		FOR BHF USE					

LL1

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

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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: Aaron Mauer **Telephone Number:** 773-747-4506
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 1/1/20 to 12/31/20 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) _____ 3/5/2021 (Date)
(Print Name and Title) Aaron Mauer, President
(Firm Name & Address) GGM Associates, Inc., 6101 Nimtz Parkway South Bend IN 46628
(Telephone) 773-747-4506 Fax # 773-747-4725

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: 1/1/20 Ending: 12/31/20

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 NA

	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	57,484	5	6,444	63,933	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	57,484	5	6,444	63,933	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.82%

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 5,540

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: 12/31/20 Fiscal Year: 12/31/20

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

Facility Name & ID Number Southpoint Nrsg & Rehab Ctr # 0050450 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	556,208	55,353	19,475	631,036		631,036		631,036			1
2	Food Purchase		448,098		448,098		448,098		448,098			2
3	Housekeeping	690,316	106,961		797,277		797,277		797,277			3
4	Laundry	92,354	58,988		151,342		151,342		151,342			4
5	Heat and Other Utilities			348,329	348,329		348,329	(2,568)	345,761			5
6	Maintenance	103,927	95,104	127,300	326,331		326,331	1,532	327,863			6
7	Other (specify):*											7
8	TOTAL General Services	1,442,805	764,504	495,104	2,702,413		2,702,413	(1,035)	2,701,378			8
	B. Health Care and Programs											
9	Medical Director			42,000	42,000		42,000		42,000			9
10	Nursing and Medical Records	5,187,142	420,740	114,407	5,722,289		5,722,289	(215,361)	5,506,928			10
10a	Therapy			1,411,260	1,411,260		1,411,260		1,411,260			10a
11	Activities	231,218	17,025		248,243		248,243		248,243			11
12	Social Services	178,168		5,339	183,507		183,507		183,507			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* RX Consultants			15,786	15,786		15,786	(381)	15,405			15
16	TOTAL Health Care and Programs	5,596,528	437,765	1,588,792	7,623,085		7,623,085	(215,742)	7,407,343			16
	C. General Administration											
17	Administrative	152,488		3,022	155,510		155,510	72,723	228,233			17
18	Directors Fees											18
19	Professional Services			1,047,462	1,047,462		1,047,462	52,808	1,100,270			19
20	Dues, Fees, Subscriptions & Promotions			1,740	1,740		1,740	115	1,855			20
21	Clerical & General Office Expenses	367,840	65,886	758,540	1,192,266		1,192,266	69,787	1,262,053			21
22	Employee Benefits & Payroll Taxes			1,237,824	1,237,824		1,237,824	53,767	1,291,591			22
23	Inservice Training & Education											23
24	Travel and Seminar			23,247	23,247		23,247	14,556	37,803			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			2,105,127	2,105,127		2,105,127	113,519	2,218,646			26
27	Other (specify):*											27
28	TOTAL General Administration	520,328	65,886	5,176,962	5,763,176		5,763,176	377,275	6,140,451			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,559,661	1,268,155	7,260,858	16,088,674		16,088,674	160,498	16,249,172			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: 1/1/20 Ending: 12/31/20

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			168,834	168,834		168,834	77,834	246,668			30
31	Amortization of Pre-Op. & Org.			14,929	14,929		14,929	1,099,748	1,114,677			31
32	Interest			2,177,420	2,177,420		2,177,420	515,240	2,692,660			32
33	Real Estate Taxes							361,040	361,040			33
34	Rent-Facility & Grounds			2,640,000	2,640,000		2,640,000	(2,633,493)	6,507			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			5,001,183	5,001,183		5,001,183	(579,631)	4,421,552			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			15,417	15,417		15,417		15,417			38
39	Ancillary Service Centers		115,206		115,206		115,206	(2,642)	112,564			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			476,989	476,989		476,989		476,989			42
43	Other (specify):*			300,419	300,419		300,419	(300,419)				43
44	**TOTAL Special Cost Centers**		115,206	792,825	908,031		908,031	(303,061)	604,970			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	7,559,661	1,383,361	13,054,866	21,997,888		21,997,888	(722,194)	21,275,694			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: 1/1/20 Ending: 12/31/20

