		FOR BHF USE					

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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: 0017996

Facility Name: Southgate Health Care Center

Address: 900 E 9th St Box 843 (Number) Metropolis (City) 62960 (Zip Code)

County: Massac

Telephone Number: (618) 524-2863 **Fax #** (618) 524-3048

HFS ID Number:

Date of Initial License for Current Owners: 1/1/1964

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2025 to 12/31/2025 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)	
	(Title)	
Paid Preparer	(Signed)	(Date)
	(Print Name and Title)	Andrew B. Cutler Managing Director, Healthcare
	(Firm Name & Address)	FGMK, LLC 2801 Lakeside Dr., 3rd Floor, Bannockburn, IL 60015
	(Telephone)	(847) 940-3269 Fax # (847)964-5469

In the event there are further questions about this report, please contact:
Name: Andrew B. Cutler Telephone Number: (847) 940-3269
Email Address:

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406 Phone # (217) 782-1630

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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	106	Skilled (SNF)	106	38,690	1
2		Skilled Pediatric (SNF/PED)			2
3	34	Intermediate (ICF)	34	12,410	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	140	TOTALS	140	51,100	7

B. Census-For the entire report period.

	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI Medicaid Primary	MMAI Medicare Primary	Private Pay	Medicare Part A Only	Other	Total	
8	SNF				410		2,266		2,676	8
9	SNF/PED									9
10	ICF	14,459	1,052			7,424		5,182	28,117	10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	14,459	1,052		410	7,424	2,266	5,182	30,793	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 60.26%

D. How many bed reserve days during this year were paid by the Department?
None (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 [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] 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 [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter certified beds.
number of certified beds 106

Medicare Intermediary Cigna Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2025 Fiscal Year: 12/31/2025

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

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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	382,455	1,808		384,263		384,263		384,263			1
2	Food Purchase		366,043		366,043		366,043		366,043			2
3	Housekeeping	332,209	37,060		369,269		369,269		369,269			3
4	Laundry	132,769	6,835	130	139,734		139,734		139,734			4
5	Heat and Other Utilities			153,597	153,597		153,597		153,597			5
6	Maintenance	77,412	13,607	114,895	205,914		205,914		205,914			6
7	Other (specify):*											7
8	**TOTAL General Services**	924,845	425,353	268,622	1,618,820		1,618,820		1,618,820			8
	B. Health Care and Programs											
9	Medical Director			22,072	22,072		22,072		22,072			9
10	Nursing and Medical Records	2,722,829	218,941	237,477	3,179,247		3,179,247		3,179,247			10
10a	Therapy			22,000	22,000		22,000		22,000			10a
11	Activities	97,770	4,401		102,171		102,171		102,171			11
12	Social Services	50,401			50,401		50,401		50,401			12
13	CNA Training			6,820	6,820		6,820		6,820			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,871,000	223,342	288,369	3,382,711		3,382,711		3,382,711			16
	C. General Administration											
17	Administrative	253,000			253,000		253,000		253,000			17
18	Directors Fees			1,671	1,671		1,671		1,671			18
19	Professional Services			50,633	50,633		50,633		50,633			19
20	Dues, Fees, Subscriptions & Promotions			45,371	45,371		45,371	(7,747)	37,624			20
21	Clerical & General Office Expenses	139,143	15,408	625,290	779,841		779,841	(460,849)	318,992			21
22	Employee Benefits & Payroll Taxes			551,888	551,888		551,888		551,888			22
23	Inservice Training & Education											23
24	Travel and Seminar			545	545		545		545			24
25	Other Admin. Staff Transportation			62,304	62,304		62,304	(5,919)	56,385			25
26	Insurance-Prop.Liab.Malpractice			334,189	334,189		334,189		334,189			26
27	Other (specify):*											27
28	**TOTAL General Administration**	392,143	15,408	1,671,891	2,079,442		2,079,442	(474,515)	1,604,927			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,187,988	664,103	2,228,882	7,080,973		7,080,973	(474,515)	6,606,458			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 Southgate Health Care Center #0017996 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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			152,283	152,283		152,283		152,283			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			366,381	366,381		366,381	(2,243)	364,138			32
33	Real Estate Taxes			42,625	42,625		42,625		42,625			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			25,295	25,295		25,295		25,295			35
36	Other (specify):*											36
37	TOTAL Ownership			586,584	586,584		586,584	(2,243)	584,341			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	403,187	207,728	33,339	644,254		644,254		644,254			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			462,743	462,743		462,743		462,743			42
43	Other (specify):*	188,044		36,733	224,777		224,777	(224,777)				43
44	TOTAL Special Cost Centers	591,231	207,728	532,815	1,331,774		1,331,774	(224,777)	1,106,997			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,779,219	871,831	3,348,281	8,999,331		8,999,331	(701,535)	8,297,796			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 Southgate Health Care Center # 0017996 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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				9
10	Interest and Other Investment Income	(2,243)	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	(165)	21		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	(460,684)	21		24
25	Fund Raising, Advertising and Promotional	(6,518)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(12,710)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(219,215)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (701,535)		$	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
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (701,535)		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			(2,243)		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)**			$ (2,243)		47

