

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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: <u>0017996</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Southgate Health Care Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2016</u> to <u>12/31/2016</u> 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.	
Address: <u>900 E 9th St Box 843</u> <u>Metropolis</u> <u>62960</u>		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Massac</u>			
Telephone Number: <u>(618) 524-2683</u> Fax # <u>(618) 524-3048</u>			
HFS ID Number: _____			
Date of Initial License for Current Owners: <u>1/1/1964</u>			
Type of Ownership:			
☐ VOLUNTARY, NON-PROFIT		☒ PROPRIETARY	
☐ Charitable Corp.		☐ Individual	
☐ Trust		☐ Partnership	
IRS Exemption Code _____		☐ Corporation	
		☒ "Sub-S" Corp.	
		☐ Limited Liability Co.	
		☐ Trust	
		☐ Other _____	
In the event there are further questions about this report, please contact:			
Name: <u>Andrew B. Cutler</u>			
Telephone Number: <u>(847) 374-0400</u>			
Email Address: _____			
		Officer or Administrator of Provider	
		(Signed) _____ (Date) _____	
		(Type or Print Name) _____	
		(Title) _____	
		(Signed) _____ (Date) _____	
		Paid Preparer	
		(Print Name and Title) <u>Andrew B. Cutler</u> <u>Managing Director, Healthcare</u>	
		(Firm Name & Address) <u>FGMK, LLC</u> <u>2801 Lakeside Dr., 3rd Floor, Bannockburn, IL 60015</u>	
		(Telephone) <u>(847) 374-0400</u> Fax # <u>(847)964-5469</u>	
		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 Southgate Health Care Center

0017996 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>106</u>	Skilled (SNF)	<u>106</u>	<u>38,796</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>34</u>	Intermediate (ICF)	<u>34</u>	<u>12,444</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>140</u>	TOTALS	<u>140</u>	<u>51,240</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>17,470</u>	<u>10,459</u>	<u>5,309</u>	<u>33,238</u>	8
9	SNF/PED					9
10	ICF	<u>5,823</u>	<u>3,487</u>	<u>1,029</u>	<u>10,339</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>23,293</u>	<u>13,946</u>	<u>6,338</u>	<u>43,577</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.04%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☒ NO ☐ Note: Non-Allowable costs have been eliminated Sc.V Col. 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☒ NO ☐

I. On what date did you start providing long term care at this location?
Date started 8/25/1972

J. Was the facility purchased or leased after January 1, 1978?
YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 106 and days of care provided 2,225

Medicare Intermediary Cigna Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

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

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

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 1/1/2016 Ending: 12/31/2016
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	265,938	28,402	7,650	301,990		301,990		301,990			1
2	Food Purchase		247,474		247,474		247,474		247,474			2
3	Housekeeping	191,691	43,156		234,847		234,847		234,847			3
4	Laundry	141,652	34,752	696	177,100		177,100		177,100			4
5	Heat and Other Utilities			181,030	181,030		181,030		181,030			5
6	Maintenance	81,338	21,110	79,821	182,269		182,269		182,269			6
7	Other (specify):*											7
8	TOTAL General Services	680,619	374,894	269,197	1,324,710		1,324,710		1,324,710			8
	B. Health Care and Programs											
9	Medical Director			8,700	8,700		8,700		8,700			9
10	Nursing and Medical Records	2,249,370	219,545	93,864	2,562,779		2,562,779		2,562,779			10
10a	Therapy											10a
11	Activities	83,259	36,722		119,981		119,981		119,981			11
12	Social Services	54,580			54,580		54,580		54,580			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,387,209	256,267	102,564	2,746,040		2,746,040		2,746,040			16
	C. General Administration											
17	Administrative	341,785			341,785		341,785		341,785			17
18	Directors Fees			9,105	9,105		9,105		9,105			18
19	Professional Services			41,258	41,258		41,258	(1,294)	39,964			19
20	Dues, Fees, Subscriptions & Promotions			94,294	94,294		94,294	(57,281)	37,013			20
21	Clerical & General Office Expenses	111,367	24,066	284,609	420,042		420,042	(172,249)	247,793			21
22	Employee Benefits & Payroll Taxes			449,452	449,452		449,452		449,452			22
23	Inservice Training & Education			2,502	2,502		2,502		2,502			23
24	Travel and Seminar			23,986	23,986		23,986	(16,541)	7,445			24
25	Other Admin. Staff Transportation			31,848	31,848		31,848	(1,356)	30,492			25
26	Insurance-Prop.Liab.Malpractice			121,649	121,649		121,649		121,649			26
27	Other (specify):*											27
28	TOTAL General Administration	453,152	24,066	1,058,703	1,535,921		1,535,921	(248,721)	1,287,200			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,520,980	655,227	1,430,464	5,606,671		5,606,671	(248,721)	5,357,950			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.