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	(86,351)	30		9
10	Interest and Other Investment Income	(18,649)	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	(16,250)	21		18
19	Entertainment				19
20	Contributions	(2,280)	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	(300,419)	43		24
25	Fund Raising, Advertising and Promotional	(6,353)	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	(9,064)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (439,366)		$	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)			34
35	Other- Attach Schedule	(282,828)	Various	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (282,828)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (722,194)		37

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

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

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

Southpoint Nrsg & Rehab Ctr
ID# 0050450
Report Period Beginning: 1/1/20
Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	RP Profit	$ (302)	10	1
2	RP Profit	(381)	15	2
3	RP Profit	(2,642)	39	3
4	Misc Income - Vending Income	(5,259)	5	4
5	Misc Income - Med Records	(480)	10	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
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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**	(9,064)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Southpoint Nrsg & Rehab Ctr # 0050450 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	0	0	0	0	0	0	0	0	0	0	0	0	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	(5,259)	2,692	0	0	0	0	0	0	0	0	0	(2,568)	5
6	Maintenance	0	1,532	0	0	0	0	0	0	0	0	0	1,532	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(5,259)	4,224	0	0	0	0	0	0	0	0	0	(1,035)	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	(782)	(214,579)	0	0	0	0	0	0	0	0	0	(215,361)	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):*	(381)	0	0	0	0	0	0	0	0	0	0	(381)	15
16	**TOTAL Health Care and Programs**	(1,163)	(214,579)	0	0	0	0	0	0	0	0	0	(215,742)	16
	C. General Administration													
17	Administrative	0	72,723	0	0	0	0	0	0	0	0	0	72,723	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(44,159)	96,967	0	0	0	0	0	0	0	0	52,808	19
20	Fees, Subscriptions & Promotions	0	115	0	0	0	0	0	0	0	0	0	115	20
21	Clerical & General Office Expenses	(24,883)	94,670	0	0	0	0	0	0	0	0	0	69,787	21
22	Employee Benefits & Payroll Taxes	0	53,767	0	0	0	0	0	0	0	0	0	53,767	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	14,556	0	0	0	0	0	0	0	0	0	14,556	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	2,854	110,665	0	0	0	0	0	0	0	0	113,519	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(24,883)	194,526	207,632	0	0	0	0	0	0	0	0	377,275	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(31,305)	(15,829)	207,632	0	0	0	0	0	0	0	0	160,498	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Southpoint Nrsg & Rehab Ctr # 0050450 **Report Period Beginning:** 1/1/20 **Ending:** 12/31/20

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	(86,351)	85	164,100	0	0	0	0	0	0	0	0	77,834	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	(18,649)	7,167	526,722	0	0	0	0	0	0	0	0	515,240	32
33	Real Estate Taxes	0	0	361,040	0	0	0	0	0	0	0	0	361,040	33
34	Rent-Facility & Grounds	0	6,507	(2,640,000)	0	0	0	0	0	0	0	0	(2,633,493)	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	(105,000)	13,759	(488,390)	0	0	0	0	0	0	0	0	(579,631)	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	(2,642)	0	0	0	0	0	0	0	0	0	0	(2,642)	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):*	(300,419)	0	0	0	0	0	0	0	0	0	0	(300,419)	43
44	TOTAL Special Cost Centers	(303,061)	0	0	0	0	0	0	0	0	0	0	(303,061)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(439,366)	(2,070)	(280,758)	0	0	0	0	0	0	0	0	(722,194)	45