STATE OF ILLINOIS

Southgate Health Care Center

ID# 0017996

Report Period Beginning: 1/1/2025

Ending: 12/31/2025

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Political Action Committee Payments	$ (560)	20	1
2	Other Expenses Related to Lobbying Activities	(669)	20	2
3	Personal Portion Travel Expense	(5,919)	25	3
4	Non-Allowable Health Insurance Directors	(5,784)	43	4
5	Non-Allowable Marketing Expense and Salaries	(123,060)	43	5
6	Non-Allowable Admin Salaries	(81,111)	43	6
7	Non-Allowable Travel Expense	(1,112)	43	7
8	Non-Allowable Charitable Donations	(1,000)	43	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(219,215)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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	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	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(7,747)	0	0	0	0	0	0	0	0	0	0	(7,747)	20
21	Clerical & General Office Expenses	(460,849)	0	0	0	0	0	0	0	0	0	0	(460,849)	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	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(5,919)	0	0	0	0	0	0	0	0	0	0	(5,919)	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**	(474,515)	0	0	0	0	0	0	0	0	0	0	(474,515)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(474,515)	0	0	0	0	0	0	0	0	0	0	(474,515)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,243)	0	0	0	0	0	0	0	0	0	0	(2,243)	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**	(2,243)	0	0	0	0	0	0	0	0	0	0	(2,243)	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):*	(224,777)	0	0	0	0	0	0	0	0	0	0	(224,777)	43
44	**TOTAL Special Cost Centers**	(224,777)	0	0	0	0	0	0	0	0	0	0	(224,777)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(701,535)	0	0	0	0	0	0	0	0	0	0	(701,535)	45

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
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: 1/1/2025 Ending: 12/31/2025

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. ☐ 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		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)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

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

STATE OF ILLINOIS

Ownership Listing-1

Southgate Health Care Center

ID# 0017996

Report Period Beginning: 1/1/2025

Ending: 12/31/2025

N/A

N/A

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)

-Owners of companies must be listed instead of company names.

-Names of trust beneficiaries must be listed.

	First Name	M.I.	Last Name	Place of Residence City	State	Operator/Licensee Ownership Percentage	Building Co. Ownership Percentage	Management Co. /Home Office Ownership Percentage	
1	Jane		Parker	Paducah	KY	81.25000			1
2	Samuel		Thompson	Paducah	KY	6.25000			2
3	Jeff		Thompson	Paducah	KY	6.25000			3
4	Shelly		Bell	Paducah	KY	6.25000			4
5									5
6									6
7									7
8									8
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72									72
73									73
74									74
75									75

STATE OF ILLINOIS

Ownership Listing-2

Southgate Health Care Center

ID# 0017996

Report Period Beginning: 1/1/2025

Ending: 12/31/2025

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)

-Owners of companies must be listed instead of company names.

