			$	20,614	$ 1,299,901	$ 102,221	20,614	$ 1,402,122	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 Southpoint Nursing & Rehabilitation Center # 0050450 Report Period Beginning: 1/1/18 Ending: 12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/18 (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	$ (468,101)	$ 138,187	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	4,881,310	4,881,310	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	710,202	710,202	6
7	Other Prepaid Expenses	195,823	195,823	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Escrow Accounts		223,556	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,319,234	$ 6,149,078	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	735,599	735,599	15
16	Equipment, at Historical Cost	682,785	1,182,785	16
17	Accumulated Depreciation (book methods)	(656,957)	(2,524,467)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	67,848	16,581,659	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(11,169)	(9,175,752)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Replacement reserves		397,897	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 818,106	$ 14,097,721	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,137,340	$ 20,246,799	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 530,729	$ 1,248,689	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	114,654	114,654	28
29	Short-Term Notes Payable		272,289	29
30	Accrued Salaries Payable	421,609	421,609	30
31	Accrued Taxes Payable (excluding real estate taxes)	45,133	45,133	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		53,001	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Line of Credit	10,520,288	10,520,288	36
37	Infinity Funding	(27,169)	(27,169)	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 11,605,244	$ 12,648,494	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		15,932,535	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)**	$	$ 15,932,535	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 11,605,244	$ 28,581,029	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (5,467,904)	$ (8,334,230)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,137,340	$ 20,246,799	48

*(See instructions.)

Facility Name & ID Number Southpoint Nursing & Rehabilitation Center # 0050450 Report Period Beginning: 1/1/18 Ending: 12/31/18

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,970,089)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,970,089)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,497,816)	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) **Rounding**	1	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (2,497,815)	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)**	$ (5,467,904)	24 *

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

Facility Name & ID Number Southpoint Nursing & Rehabilitation Center # 0050450 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	$ 13,261,995	1
2	Discounts and Allowances for all Levels	781,973	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 14,043,968	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	501,397	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 501,397	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	49,977	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,797	19
20	Radiology and X-Ray	2,780	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 55,554	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	16,218	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 16,218	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a	Miscellaneous Revenue	5,369	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 5,369	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 14,622,506	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,084,802	31
32	Health Care	6,725,910	32
33	General Administration	3,876,650	33
	B. Capital Expense		
34	Ownership	3,630,326	34
	C. Ancillary Expense		
35	Special Cost Centers	102,221	35
36	Provider Participation Fee	503,234	36
	D. Other Expenses (specify):		
37	Medicall Necessary Transportation	15,493	37
38	Bad Debt Expense	181,686	38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 17,120,322	40
41	**Income before Income Taxes (line 30 minus line 40)****	(2,497,816)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (2,497,816)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 11,908,229	44
45	Private Pay - Net Inpatient Revenue	2,580	45
46	Medicare - Net Inpatient Revenue	1,192,686	46
47	Other-(specify)	940,473	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 14,043,968	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 Nursing & Rehabilitation Center # 0050450 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	2,177	2,294	$ 144,190	$ 62.86	1
2	Assistant Director of Nursing	7,089	7,803	287,683	36.87	2
3	Registered Nurses	8,681	9,555	353,688	37.02	3
4	Licensed Practical Nurses	50,105	54,441	1,913,626	35.15	4
5	CNAs & Orderlies	111,988	124,964	1,745,931	13.97	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	11,251	12,563	170,253	13.55	9
10	Activity Assistants					10
11	Social Service Workers	5,950	6,412	114,580	17.87	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	25,074	27,898	415,456	14.89	15
16	Dishwashers					16
17	Maintenance Workers	6,961	7,618	128,608	16.88	17
18	Housekeepers	22,800	25,600	346,848	13.55	18
19	Laundry	7,890	8,900	113,467	12.75	19
20	Administrator	2,215	2,309	134,251	58.14	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,114	11,121	193,390	17.39	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	2,187	2,425	49,694	20.49	31
32	Other Health Care(specify)					32
33	Other(specify) Admissions	2,936	3,164	84,225	26.62	33
34	TOTAL (lines 1 - 33)	277,418	307,067	$ 6,195,890 *	$ 20.18	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	516	$ 18,048	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	1,457	50,983	10-3	38
39	Pharmacist Consultant	359	17,946	15-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	(510)	(25,500)	10a-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	84	2,940	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,906	$ 64,417		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 Nursing & Rehabilitation Center # 0050450 Report Period Beginning: 1/1/18 Ending: 12/31/18

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Monica Winkelman	Administrator		$ 21,949
John Stare	Administrator		112,302
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 134,251

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	$ 12,129
Lewis, Brisbois	Legal	(1,629)
Johnson & Bell	Legal	29,689
Medlegal Consultants	Legal	3,010
Segal, McCambridge	Legal	4,444
Infinity Funding/Sedgwick	Legal	312,244
MTS Consulting	Professional	(12,996)
Capital One	Professional	8,064
Infinity Healthcare	Professional/Mgmt	531,388
Empire Risk	Mgmt	12,000
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 898,343

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 380,323
Unemployment Compensation Insurance	(38,370)
FICA Taxes	484,236
Employee Health Insurance	327,911
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Uniform Expense	8,009
Employee Background Checks	362
Pension	68,048
Employee Expense	10,887
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,241,406

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	2,690
IDPH	1,647
Collaborative Healthcare	1,600
City of Chicago	1,200
Various	542
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,679

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Mileage	8,125
Auto Allowance	(1,817)
Seminar Expense	
Education & Seminars	6,067
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 12,375

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Southpoint Nursing & Rehabilitation Center # 0050450 Report Period Beginning: 1/1/18 Ending: 12/31/18

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 - $2,690**

(3) Did the nursing home make political contributions or payments to a politica
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? **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. $ **107,270** 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 fo
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 Departmen
during this cost report period. $ **503,324**
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 tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions.

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

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo
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 othe
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