Facility Name & ID Number Southpoint Nrsg & Rehab Ctr # 0050450 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	Consulting Co.
GELP	29.615	Belhaven Nursing & Rehab Center	Chicago	Southpoint Realty		Realty Co.
A&F Realty, LLC	10.070	Citi View Multicare Center	Cicero	United Rx		Pharmacy Co.
Wissati Irrevocable Trust/Atied Associates LL	30.00	Continental Nursing & Rehab Center	Chicago			
Ted Lerman	00.700	Forest View Nursing & Rehab 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	5	Heat and Other Utilities	$	Infinity Healthcare Management of IL LLC		$ 2,692	$ 2,692	1
2	V	6	Maintenance		Infinity Healthcare Management of IL LLC		1,532	1,532	2
3	V	10	Nursing and Medical Records	293,182	Infinity Healthcare Management of IL LLC		78,603	(214,579)	3
4	V	17	Administrative	1,786	Infinity Healthcare Management of IL LLC		74,509	72,723	4
5	V	19	Professional Services	844,768	Infinity Healthcare Management of IL LLC		800,609	(44,159)	5
6	V	20	Dues, Fees, Subscriptions & Promotion	77	Infinity Healthcare Management of IL LLC		192	115	6
7	V	21	Clerical & General Office Expenses	180,204	Infinity Healthcare Management of IL LLC		274,874	94,670	7
8	V	22	Employee Benefits & Payroll Taxes		Infinity Healthcare Management of IL LLC		53,767	53,767	8
9	V	24	Travel and Seminar	3,899	Infinity Healthcare Management of IL LLC		18,455	14,556	9
10	V	26	Insurance-Prop.Liab.Malpractice		Infinity Healthcare Management of IL LLC		2,854	2,854	10
11	V	30	Depreciation		Infinity Healthcare Management of IL LLC		85	85	11
12	V	32	Interest		Infinity Healthcare Management of IL LLC		7,167	7,167	12
13	V	34	Rent-Facility & Grounds		Infinity Healthcare Management of IL LLC		6,507	6,507	13
14	Total			$ 1,323,916			$ 1,321,846	$ * (2,070)	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: 1/1/20 Ending: 12/31/20

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	34	Rent	$ 2,640,000	Southpoint Realty		$	$ (2,640,000)	15
16	V	31	Amortization		Southpoint Realty		1,099,748	1,099,748	16
17	V	30	Depreciation		Southpoint Realty		164,100	164,100	17
18	V	26	Insurance		Southpoint Realty		110,665	110,665	18
19	V	32	Interest		Southpoint Realty		526,722	526,722	19
20	V	19	Management Fee		Southpoint Realty		52,800	52,800	20
21	V	19	Professional Services		Southpoint Realty		44,167	44,167	21
22	V	33	Real Estate Taxes		Southpoint Realty		361,040	361,040	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			$ 2,359,242	$ * (280,758)	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: 1/1/20 Ending: 12/31/20

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 Ctr	Oak Lawn				3
4			Parker Nursing & Rehab Center	Streater				4
5			Parkshore Estates Nursing & Rehab Ctr	Chicago				5
6			West Suburban Nursing & Rehab Center	Bloomington				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: 1/1/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Southpoint Nrsg & Rehab Ctr # 0050450 Report Period Beginning: 1/1/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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: 1/1/20 Ending: 12/31/20

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		X	Mortgage	$71,348.00	6/1/14	$ 17,332,100	$ 15,640,058	6/1/49	3.4000	$ 573,602	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Credit Suisse		X	Working Capital	None	8/31/14	26,000,000	Various	3/14/22	4.5000	155,240	6
7	Infintiy Funding	X		Working Capital	Various	Various	Various	Various	Various	Various	2,022,180	7
8												8
9	TOTAL Facility Related				$71,348.00		$ 43,332,100	$ 15,640,058			$ 2,751,022	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	$ 15,640,058			$ 2,751,022	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 95,266 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: 1/1/20 Ending: 12/31/20

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 608,013	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.)		$ 513,042	2
3. Under or (over) accrual (line 2 minus line 1).		$ (94,971)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 456,011	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.		$ 361,040	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	455,122	8
	2016	497,403	9
	2017	534,513	10
	2018	504,360	11
	2019	513,042	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	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.

2019 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 Aaron Mauer

TELEPHONE 773-747-4506 FAX #: 773-747-4725

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

Enter the tax index number and real estate tax assessed for 2019 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 2019.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	25-05-423-001-0000	Nursing Home	$ 2,622.28	$ 2,622.28
2.	25-05-423-002-0000	Nursing Home	$ 2,983.70	$ 2,983.70
3.	25-05-423-003-0000	Nursing Home	$ 3,447.23	$ 3,447.23
4.	25-05-423-004-0000	Nursing Home	$ 3,729.84	$ 3,729.84
5.	25-05-423-005-0000	Nursing Home	$ 13,884.87	$ 13,884.87
6.	25-05-423-006-0000	Nursing Home	$ 63,079.71	$ 63,079.71
7.	25-05-423-007-0000	Nursing Home	$ 75,903.79	$ 75,903.79
8.	25-05-423-008-0000	Nursing Home	$ 192,208.61	$ 192,208.61
9.	25-05-423-009-0000	Nursing Home	$ 155,182.28	$ 155,182.28
10.			$	$
		TOTALS	$ 513,042.31	$ 513,042.31