-Names of trust beneficiaries must be listed.

	First Name	M.I.	Last Name	Place of Residence City	State	Operator/Licensee Ownership Percentage	Building Co. Ownership Percentage	Management Co. /Home Office Ownership Percentage	
76									76
77									77
78									78
79									79
80									80
81									81
82									82
83									83
84									84
85									85
86									86
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124									124
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140									140
141									141
142									142
143									143
144									144
145									145
146									146
147									147
148									148
149									149
150									150

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

VII. RELATED PARTIES

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

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

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Sam Thompson	Operations	Administrative	6.25	None	40+	100.00	Salary	$ 253,000	17-1	1
2	Jeff Thompson	Maintenance	Maintenance	6.25	None	40+	100.00	Salary	28,507	6-1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Salaries on this page have been adjusted										11
12											12
13								TOTAL	$ 281,507		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: 1/1/2025 Ending: 2/31/2025

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 1/1/2025 Ending: 2/31/2025

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 Southgate Health Care Center # 0017996 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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			$	$ 3,899,813			$ 366,381	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$ 3,899,813			$ 366,381	9
	B. Non-Facility Related*											
10	Interest Income		X								(2,243)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (2,243)	14
15	TOTALS (line 9+line14)						$	$ 3,899,813			$ 364,138	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.)

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2024 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 37,601	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.)		$ 35,910	2
3. Under or (over) accrual (line 2 minus line 1).		$ (1,691)	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 44,316	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.		$ 42,625	7

Assessed Value from Real Estate Tax Bill:	2024	437,034	8
Real Estate Tax Bill for Calendar Year:	2020	47,835	9
	2021	49,588	10
	2022	50,006	11
	2023	37,600	12
	2024	35,910	13

Real Estate tAx Accrual = 2024 tax bill 35910*1.24 (Estimated) = $44316

	FOR BHF USE ONLY		
14	FROM R. E. TAX STATEMENT FOR 2024	$	14
15	PLUS APPEAL COST FROM LINE 5	$	15
16	LESS REFUND FROM LINE 6	$	16
17	AMOUNT TO USE FOR RATE CALCULATION	$	17

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.

2024 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 B. Cutler

TELEPHONE (847) 940-3269 FAX #: (847) 964-5469

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

Enter the tax index number and real estate tax assessed for 2024 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 2024.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-01-440-001	Long-Term Care Property	$ 831.30	$ 831.30
2.	08-01-448-999	Long-Term Care Property	$ 34,116.00	$ 34,116.00
3.	08-01-448-007	Long-Term Care Property	$ 532.38	$ 532.38
4.	08-01-448-009	Long-Term Care Property	$ 430.64	$ 430.64
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 35,910.32	$ 35,910.32

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 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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 Numb Southgate Health Care Center # 0017996 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 42,622 B. General Construction Type: Exterior Brick Frame Concrete Number of Stories 1

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

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

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

None

F. List the bed capacity for the building if it differs from the licensed total. N/A

G. Have you properly capitalized all major repairs and equipment purchases? Yes

H. Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A

I. Are you presently operating under a sublease agreement? No

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

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Residential Care	185,500	1972	$ 5,000	1
2	Residential 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: 1/1/2025 Ending: 12/31/2025