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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			307,185	307,185		307,185	(87,891)	219,294			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			27,942	27,942		27,942	(786)	27,156			32
33	Real Estate Taxes			47,347	47,347		47,347		47,347			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			22,801	22,801		22,801		22,801			35
36	Other (specify):*											36
37	TOTAL Ownership			405,275	405,275		405,275	(88,677)	316,598			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		140,616	341,158	481,774		481,774		481,774			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			327,982	327,982		327,982		327,982			42
43	Other (specify):*	32,807		56,423	89,230		89,230	(89,230)				43
44	TOTAL Special Cost Centers	32,807	140,616	725,563	898,986		898,986	(89,230)	809,756			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	3,553,787	795,843	2,561,302	6,910,932		6,910,932	(426,628)	6,484,304			45

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

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	(87,891)	30		9
10	Interest and Other Investment Income	(786)	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				24
25	Fund Raising, Advertising and Promotional	(53,635)	20		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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (142,312)		\$	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			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (142,312)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Out of State Marketing & Travel	\$ (13,966)	24	1
2	Out of State Seminar Expense	(2,575)	24	2
3	Personal Portion of Travel Expense	(1,356)	25	3
4	Non-Allowable Legal Retainer Fees	(1,294)	19	4
5	Non-Allowable Marketing Salaries	(32,807)	43	5
6	Bad Debt Expense	(164,298)	21	6
7	Non-Allowable Charitable Cont.	(2,884)	43	7
8	Non-Allowable Marketing Expense	(29,900)	43	8
9	Non-Allowable Tax Expense	(11,702)	43	9
10	Non-Allowable Health Ins. Dir.	(4,035)	43	10
11	Non-Allowable Disabilit/Life Dir.	(515)	43	11
12	Non-Allowable IHCA PAC	(6,699)	43	12
13	Non-Allowable Auto Expense	(688)	43	13
14	Non-Allowable Chamber of Commerce Dues	(300)	20	14
15	Non-Alloable IHCA Lobbying Exp.	(3,346)	20	15
16	Offset Other Income	(7,951)	21	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	(284,316)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Southgate Health Care Center# 0017996

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	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	(1,294)	0	0	0	0	0	0	0	0	0	0	(1,294)	19
20	Fees, Subscriptions & Promotions	(57,281)	0	0	0	0	0	0	0	0	0	0	(57,281)	20
21	Clerical & General Office Expenses	(172,249)	0	0	0	0	0	0	0	0	0	0	(172,249)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(16,541)	0	0	0	0	0	0	0	0	0	0	(16,541)	24
25	Other Admin. Staff Transportation	(1,356)	0	0	0	0	0	0	0	0	0	0	(1,356)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(248,721)	0	0	0	0	0	0	0	0	0	0	(248,721)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(248,721)	0	0	0	0	0	0	0	0	0	0	(248,721)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(87,891)	0	0	0	0	0	0	0	0	0	0	(87,891)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(786)	0	0	0	0	0	0	0	0	0	0	(786)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	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	(88,677)	0	0	0	0	0	0	0	0	0	0	(88,677)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(89,230)	0	0	0	0	0	0	0	0	0	0	(89,230)	43
44	TOTAL Special Cost Centers	(89,230)	0	0	0	0	0	0	0	0	0	0	(89,230)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(426,628)	0	0	0	0	0	0	0	0	0	0	(426,628)	45

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
Jane Ann Parker	81.25	N/A		N/A		
Sam Thompson	6.25					
Jeff Thompson	6.25					
Shelly Bell	6.25					

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.