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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: 1/1/20 Ending: 12/31/20

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: 04/01/09

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 Nrsg & Rehab Ctr # 0050450 Report Period Beginning: 1/1/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	228		2010		$ 6,400,000	$ 164,100	39	$ 164,103	$ 3	$ 1,531,610	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Signs for Facility			2009	4,765	122	39	122		1,485	9
10	Signs for Facility			2009	4,765	122	39	122		1,465	10
11	New Flooring 1st and 2 nd Floor			2009	40,859	1,048	39	1,048		12,226	11
12	New Flooring			2009	20,000	513	39	513		6,072	12
13	New Flooring			2009	20,000	513	39	513		5,986	13
14	TV Cabling			2009	1,500	38	39	38		455	14
15	Patch to the Field or Wall Flashings			2010	2,975	76	39	76		839	15
16	Patch to the Field or Wall Flashings			2010	2,975	76	39	76		839	16
17	Water Service Maint. And Insulation			2010	1,540	39	39	39		433	17
18	Leak Testing			2010	1,350	35	39	35		382	18
19	Misc. Construction Items Reclass from Repairs			2010	6,684	171	39	171		1,884	19
20	Water Heater Controller Replacement			2011	1,298	33	39	33		983	20
21	Removal of Closets, Eliminate Lights, Storage Room, etc.			2011	2,432	62	39	62		285	21
22	Cabinet Removal and Drywall Work			2011	3,960	102	39	102		468	22
23	Replacement Floors and Carpets			2011	2,480	64	39	64		624	23
24	Tile Work			2011	4,467	115	39	115		739	24
25	Pump - Harris Equip			2011	788		39			788	25
26	Removal of Old Carpet and Installation of New Carpet			2011	1,500	38	39	38		383	26
27	Installation of Cove Base in Office Areas			2011	246	6	39	6		62	27
28	Door Frame, Door Repairs, Hinge Replacement			2011	1,113	29	39	29		287	28
29	Patio Door Repairs, Hinge Replacement, Wall Work			2011	687	18	39	18		177	29
30	National Retrofitting Lights			2011	39,416	1,011	39	1,011		10,110	30
31	Heavy Duty Carpet and Spray Adhesive			2011	520	13	39	13		132	31
32	Reapaired and Sealcoated/Striped Driveway			2011	2,100	54	39	54		539	32
33	Kohlman Chutes			2011	1,549	40	39	40		398	33
34	New Power Supply			2012	4,038	104	39	104		934	34
35	Roof Repair and maintenance			2012	2,000	51	39	51		461	35
36	Kitchen Ceiling Tiles			2012	1,129	29	39	29		261	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: 1/1/20 Ending: 12/31/20

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	$	$ 603	37
38	Re pair and re placement of pum p and motor	2012	1,581	41	39	41		367	38
39	Ca pret Installation	2012	1,011	26	39	26		234	39
40	Concrete for patio	2012	1,850	47	39	47		425	40
41	Regrouting in Kitchen	2012	1,200	31	39	31		278	41
42	Com pressor	2012	20,599	528	39	528		4,748	42
43	Crain Service o perator	2012	700	18	39	18		162	43
44	Painting in kitchen	2012	1,900	49	39	49		439	44
45	Painting in dining room	2012	3,000	77	39	77		693	45
46	Installation of door	2012	2,751	71	39	71		637	46
47	Install dr ywall type sidewall heads	2013	2,318	59	39	59		384	47
48	paint / sand 1st floor	2013	3,090	79	39	79		514	48
49	T pered ISO - re-roof	2013	9,785	251	39	251		1,631	49
50	Chller com pressor	2013	42,500	1,090	39	1,090		7,085	50
51	Install Sidewalk	2013	2,950	76	39	76		493	51
52	sildwalk from slabs	2013	2,560	66	39	66		428	52
53	Replace Door	2013	2,150	55	39	55		358	53
54	Cook blower - dishwasher	2013	2,092	54	39	54		350	54
55	Asphalt lot	2013	8,500	218	39	218		1,419	55
56	Handrails - 1st floor	2013	1,689	43	39	43		280	56
57	Flooring - 1st floor	2013	1,520	39	39	39		253	57
58	Exhaust Fans Throughout Building	2014	3,935	101	39	101		707	58
59	Re pair Dr ywall and Paint Patient Room	2014	1,600	41	39	41		287	59
60	Install New Fire S ystem	2014	6,688	171	39	171		1,198	60
61	Install New S prinkler S ystem	2014	8,715	223	39	223		1,562	61
62	Re pair Leaks and Cooling Change Over	2014	5,854	150	39	150		1,050	62
63	Condenser & Welding Supplies	2014	3,932	101	39	101		707	63
64	Remove & Re place Ram p	2014	17,500	449	39	449		3,142	64
65	Re pair Concrete and Remove Debris	2014	750	19	39	19		133	65
66	Re place Filter Dr yer Cores	2014	1,916	49	39	49		343	66
67	Add Freon to Condenser and Change Core	2014	3,662	94	39	94		658	67
68	Re pair Model # PL130B	2014	1,538	39	39	39		274	68
69	Re pair Pum p Assembl y	2014	1,795	46	39	46		322	69
70	TOTAL (lines 4 thru 69)		$ 6,751,379	$ 173,090		$ 173,093	$ 3	$ 1,613,469	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: 1/1/20 Ending: 12/31/20