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	$ 202,276	$		$	$	$	4
5	10		1976	1976	292,230						5
6	5		1989	1989	583,147						6
7			1993	1993	629,889		30				7
8	32		2012	2012	2,124,783		30				8
	Improvement Type**										
9	Various			1975	7,341		30				9
10	Various			1977	1,098		28				10
11	Various			1980	1,014		20				11
12	Various			1981	57,891		15				12
13	Various			1982	17,279		20				13
14	Various			1983	675		10				14
15	Various			1984	114,893		20				15
16	Various			1985	28,893		20				16
17	Various			1986	13,163		15				17
18	Various			1988	32,477		30				18
19	Various			1989	852		15				19
20	Various			1990	10,266		20				20
21	Various			1992	1,824		10				21
22	Various			1995	3,742		15				22
23	Various			1996	2,240		10				23
24	Various			1997	10,317		20				24
25	Various			1998	1,130		10				25
26	Various			1999	17,240		20				26
27	Various			2000	17,005		20				27
28	Various			2001	259,580		20				28
29	Various			2002	145,221		40				29
30	Various			2003	3,238		10				30
31	Various			2004	18,000		10				31
32	Various			2005	54,191		10				32
33	Various			2006	13,365		15				33
34	Various			2007	25,309		7				34
35	Various			2008	4,318		7				35
36	Book Depreciation					152,283		152,283		(5,839,800)	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: 1/1/2025 Ending: 12/31/2025

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	Various	2009	$ 49,584	$		$	$	$	37
38	Various	2010	37,748						38
39	Various	2011	22,449						39
40	Various	2013	36,890		15				40
41	Various	2014	192,136		20				41
42	Various	2015	42,915		15				42
43	Various	2016	7,021		7				43
44	Various	2017	18,649		7				44
45	Various	2018	39,746		5				45
46	Various	2019	36,923						46
47	Glass Doors	2020	2,087		20				47
48	Water Heater	2020	4,135		10				48
49	Heating System Boiler	2023	14,297		39				49
50	Plumbing work and replacement water heaters	2023	13,435		39				50
51	Back Flow Preventer for Fire Sprinkler System	2023	4,997		39				51
52	5 Ton Gas Pack HVAC Unit	2024	8,914		20				52
53	Boiler Water Heater for Laundry	2024	16,000		20				53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 5,242,813	$ 152,283		$ 152,283	$	$ (5,839,800)	70

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

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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	$ 536,318	$	$	$	5	$	71
72	Current Year Purchases	13,326						72
73	Fully Depreciated Assets	1,344,117						73
74								74
75	TOTALS	$ 1,893,761	$	$	$		$	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	Residential Care	Dodge Caravan/Buick Enclave		$ 73,952	$	$	$	5	$	76
77	Residential Care	Pick Up Truck		17,266				5		77
78	Residential Care	Dodge Durango		48,664				5		78
79	Residential Care	Dodge Van		44,346				5		79
80	TOTALS			$ 184,228	$	$	$		$	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)	$ 7,420,802	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 152,283	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 152,283	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ (5,839,800)	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	Other Vehicles	$ 31,855	$	$	86
87	Land	108,811			87
88					88
89					89
90					90
91	TOTALS	$ 140,666	$	$	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 Southgate Health Care Center # 0017996 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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.	/2026	$
13.	/2027	$
14.	/2028	$

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: $ 25,295 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

* 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	5,500
Propane Gas Tanks	250
Ice Machines	1529
Oxygen Rental/Supplies	18,016
	25,295

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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? [X] 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	X
IN OTHER FACILITY	
COMMUNITY COLLEGE	
HOURS PER CNA	80

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
HOURS PER CNA	40

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$ 1,120	$ 4,480	$	$ 5,600
2	Books and Supplies	244	976		1,220
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	$ 1,364	$ 5,456	$	$ 6,820
10	SUM OF line 9, col. 1 and 2 (e)	$ 6,820			

(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.

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	6
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	2
2. From other facilities (f)	
TOTAL TRAINED	8

(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.

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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	39-1	hrs	$ 99,746		$	$		$ 99,746	1
2	Licensed Speech and Language Development Therapist	39-1	hrs	106,119					106,119	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-1	hrs	197,322					197,322	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				181,967		181,967	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Attached	39-2					25,761		25,761	12
13	Other (specify): See Attached	39-3				33,339			33,339	13
14	TOTAL			$ 403,187		$ 33,339	$ 207,728		$ 644,254	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.