YES

X 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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

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

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	Sam Thompson	Operations	Administrative	6.25	None	40+	100.00	Salary	\$ 269,200	17-1	1
2	Jeff Thompson	Maintenance	Maintenance	6.25	None	40+	100.00	Salary	33,280	6-1	2
3											3
4											4
5	Sam Thompson	Director	Administrative	6.25	None	40+	100.00	Dir. Fees (A)	2,276	18-3	5
6	Jeff Thompson	Director	Administrative	6.25	None	40+	100.00	Dir. Fees (A)	2,276	18-3	6
7	Shelly Bell	Director	Administrative	6.25	None	<1	<2%	Dir. Fees (A)	2,276	18-3	7
8	William Parker	Director	Administrative	0.00	None	<1	<2%	Dir. Fees (A)	2,277	18-3	8
9											9
10	William Parker	Consultant	Administrative	0.00	None			Consulting Fees	14,000	10-3	10
11											11
12	(A) Director Fees - Board Meeting Expenses Reimbursed										12
13								TOTAL	\$ 325,585		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 Southgate Health Care Center # 0017996 Report Period Beginning: 1/1/2016 Ending: 2/31/2016

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 N/A _____
City / State / Zip Code _____
Phone Number () _____
Fax Number () _____

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5		N/A								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

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	City National Bank		X	Mortgage Note Payable	\$7,683.40	6/15/2012	\$ 1,000,000	\$ 460,599	6/15/2027	4.5000	\$ 25,350	1
2	Wells Fargo Dealer Service		X	Auto Loan	\$548.80	10/24/12	39,513	12,073	10/24/2017			2
3	Chrysler Capital		X	Auto Loan	\$719.12	5/25/15	43,147	28,765	4/25/2020			3
4												4
5												5
	Working Capital											
6	City National Bank		X	LOC		3/1/2016		301,063	3/2/2017	4.2500	2,592	6
7												7
8												8
9	TOTAL Facility Related				\$8,951.32		\$ 1,082,660	\$ 802,500			\$ 27,942	9
	B. Non-Facility Related*											
10	Interest Income										(786)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ (786)	14
15	TOTALS (line 9+line14)						\$ 1,082,660	\$ 802,500			\$ 27,156	15

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

* 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.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2015 report.			\$	44,652	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.)			\$	45,999	2
3. Under or (over) accrual (line 2 minus line 1).			\$	1,347	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	46,000	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.			\$	47,347	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2011	40,631	8	
		2012	40,461	9	
		2013	43,379	10	
		2014	44,652	11	
		2015	45,999	12	
Accrual based on PY real estate tax bill.					

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	\$	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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Southgate Health Care Center COUNTY Massac

FACILITY IDPH LICENSE NUMBER 0017996

CONTACT PERSON REGARDING THIS REPORT Andrew Cutler

TELEPHONE (847) 374-0400 FAX #: (847) 964-5469

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. 08-01-448-004	Nursing Facility	\$ 311.78	\$ 311.78
2. 08-01-448-005	Nursing Facility	\$ 300.70	\$ 300.70
3. 08-01-448-008	Nursing Facility	\$ 1,310.00	\$ 1,310.00
4. 08-01-450-999	Nursing Facility	\$ 43,297.52	\$ 43,297.52
5. 08-01-440-001	Nursing Facility	\$ 779.38	\$ 779.38
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 45,999.38	\$ 45,999.38

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

- A. Square Feet: 42,622
- B. General Construction Type: Exterior Brick Frame Concrete Number of Stories 1
- C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (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? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)
- E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

- F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO
If so, please complete the following:
1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:
- Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Resident Care	185,500	1972	\$ 5,000	1
2	Resident Care	193,500	2002	95,000	2
3	TOTALS	379,000		\$ 100,000	3