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	$ 173,090		$ 173,093	$ 3	$ 1,613,469	1
2	Deliver & Install Washers	2014	9,000	231	39	231		1,617	2
3	Tra p Two Valve Cover	2014	2,925	75	39	75		525	3
4	3rd Floor Elevator and Wanderer S ystem	2015	2,842	73	39	73		438	4
5	Add Exterior Lighting	2015	4,114	105	39	105		631	5
6	Paint 9 Resident Rooms	2015	5,495	141	39	141		846	6
7	Heating/Cooling Ex pansion Tank	2015	8,500	218	39	218		1,308	7
8	Paint 10 Resident Rooms	2015	6,240	160	39	160		960	8
9	Repair and Repave Parking lot	2015	35,000	897	39	897		5,383	9
10	Paint 2nd and 3rd Floor Activity Rooms	2015	2,974	76	39	76		457	10
11	Install Fire Alarm S ystem	2015	6,726	172	39	172		1,033	11
12	Main Entrance Door	2016	2,995	77	39	77		385	12
13	New Com pressor for Freezer	2016	5,700	146	39	146		730	13
14	S prinkler pip re placement	2016	3,578	92	39	92		459	14
15	Re pair & Configure Fire Pum p Controller	2016	3,375	87	39	87		434	15
16	Redo Ceiling in Oxygen Room	2016	3,284	84	39	84		420	16
17	Laundr y Room Exhaust Fan	2016	3,377	87	39	87		434	17
18	Roofto p Exhaust Fan	2016	3,865	99	39	99		495	18
19	Re place Laundr y Room Motor Starter	2016	3,550	91	39	91		455	19
20	Re place 2 Norton Electromechanical Closers	2016	3,894	100	39	100		500	20
21	2 Fire Dam pers in Oxygen Room	2016	3,175	81	39	81		406	21
22	Lobb y Renovations	2016	3,384	87	39	87		435	22
23	New Door	2016	1,459	37	39	37		186	23
24	Paint Therapy Room	2017	3,072	79	39	79		276	24
25	Kitchen Air Handler Coil Re placement	2017	13,225	339	39	339		1,187	25
26	225 Ton Carrier Chiller	2017	172,000	4,410	39	4,410		15,436	26
27	Front Entrance Interior Door	2017	4,298	110	39	110		385	27
28	2 To p Latches on Fire Door	2017	3,041	78	39	78		273	28
29	Re pairs to Rear Door	2017	2,708	69	39	69		243	29
30	Re pair & Rebuild Pum p	2017	4,299	110	39	110		385	30
31	Dining Room Pedestrian Door	2017	3,663	94	39	94		329	31
32	Paint Rooms 127,125,104,100,103,101,105 & Exam Room	2017	4,663	120	39	120		419	32
33	Custom Made Blinds	2017	2,965	76	39	76		266	33
34	TOTAL (lines 1 thru 33)		$ 7,090,765	$ 181,792		$ 181,795	$ 3	$ 1,651,204	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: 1/1/20 Ending: 12/31/20