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Description	Amount
39-2	
Medicare x-Ray	4,060.00
VA Xray	21,701.00
Total	**25,761.00**

39-3	
Medicare Lab	9,705.00
Medicare Support Services	0.00
MEDICARE-PROSTHETICS	0.00
VA Lab	12,365.00
VA Physician	10,744.00
VA Rehab	0.00
VA Podiatrist	525.00
Total	**33,339.00**

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2025 (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	$ (1,703,201)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	8,403,877		3
4	Supply Inventory (priced at)	3,541		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	13,099		7
8	Accounts Receivable (owners or related parties)	62,500		8
9	Other(specify): See Attached	(19,746)		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 6,760,070	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	208,811		13
14	Buildings, at Historical Cost	4,729,754		14
15	Leasehold Improvements, at Historical Cost	2,604,903		15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(5,839,800)		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)**	$ 1,703,668	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 8,463,738	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 90,018	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,154,837		29
30	Accrued Salaries Payable	19,077		30
31	Accrued Taxes Payable (excluding real estate taxes)	621,620		31
32	Accrued Real Estate Taxes(Sch.IX-B)	44,316		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	424,711		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,354,579	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	7,852		39
40	Mortgage Payable	3,899,813		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)**	$ 3,907,665	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,262,244	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,201,494	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 8,463,738	$	48

*(See instructions.)

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	Other Current Assets:	Amount
9	A/R Employee	(19,746)
9		
9		
9		
9		
9		
	Total Line 9	(19,746)

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

	Other Current Liabilities:	Amount
36	BCBS Payments	7,794
36	Insurance - W/H Life Ins	5,049
36	Insurance - W/H Health Ins	7,232
36	Due to DPA Audit	(4,361)
36	Construction Loan	7,130
36	Other Accrued Expenses	243,571
36	Relay for Life	675
36	Accrued Licensed Bed Tax	158,162
36	Garnishment Withholding	(541)
	Total Line 36	424,711

	Other Non-Current Liabilities:	Amount
43		
43		
43		
43		
43		
43		
43		
43		
	Total Line 43	-

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,501,714	1
2	Restatements (describe):		2
3	PY Post Close adjustments	(117,297)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,384,417	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(182,923)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (182,923)	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)**	$ 2,201,494	24 *

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

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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	$ 7,853,674	1
2	Discounts and Allowances for all Levels	(666,226)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,187,448	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	25,684	5
6	Therapy	1,454,490	6
7	Oxygen	9,710	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,489,884	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	121,065	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	25,767	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 146,832	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,243	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,243	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Income/Misc. Exp.	(9,999)	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (9,999)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,816,408	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,618,820	31
32	Health Care	3,382,711	32
33	General Administration	2,079,442	33
	B. Capital Expense		
34	Ownership	586,584	34
	C. Ancillary Expense		
35	Special Cost Centers	869,031	35
36	Provider Participation Fee	462,743	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,999,331	40
41	**Income before Income Taxes (line 30 minus line 40)****	(182,923)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (182,923)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	$ 3,374,900.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	245,549.00	45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer	95,699.00	47
48	Private Pay	1,732,849.00	48
49	Medicare Part A	528,911.00	49
50	Other-(specify) VA	1,209,540.00	50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,187,448	56