Facility Name & ID Number Southgate Health Care Center

0017996

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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	93		1972	1972	\$ 207,276	\$		\$	\$	202,276	4
5	10		1976	1976	292,230					292,230	5
6	5		1989	1989	583,147					583,147	6
7			1993	1993	629,889		30	20,996	20,996	479,816	7
8	32		2012	2012	2,124,783		30	70,826	70,826	316,618	8
	Improvement Type**										
9	Various		1975		7,341		30			7,341	9
10	Various		1977		1,098		28			1,098	10
11	Various		1980		1,014		20			1,014	11
12	Various		1981		57,891		15			57,891	12
13	Various		1982		17,279		20			17,279	13
14	Various		1983		675		10			675	14
15	Various		1984		114,893		20			114,893	15
16	Various		1985		28,893		20			28,893	16
17	Various		1986		13,163		15			13,163	17
18	Various		1988		32,477		30	1,084	1,084	30,882	18
19	Various		1989		852		15			852	19
20	Various		1990		10,266		20			10,266	20
21	Various		1992		1,824		10			1,824	21
22	Various		1995		3,742		15			3,742	22
23	Various		1996		2,240		10			2,240	23
24	Various		1997		10,317		20	97	97	10,262	24
25	Various		1998		1,130		10			1,130	25
26	Various		1999		17,240		20	862	862	15,408	26
27	Various		2000		17,005		20	850	850	13,175	27
28	Various		2001		259,580		20	13,187	13,187	206,109	28
29	Various		2002		145,221		40	2,443	2,443	48,751	29
30	Various		2003		3,238		10			3,238	30
31	Various		2004		18,000		10			18,000	31
32	Various		2005		54,191		10	3,178	3,178	43,444	32
33	Various		2006		13,365		15	222	222	12,371	33
34	Various		2007		25,309		7			25,309	34
35	Various		2008		4,318		7	264	264	4,318	35
36	Book Depreciation					307,185					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 Southgate Health Care Center

0017996

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Various	2009	\$ 49,584	\$		\$ 4,036	\$ 4,036	\$ 30,376	37
38	Various	2010	37,748			3,458	3,458	22,477	38
39	Various	2011	22,449			3,800	3,800	20,950	39
40	Remodel & Rewire - Phone & Cable Wiring 300 Wing Addition	2013	9,874		15	658	658	2,303	40
41	Remodel & Rewire - B Hall Nurse Call System								41
42	(Micro Vision 200Z) Skilled Portion of Facility	2013	3,058		15	204	204	714	42
43	100 & 200 Hall Resident Bathrooms, Sinks, Countertops, Wall								43
44	Board, New Handrails installed and Painted In Hallways	2013	6,955		15	464	464	1,624	44
45	Rewiring B Hall - Electric rewiring entire B Hallway	2013	13,478		15	899	899	3,146	45
46	Hot Water Heater	2013	3,525		7	504	504	1,764	46
47	Remodel of B/C Hall - Install, Finish Paint Sheetrock, new floor								47
48	In resident rooms and hallways, new handrails- hallways	2014	171,980		39	4,410	4,410	11,025	48
49	HVAC Unit by Dining Room	2014	5,643		7	806	806	2,015	49
50	Pellet Heater - Kitchen	2014	6,264		7	895	895	2,237	50
51	Engineering work for parking lot renovation	2014	8,249		15	550	550	1,375	51
52	Water heater - Laundry	2015	9,504		7	1,358	1,358	2,037	52
53	Parking Lot Improvements	2015	22,007		15	1,467	1,467	2,201	53
54	Flooring - Resident Rooms on Intermediate A Hall	2015	11,404		15	760	760	1,140	54
55	Hot Water Heater	2016	7,021		7	501	501	501	55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,088,630	\$ 307,185		\$ 138,778	\$ 138,778	\$ 2,673,540	70

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

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	\$347,586	\$	\$61,372	\$61,372	6	\$211,991	71
72	Current Year Purchases	41,296		4,354	4,354	3-7	4,354	72
73	Fully Depreciated Assets	870,435					870,435	73
74								74
75	TOTALS	\$1,259,317	\$	\$65,726	\$65,726		\$1,086,780	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	Resident Care	Chevy Van	1989	\$18,500	\$	\$	\$		\$18,500	76
77	Resident Care	Dodge Dakota	2000	14,504					14,504	77
78	Resident Care	Buick Enclave	2012	30,805		6,161	6,161	5	25,670	78
79	Resident Care	Dodge Caravan	2015	43,147		8,629	8,629	5	12,944	79
80	TOTALS			\$106,956	\$	\$14,790	\$14,790		\$71,618	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)	\$6,554,903	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$307,185	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$219,294	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(87,891)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$3,831,938	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	2005 Mercedes Benz	\$76,104	\$	\$76,104	86
87	Jeep	57,504		57,291	87
88	Jeep	40,189		32,151	88
89	Pick Up Truck	17,266		5,180	89
90	Land	93,196			90
91	TOTALS	\$284,259	\$	\$170,726	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.