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		$ 7,090,765	$ 181,792		$ 181,795	$ 3	$ 1,651,204	1
2	Fire-Rated Access Panels and Sub Floor for Oxygen Room	2017	3,531	91	39	91		317	2
3	Replace Main Exhaust for Three Water Boilers	2017	4,445	114	39	114		399	3
4	New Doors for Rooms 126,223,224,231,208,206 Oxygen Room & K	2017	2,918	75	39	75		262	4
5	Replace Sidewalk in Back of Building,Replace a Section of Drivew	2017	2,500	64	39	64		224	5
6	Surveillance cameras for 1st-3rd floor & basement	2018	2,760	71	39	71		177	6
7	Paint lobby, 1st and 2nd floor main dining rooms	2018	3,627	93	39	93		232	7
8	New sewage ejector pump (1st payment)	2018	5,743	147	39	147		369	8
9	New contactor and overloads for ejector pump	2018	2,045	52	39	52		131	9
10	New sewage ejector pump (2nd payment)	2018	6,248	160	39	160		400	10
11	Installation of rental pump for ejector system	2018	1,719	44	39	44		110	11
12	Laundry exhaust fan	2018	4,650	389	39	119	(270)	838	12
13									13
14	New Automated Door for Front & Patio	2019	4,238	109	39	109		17	14
15	Replace Exhaust Fan for Main Exhaust	2019	3,337	86	39	86		71	15
16	Replace 10' Section of Plumbing Pipe in Basement	2019	2,326	60	39	60		93	16
17	Replace Carpet in Administrator & DON Office	2019	2,499	64	39	64		28	17
18	Replace Blower Motor, Blower Wheel, Control Wiring Harness or	2019	2,685	69	39	69		38	18
19	Fire Alarms for East Side Basement, West Side 1st Floor, Northea	2019	3,674	94	39	94		88	19
20	Flood Lights for West Side of Building	2019	5,500	141	39	141		82	20
21	New Doors for Elevator Room	2019	1,885	48	39	48		93	21
22	Replace Flow Switches on Domestic Hot Water Boilers	2019	2,244	58	39	58		105	22
23	Delay Relays for Hot Water Boilers	2019	2,643	68	39	68		124	23
24	New Burner Assembly for Water Boiler	2019	3,624	93	39	93		170	24
25	New Burner for Kitchen/Laundry Hot Water Boiler	2019	2,845	73	39	73		134	25
26	New Kitchen Exhaust Fan	2019	4,675	120	39	120		210	26
27	Apply Patch to Wall Flashing	2019	13,950	358	39	358		566	27
28	Install 2 New Doors in Elevator Room & Laundry Room	2019	7,598	195	39	195		292	28
29	Seal coat & Stripe Parking Lot	2019	4,448	114	39	114		162	29
30	New Return Replacement Pump for Building Domestic Hot Water	2019	4,711	121	39	121		161	30
31	Concrete Walkway & Patio Lifting	2019	4,168	107	39	107		143	31
32	Repair Mulitiple Leaks in Flat Roof	2019	4,328	111	39	111		139	32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,212,330	$ 185,179		$ 184,912	$ (267)	$ 1,657,379	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: 1/1/20 Ending: 12/31/20

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 12C, Carried Forward		$ 7,212,330	$ 185,179		$ 184,912	$ (267)	$ 1,657,379	1
2									2
3	Paint 3rd and 2nd floor corridors and Dining Rooms	2020	3,975	102	39	102		102	3
4	Paint 1st Floor Dining Room, 2nd and 3rd Floor Activity rooms ar	2020	2,995	77	39	77		77	4
5	Paint & Repair 2nd Floor Patient Rooms. Patch Walls, Sand & Re	2020	2,495	64	39	64		64	5
6	Repair and Paint Rooms on 2nd Floor East Hallway	2020	2,400	62	39	56	(5)	62	6
7	Repair, Patch, Paint 1st floor Reception Area. Repair, Patch, Pain	2020	2,290	59	39	54	(5)	59	7
8	Repair 2nd & 3rd floor Shower Rooms from Water Damage. Repa	2020	3,275	84	39	77	(7)	84	8
9	New Right Hand Storage Tank	2020	11,325	290	39	242	(48)	290	9
10	New Left Hand Storage Tank	2020	9,850	253	39	210	(42)	253	10
11	Install New Soft Start for Down Freight Elevator	2020	4,230	108	39	90	(18)	108	11
12	Kitchen/Laundry Boiler	2020	13,876	356	39	267	(89)	356	12
13	Labor & Material to Repair Generator	2020	2,429	62	39	36	(26)	62	13
14	Change filters for all Air Handlers and Clean Chiller	2020	3,070	79	39	46	(33)	79	14
15	Surveillance System for Nurse's Station	2020	3,938	101	39	59	(42)	101	15
16	New Lower Pump for Pump 6	2020	3,261	84	39	49	(35)	84	16
17	Surveillance System for 2nd floor	2020	5,382	138	39	80	(57)	138	17
18	Kitchen/Laundry Circulating Pump	2020	2,612	67	39	17	(50)	67	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)		$ 7,289,732	$ 187,163		$ 186,439	$ (725)	$ 1,659,364	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: 1/1/20 Ending: 12/31/20