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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	2,028	2,028	$ 79,958	$ 39.43	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,421	10,051	415,100	41.30	3
4	Licensed Practical Nurses	21,368	23,905	766,738	32.07	4
5	CNAs & Orderlies	53,385	55,169	1,197,731	21.71	5
6	CNA Trainees					6
7	Licensed Therapist	10,021	10,068	403,187	40.05	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,037	2,059	97,770	47.48	9
10	Activity Assistants					10
11	Social Service Workers	2,024	2,024	50,401	24.90	11
12	Dietician					12
13	Food Service Supervisor	2,256	2,256	47,421	21.02	13
14	Head Cook	5,217	5,318	79,181	14.89	14
15	Cook Helpers/Assistants	6,683	6,785	99,987	14.74	15
16	Dishwashers	9,614	9,955	155,866	15.66	16
17	Maintenance Workers	3,425	3,425	77,412	22.60	17
18	Housekeepers	22,397	22,434	332,209	14.81	18
19	Laundry	9,929	9,951	132,769	13.34	19
20	Administrator	2,080	2,080	253,000	121.63	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,445	6,445	139,614	21.66	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,282	2,282	49,883	21.86	31
32	Other Health C: CNA Assistants	12,408	13,205	212,940	16.13	32
33	Other(specify) Marketing/Admini	3,744	3,744	188,044	50.23	33
34	TOTAL (lines 1 - 33)	186,764	193,184	$ 4,779,211 *	$ 24.74	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		$		35
36	Medical Director	Monthly	22,072	10-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	Monthly	22,000	10A-3	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	Medicare Physisican	Monthly	19,993	10-3	47
48					48
49	TOTAL (lines 35 - 48)		$ 64,065		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	3,814	159,791	10-3	51
52	Certified Nurse Assistants/Aides	2,206	57,753	10-3	52
53	TOTAL (lines 50 - 52)	6,020	$ 217,544		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
Sam Thompson	Administrator	6.25%	246,547
			6,453
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 253,000

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
		$
Blythe CPA	Tax Retruns	2,550
Duane Morris	Legal	972
FGMK, LLC	Cost Reporting/Consulting	15,746
JHG, LLC	Conusltant	13,111
Kemper CPA Group	401K/Admin	15,140
McMurry and Livingston	Legal	1,925
Whitlow, Roberts, Houston & Straub	Legal	1,189
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 50,633

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 41,901
Unemployment Compensation Insurance	
FICA Taxes	404,050
Employee Health Insurance	61,496
Employee Meals	999
Illinois Municipal Retirement Fund (IMRF)*	
401K Match	32,004
Employee Benefits	11,438
TOTAL (agree to Schedule V, line 22, col.8)	$ 551,888

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,991
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 104)	1,042
Patient Background Checks 84	2,872
Association Dues (total from pg 22, #4)	2,128
Licenses & Dues	30,929
Less: Public Relations Expense	( )
PAC and Lobbying payments	(669)
All non-allowable advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 38,293

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	545
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 545

**See instructions.

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Date	Vendor	Descriptior	Amount
3/24/2025	DUANE MORRIS LLP	Legal	$ 540
4/11/2025	DUANE MORRIS LLP	Legal	$ 432
8/1/2025	Whitlow, Roberts, Houston & Straub, PLLC	Legal	$ 739
8/31/2025	McMurry and Livingston - McMurry and Livingston	Legal	$ 1,100
9/2/2025	Whitlow, Roberts, Houston & Straub, PLLC	Legal	$ 450
10/31/2025	McMurry and Livingston - McMurray and Livingstor	Legal	$ 825
Total			**$ 4,086**

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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below. Use the drop down list to identify the association.

Association Name	Amount
IL HEALTHCARE ASSOCIATION (IHCA)	1,459
	1,459 Total

(3) List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

IL HEALTHCARE ASSOCIATION (IHCA)	669
	669 Total

(4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)

IL HEALTHCARE ASSOCIATION (IHCA)	2,128
	2,128 Total

(5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. $ 24,495 Line 10

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

(7) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ 462,743
This amount is to be recorded on line 42 of Schedule V.

(8) 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.

(9) 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**

(10) 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.

(11) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 999 Has any meal income been offset against related costs? **No** Indicate the amount. $ N/A

(12) 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? **LN14**
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? **Yes**
g. Does the facility transport residents to and from day training? **No**
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

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

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

(15) 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.