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:				\$ <u>N/A</u>			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: *

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: \$ 22,801 Description: See Attached

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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.	<u> </u> /2017	\$ <u> </u>
13.	<u> </u> /2018	\$ <u> </u>
14.	<u> </u> /2019	\$ <u> </u>

* 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.

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Description	Amount
Phone System	6,000
Propane Gas Tanks	497
Storage	6,000
Dish Machine	899
Wound Vac Machines	7,995
Oxygen rental	1,410
	22,801

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

☒ 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)	\$			

- (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.

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	

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 111,384	\$		\$ 111,384	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			65,613			65,613	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			132,776			132,776	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				103,600		103,600	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached	39-2/39-3				31,385	37,016		68,401	13
14	TOTAL			\$		\$ 341,158	\$ 140,616		\$ 481,774	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.

Special Services - Supplies (Column 6 - Other) Amount	
13 Medicare Medical Supplies	493
13 Medicare X-Ray	3382
13 VA Pharmacy	32308
13 VA Supplies	65
13 VA X-Ray	768
	<u>37016</u>
Special Services - Services (Column 5 - Other)	
13 Medicare Lab	5778
13 Medicare Support Services	161
13 VA Lab	2758
13 VA Physician	6588
13 VA Rehab	15660
13 VA Podiatrist	440
	<u>31385</u>

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	\$ (321,153)	\$ (321,153)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (10,697))	1,549,523	1,549,523	3
4	Supply Inventory (priced at)	3,541	3,541	4
5	Short-Term Investments			5
6	Prepaid Insurance	8,881	8,881	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>A/R Employee</u>	(12,930)	(12,930)	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,227,862	\$ 1,227,862	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	193,196	100,000	13
14	Buildings, at Historical Cost	4,323,666	3,837,325	14
15	Leasehold Improvements, at Historical Cost	2,604,903	1,251,305	15
16	Equipment, at Historical Cost		1,366,273	16
17	Accumulated Depreciation (book methods)	(4,135,556)	(3,831,938)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,986,209	\$ 2,722,965	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,214,071	\$ 3,950,827	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 89,956	\$ 89,956	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	301,063	301,063	29
30	Accrued Salaries Payable	176,207	176,207	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,247	6,247	31
32	Accrued Real Estate Taxes(Sch.IX-B)	46,000	46,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached</u>	104,988	104,988	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 724,461	\$ 724,461	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	40,838	40,838	39
40	Mortgage Payable	460,599	460,599	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)	\$ 501,437	\$ 501,437	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,225,898	\$ 1,225,898	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,988,173	\$ 2,724,929	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,214,071	\$ 3,950,827	48

*(See instructions.)

Other Current Assets:		Amount	Amount
9	A/R Employee	(12,930)	
9			
9			
9			
9			
9			
Total Line 9		(12,930)	0

Other Non-Current Assets:		Amount	Amount
23			
23			
23			
23			
23			
23			
23			
23			
Total Line 23		0	0

Other Current Liabilities:		Amount	Amount
36	Insurance - W/H Life Ins	2	
36	Credit Union Witheld	1,142	
36	Garnishment W/H	443	
36	Other Accrued Expenses	16,203	
36	Relay for Life	(675)	
36	Accrued Licensed Bed Tax	(107,336)	
36	Due To DPA Audit	(12,297)	
36	Due to Coinsurance	(2,470)	
Total Line 36		(104,988)	0

Other Non-Current Liabilitie		Amount	Amount
43			
43			
43			
43			
43			
43			
43			
43			
Total Line 43		0	0

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,146,184	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,146,184	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	32,654	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) Adjustment for Historical Asset Costs	(190,665)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (158,011)	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)	\$ 2,988,173	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Southgate Health Care Center