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	$ 279,775	$ 50,715	$ 50,715	$	5	$	71
72	Current Year Purchases	95,140	95,140	9,514	(85,626)	5		72
73	Fully Depreciated Assets	978,551				5	978,551	73
74								74
75	TOTALS	$ 1,353,466	$ 145,855	$ 60,229	$ (85,626)		$ 978,551	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)	$ 9,143,198	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 333,018	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 246,668	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (86,351)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,637,915	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: 1/1/20 Ending: 12/31/20

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.	/2021	$
13.	/2022	$
14.	/2023	$

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: 1/1/20 Ending: 12/31/20

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.

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	$	11,007	$ 638,070	$	11,007	$ 638,070	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		1,980	165,669		1,980	165,669	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		8,942	607,521		8,942	607,521	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				109,586		109,586	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): X-Ray	39-2					5,410		5,410	12
13	Other (specify): Lab	39-2					210		210	13
14	TOTAL			$	21,930	$ 1,411,260	$ 115,206	21,930	$ 1,526,466	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: 1/1/20 Ending: 12/31/20

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/20 (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	$ (257,425)	$ 537,372	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	5,920,466	5,920,466	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	828,042	828,042	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):		270,514	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 6,491,083	$ 7,556,394	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	894,380	894,380	15
16	Equipment, at Historical Cost	862,467	1,362,467	16
17	Accumulated Depreciation (book methods)	(894,200)	(3,089,910)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	108,761	16,622,572	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(38,874)	(11,402,953)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):		315,934	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 932,534	$ 11,602,490	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,423,617	$ 19,158,884	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,242,290	$ 3,013,250	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	120,675	120,675	28
29	Short-Term Notes Payable	16,666,657	16,938,946	29
30	Accrued Salaries Payable	276,281	276,281	30
31	Accrued Taxes Payable (excluding real estate taxes)	30,113	30,113	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 19,336,016	$ 20,379,265	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		15,367,769	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)**	$	$ 15,367,769	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 19,336,016	$ 35,747,034	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (11,912,399)	$ (16,588,150)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,423,617	$ 19,158,884	48

***(See instructions.)**

Facility Name & ID Number Southpoint Nrsg & Rehab Ctr # 0050450 Report Period Beginning: 1/1/20 Ending: 12/31/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (8,561,220)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (8,561,220)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(3,351,179)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe) **Rounding**		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (3,351,179)	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)**	$ (11,912,399)	24 *

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

Facility Name & ID Number Southpoint Nrsg & Rehab Ctr # 0050450 Report Period Beginning: 1/1/20 Ending: 12/31/20

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	$ 16,011,309	1
2	Discounts and Allowances for all Levels	183,738	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 16,195,047	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	449,093	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 449,093	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	1,911,673	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	2,785	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	63,723	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,978,181	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	18,649	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 18,649	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Misc Income	5,739	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 5,739	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 18,646,709	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,702,413	31
32	Health Care	7,623,085	32
33	General Administration	5,763,176	33
	B. Capital Expense		
34	Ownership	5,001,183	34
	C. Ancillary Expense		
35	Special Cost Centers	908,031	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 21,997,888	40
41	**Income before Income Taxes (line 30 minus line 40)****	(3,351,179)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (3,351,179)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 12,216,345	44
45	Private Pay - Net Inpatient Revenue	1,075	45
46	Medicare - Net Inpatient Revenue	3,412,358	46
47	Other-(specify) NET PATIENT REVENUE	565,269	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 16,195,047	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: 1/1/20 Ending: 12/31/20

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	2,100	2,232	$ 119,855	$ 53.70	1
2	Assistant Director of Nursing	5,660	5,967	231,844	38.85	2
3	Registered Nurses	10,569	12,738	651,190	51.12	3
4	Licensed Practical Nurses	36,386	46,673	1,921,308	41.17	4
5	CNAs & Orderlies	92,151	110,511	2,204,904	19.95	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	11,552	13,276	231,218	17.42	10
11	Social Service Workers	7,227	7,763	178,168	22.95	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	28,941	32,080	556,208	17.34	15
16	Dishwashers					16
17	Maintenance Workers	3,922	4,173	103,927	24.90	17
18	Housekeepers	32,967	37,908	650,448	17.16	18
19	Laundry	4,727	5,497	92,354	16.80	19
20	Administrator	2,874	3,028	152,488	50.36	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,732	17,458	367,840	21.07	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	3,534	3,862	97,909	25.35	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	258,342	303,166	$ 7,559,661 *	$ 24.94	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	406	$ 19,475	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	974	52,014	10-3	38
39	Pharmacist Consultant	316	15,786	15-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	79	5,119	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,775	$ 92,393		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-2	50
51	Licensed Practical Nurses			10-2	51
52	Certified Nurse Assistants/Aides	2,867	62,393	10-2	52
53	TOTAL (lines 50 - 52)	2,867	$ 62,393		53

Facility Name & ID Number Southpoint Nrsg & Rehab Ctr # 0050450 Report Period Beginning: 1/1/20 Ending: 12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Williams, Linda F	Administrators	0	$ 74,506
Harris, LaDon	Administrators	0	31,894
Rudolph, Ladwina D	Administrators	0	26,308
Williams, Lauren M	Administrators	0	19,779
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 152,488

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
Infinity Funding / Sedgwick	LEGAL SERVICE	$ 145,586
KFF LLC	LEGAL SERVICE	448
Klauke Law Group LLC	LEGAL SERVICE	2,969
McGuire Woods - 10/12/20	LEGAL SERVICE	2,099
RECORD COPY SERVICES - Rever	LEGAL SERVICE	(1,260)
Empire Risk Management Services, L	PROFESSIONAL FEES	12,175
Genex Services, LLC.	PROFESSIONAL FEES	14
GGM Associates, INC.	PROFESSIONAL FEES	6,000
Infinity Healthcare Management of I	PROFESSIONAL FEES	1,373
Credit Suisse	PROFESSIONAL FEES	13,099
See attached Professional Fees		864,958
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 1,047,462

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 128,825
Unemployment Compensation Insurance	44,608
FICA Taxes	617,698
Employee Health Insurance	416,523
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Uniforms	8,499
Pension	62,776
Employee backround checks	4,193
Other employee benefits	8,469
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,291,591

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	$ 475
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Mannagement and network services	750
Clia Laboratory	320
Secretary of state	102
Other license and dues	208
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 1,855

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
Travel Reimbursement	843
In-State Travel	
Travel Reimbursement	14,556
Travel Reimbursement	6,535
Seminar Expense	
Education and Seminars	15,868
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 37,803

* Attach copy of IMRF notifications

**See instructions.

C. Professional Services

Vendor/Payee	Type	Amount
Merit Medical Staffing	PROFESSIONAL FEES	16,660
MTS Consulting	PROFESSIONAL FEES	1,101
Stout Risius Ross LLC	PROFESSIONAL FEES	5,537
Premier Destine	COVID-19 PROFESSIONAL FEES	704
People Powered LLC	COVID-19 PROFESSIONAL FEES	2,000
Infinity H Funding	COVID-19 PROFESSIONAL FEES	423
Infinity Healthcare Management of Il	MANAGEMENT FEES	835,532
Johnson and Goldburg	Accounting fees	3,000
See attached Professional Fees		
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 864,958

Facility Name & ID Number Southpoint Nrsg & Rehab Ctr # 0050450 Report Period Beginning: 1/1/20 Ending: 12/31/20

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. N/A

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 81,915 Line 10

(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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ 476,989
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.
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.