0017996

Report Period Beginning: 1/1/2016

Ending: 12/31/2016

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,370,513	1
2	Discounts and Allowances for all Levels	(786,273)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,584,240	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	10,234	5
6	Therapy	1,140,642	6
7	Oxygen	2,754	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,153,630	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	174,200	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	7,102	19
20	Radiology and X-Ray		20
21	Other Medical Services	15,677	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 196,979	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	786	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 786	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Income	7,951	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 7,951	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,943,586	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,324,710	31
32	Health Care	2,746,040	32
33	General Administration	1,535,921	33
	B. Capital Expense		
34	Ownership	405,275	34
	C. Ancillary Expense		
35	Special Cost Centers	571,004	35
36	Provider Participation Fee	327,982	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,910,932	40
41	Income before Income Taxes (line 30 minus line 40)**	32,654	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 32,654	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,794,442	44
45	Private Pay - Net Inpatient Revenue	2,168,309	45
46	Medicare - Net Inpatient Revenue	132,096	46
47	Other-(specify) VA Inpatient Revenue	439,553	47
48	Other-(specify) Medicare Replacement Inpatient Revenue	49,840	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,584,240	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.

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,177	2,177	\$ 70,230	\$ 32.26	1
2	Assistant Director of Nursing	2,164	2,164	54,626	25.24	2
3	Registered Nurses	13,690	13,690	374,723	27.37	3
4	Licensed Practical Nurses	29,991	29,991	562,571	18.76	4
5	CNAs & Orderlies	119,100	119,100	1,187,220	9.97	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,088	2,088	22,955	10.99	9
10	Activity Assistants	5,188	5,188	60,304	11.62	10
11	Social Service Workers	3,757	3,757	54,580	14.53	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	61,002	29.33	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,424	22,424	204,936	9.14	15
16	Dishwashers					16
17	Maintenance Workers	4,280	4,280	81,338	19.00	17
18	Housekeepers	21,519	21,519	191,691	8.91	18
19	Laundry	14,073	14,073	141,652	10.07	19
20	Administrator	2,080	2,080	72,585	34.90	20
21	Assistant Administrator					21
22	Other Administrative	2,160	2,160	269,200	124.63	22
23	Office Manager					23
24	Clerical	7,190	7,190	111,367	15.49	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Marketing Dir.	2,104	2,104	32,807	15.59	33
34	TOTAL (lines 1 - 33)	256,065	256,065	\$ 3,553,787 *	\$ 13.88	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 7,650	1-3	35
36	Medical Director	Monthly	8,700	9-3	36
37	Medical Records Consultant	Quarterly	1,944	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,271	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	Physician Consultant	Monthly	14,000	10-3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 33,565		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	1,704	54,556	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,704	\$ 54,556		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Sam Thompson	Administrative	6.25%	\$ 269,200
Rebekah Mahoney	Administrator	0	72,585
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 341,785
B. Administrative - Other			
Description			Amount
			\$
N/A			
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$
C. Professional Services			
Vendor/Payee	Type		Amount
Whitlow Roberts	Legal		\$ 10,807
RSM US LLP	Accounting		11,650
Kemper CPA	Accounting		5,472
The Byers Group	Legal		1,294
Duane Morris	Legal		2,760
Williams, Williams, Lentz	Accounting		4,350
Walker CPA	Accounting		4,925
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 41,258
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 90,365
Unemployment Compensation Insurance			
FICA Taxes			290,052
Employee Health Insurance			30,182
Employee Meals			4,900
Illinois Municipal Retirement Fund (IMRF)*			
Other Employee Benefits			24,339
401K Match			8,804
Personnel Expenses			810
TOTAL (agree to Schedule V, line 22, col.8)			\$ 449,452
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			\$ 3,980
Advertising: Employee Recruitment			
Health Care Worker Background Check (Indicate # of checks performed 200)			2,000
Patient Background Checks 155			2,439
IHCA			8,470
Subscriptions			848
Membership Fees			5,137
Misc. Licensing Fees			17,785
Advertising			56,635
Less: Public Relations Expense		(	)
Non-allowable advertising			(56,635)
Yellow page advertising		(	)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 40,659
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$ 12,471
Out of State Seminar Epense			2,575
In-State Travel			5,770
Marketing Travel			1,495
Seminar Expense			1,675
Non-Allowable Travel & Seminar			(16,541)
Entertainment Expense		(	)
TOTAL (agree to Sch. V, line 24, col. 8)			\$ 7,445

*** Attach copy of IMRF notifications**

****See instructions.**

Southgate Health Care Center
0017996
LEGAL SERVICES
1/1/2016-12/31/2016

DATE	G/L ACCT. #	PAYEE/VENDOR	AMOUNT	ADJ
1/1/2016	01-410	Whitlow Roberts, Houston, Straub	750.00	
3/1/2016	01-410	Whitlow Roberts, Houston, Straub	3,825.00	
3/1/2016	01-410	Whitlow Roberts, Houston, Straub	389.82	
4/1/2016	01-410	Whitlow Roberts, Houston, Straub	870.00	
5/1/2016	01-410	Whitlow Roberts, Houston, Straub	840.00	
6/1/2016	01-410	Whitlow Roberts, Houston, Straub	260.94	
8/1/2016	01-410	Whitlow Roberts, Houston, Straub	1,035.00	
9/1/2016	01-410	Whitlow Roberts, Houston, Straub	973.00	
9/1/2016	01-410	Whitlow Roberts, Houston, Straub	279.00	
11/1/2016	01-410	Whitlow Roberts, Houston, Straub	1,583.90	
		Total	10,806.66	
6/1/2016	01-410	The Byers Law Firm	294.00	ADJ
7/1/2016	01-410	The Byers Law Firm	500.00	ADJ
8/1/2016	01-410	The Byers Law Firm	500.00	ADJ
		Total	1,294.00	
6/1/2016	01-410	Duane Morris	684.50	
8/1/2016	01-410	Duane Morris	1,893.00	
12/1/2016	01-410	Duane Morris	182.50	
		Total	2,760.00	
		Unadjusted Total	14,860.66	
		ADJUSTMENTS	-1,294.00	
		TOTAL:	13,566.66	

EMPLOYEE NAME	JOB DESCRIPTION	DESTINATION	PURPOSE OF TRIP	FOOD	AIRFARE	Mileage	HOTEL	TOTAL	
Leah White	Marketing	Hospitals	Marketing			65.54		65.54	ADJ
Leah White	Marketing	Hospitals	Marketing			77.41		77.41	ADJ
Leah White	Marketing	Hospitals	Marketing			87.01		87.01	ADJ
Leah White	Marketing	Hospitals	Marketing			293.80		293.80	ADJ
Cindy Dunevant	Social Service Dir	Hospitals	Marketing			290.98		290.98	ADJ
Sam Thompson	President	Nashville	Consulting				197.27	197.27	ADJ
Sam Thompson	President	San Diego	AHCA I/O Conf		518.96			518.96	ADJ
Sam Thompson	President	Washington, DC	AHCA Legislstive		341.96			341.96	ADJ
Sam Thompson	President	San Diego	AHCA I/O Conf		67.00			67.00	ADJ
Sam Thompson	President	Washington, DC	AHCA Legislstive		21.99			21.99	ADJ
Sam Thompson	President	Washington, DC	AHCA Legislstive	187.30				187.30	ADJ
Sam Thompson	President	Champaign	NHRMA	332.60				332.60	
Sam Thompson	President	Nashville	Consulting	20.29				20.29	ADJ
Leah White	Marketing	Hospitals	Marketing			84.19		84.19	ADJ
Leah White	Marketing	Hospitals	Marketing			75.15		75.15	ADJ
Sam Thompson	President	San Diego	AHCA I/O Conf	703.79			1,003.16	1,706.95	ADJ
Leah White	Marketing	Hospitals	Marketing			67.24		67.24	ADJ
Rebekah	Administrator	Effingham	NHRMA Training			175.15		175.15	
Sam Thompson	President	Champaign	NHRMA	65.46				65.46	
Leah White	Marketing	Hospitals	Marketing			80.23		80.23	ADJ
Sam Thompson	President	Washington, DC	AHCA Legislstive				979.41	979.41	ADJ
Leah White	Marketing	Hospitals	Marketing			122.60		122.60	ADJ
Leah White	Marketing	Hospitals	Marketing			136.73		136.73	ADJ
Sam Thompson	President	Champaign	NHRMA	311.31				311.31	
Sam Thompson	President	Champaign	NHRMA	77.02				77.02	
Leah White	Marketing	Hospitals	Marketing				87.01	87.01	ADJ
Sam Thompson	President	Peoria	IHCA Annual				1,777.90	1,777.90	
Sam Thompson	President	Champaign	NHRMA	4.93				4.93	
Sam Thompson	President	Champaign	NHRMA	36.92				36.92	
Resident Transportation		Dr. Visit	Dr. Visit			20.00		20.00	
Sam Thompson	President	Peoria	IHCA Annual	395.87				395.87	
Rebekah Mahoney	Adminidtrator	Peoria	IHCA Annual	395.86				395.86	
Rhonda Johnson	Dir of Nurses	Peoria	IHCA Annual	395.86				395.86	
DJ Fasolo	Assi Dir of Nurses	Peoria	IHCA Annual	395.86				395.86	
Cindy Dunevant	Social Serv Dir	Peoria	IHCA Annual	395.86				395.86	
Deanna Varnum	Activity Dir	Peoria	IHCA Annual	395.86				395.86	
Jane Parker	Chairman	Peoria	IHCA Annual	395.86				395.86	
Leah White	Marketing	Hospitals	Marketing	136.73				136.73	ADJ
Sam Thompson	President	Nashville	AHCA Annual	500.00			1,100.75	1,600.75	ADJ
Jane Parker	Chairman	Nashville	AHCA Annual	500.00				500.00	ADJ
Sam Thompson	President	Nashville	AHCA Annual	1,255.46			1,908.94	3,164.40	ADJ
Jane Parker	Chairman	Nashville	AHCA Annual	1,255.45			1,908.94	3,164.39	ADJ
Leah White	Marketing	Hospitals	Marketing	88.14				88.14	ADJ
							Total	19,735.75	
							Adjustments	-13966.16	
							Total	5,769.59	

DATE	PAYEE	TOPIC	ATTENDEE	JOB DESCRIPTION	CITY/STATE	FEE	
01/22/16	Skillpath	MDS	Rebekah Mahoney	Administrator	Metropolis/webinar	99.95	
04/01/16	AHCA	Congressional Briefing	Sam Thompson	President	Washington, DC	500.00	ADJ
04/12/16	IHCA	Legislative Day	Sam Thompson	President	Springfield	50.00	
03/01/16	AHCA	Independent Owners Conf	Sam Thompson	President	San Diego	950.00	ADJ
09/01/16	IHCA	Annual Conference	Sam Thompson	President	Peoria,	975.00	
			Jane Parker	Chairman			
			Rebekah Mahoney	Administrator			
			Rhonda Johnson	Dir Of Nurses			
			DJ Fasolo	Assi Dir of Nurses			
			Cindy Dunevant	Soc Serv Dir			
			Deanna Varnum	Activity Director			
10/01/16	AHCA	Annual Conference	Sam Thompson	President	Nashville	700.00	ADJ
			Brookly Becke	Consultant	Nashville	425.00	ADJ
11/01/16	IHCA	MDS	Chris Shepler	Care Plan Coord	Effingham	550.00	
					Total	4,249.95	
					Adjustments	-2575	
					Total	1674.95	

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?
If YES, give association name and amount.

IHCA & AHCA -\$5,124

(3)

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

Yes
Yes

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No
N/A

(5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

Yes
3-7 Years

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 18,717 Line 10

(7)

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

Yes

(8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No
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
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

X
N/A

(11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.
This amount is to be recorded on line 42 of Schedule V.

\$ 327,982

(12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

No
- (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?
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.

No

(15)

Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V.
Has any meal income been offset against related costs?

\$ 4,900
N/A
Indicate the amount. \$ N/A

(16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

No

b.

Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

No
\$ N/A

c.

What percent of all travel expense relates to transportation of nurses and patients?

Ln. 14

d.

Have vehicle usage logs been maintained?

records available

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?

g.

Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such transportation during this reporting period.

No
\$ N/A

(17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:

No
N/A

(18)

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

Yes

(19)

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.
Attach invoices and a summary of services for all architect and appraisal fees

Yes