FOR BHF USE

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

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

I. IDPH License ID Number: 0017996

Facility Name: Southgate Health Care Center

Address: 900 E Ninth St Bx843 (Number) Metropolis (City) 62960 (Zip Code)

County: Massac

Telephone Number: (618) 524-2683 **Fax #** (618) 524-3048

HFS ID Number:

Date of Initial License for Current Owners: 01/01/1964

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		

In the event there are further questions about this report, please contact:
Name: Amanda Springborn **Telephone Number:** (314) 925-3838
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2015 to 12/31/2015 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)
(Firm Name & Address) RSM US LLP, 20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847) 517-7067

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: 01/01/2015 Ending: 12/31/2015

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	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 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	13,175	11,488	6,549	31,212	8
9	SNF/PED					9
10	ICF	7,687	2,235	2,000	11,922	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,862	13,723	8,549	43,134	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.41%

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 [X] NO [ ] Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

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 08/25/72

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date N/A NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 106 and days of care provided 2,281

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

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

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	256,841	28,921		285,762		285,762	7,860	293,622			1
2	Food Purchase		230,971		230,971		230,971	(15,000)	215,971			2
3	Housekeeping	188,231	43,032		231,263		231,263		231,263			3
4	Laundry	137,739	37,985	2,712	178,436		178,436		178,436			4
5	Heat and Other Utilities			175,022	175,022		175,022		175,022			5
6	Maintenance	90,532	35,232	58,701	184,465		184,465		184,465			6
7	Other (specify):*											7
8	TOTAL General Services	673,343	376,141	236,435	1,285,919		1,285,919	(7,140)	1,278,779			8
	B. Health Care and Programs											
9	Medical Director			7,600	7,600		7,600		7,600			9
10	Nursing and Medical Records	2,218,701	230,160	38,910	2,487,771		2,487,771	(7,860)	2,479,911			10
10a	Therapy											10a
11	Activities	49,562	9,912		59,474		59,474		59,474			11
12	Social Services	59,959			59,959		59,959		59,959			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,328,222	240,072	46,510	2,614,804		2,614,804	(7,860)	2,606,944			16
	C. General Administration											
17	Administrative	327,132			327,132		327,132		327,132			17
18	Directors Fees			4,000	4,000		4,000		4,000			18
19	Professional Services			21,851	21,851		21,851	(1,605)	20,246			19
20	Dues, Fees, Subscriptions & Promotions			74,830	74,830		74,830	(55,274)	19,556			20
21	Clerical & General Office Expenses	118,628	19,927	111,009	249,564		249,564	(6,879)	242,685			21
22	Employee Benefits & Payroll Taxes			464,461	464,461		464,461	15,000	479,461			22
23	Inservice Training & Education			393	393		393		393			23
24	Travel and Seminar			33,362	33,362		33,362	(20,033)	13,329			24
25	Other Admin. Staff Transportation			29,725	29,725		29,725		29,725			25
26	Insurance-Prop.Liab.Malpractice			116,128	116,128		116,128		116,128			26
27	Other (specify):*											27
28	TOTAL General Administration	445,760	19,927	855,759	1,321,446		1,321,446	(68,791)	1,252,655			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,447,325	636,140	1,138,704	5,222,169		5,222,169	(83,791)	5,138,378			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: 01/01/2015 Ending: 12/31/2015

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			296,096	296,096		296,096	(69,164)	226,932			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			28,080	28,080		28,080	(4,216)	23,864			32
33	Real Estate Taxes			45,914	45,914		45,914		45,914			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			22,208	22,208		22,208		22,208			35
36	Other (specify):*											36
37	**TOTAL Ownership**			392,298	392,298		392,298	(73,380)	318,918			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	314,095	151,104	28,028	493,227		493,227		493,227			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			324,634	324,634		324,634		324,634			42
43	Other (specify):* Non-Allowable Cos	30,720		105,195	135,915		135,915	(135,915)				43
44	**TOTAL Special Cost Centers**	344,815	151,104	457,857	953,776		953,776	(135,915)	817,861			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,792,140	787,244	1,988,859	6,568,243		6,568,243	(293,086)	6,275,157			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: 01/01/2015 Ending: 12/31/2015

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	(69,164)	30		9
10	Interest and Other Investment Income	(4,216)	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	(3,040)	20		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	(51,934)	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 See Page 5A	(164,732)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (293,086)		$	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))**	$ (293,086)		37

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

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

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

Southgate Health Care Center

ID# 0017996

Report Period Beginning: 01/01/2015

Ending: 12/31/2015

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Offset Other Income revenue	$ (6,879)	21	1
2	Out of state travel, meals & entertainment	(17,989)	24	2
3	Out of state travel, meals & entertainment	(2,044)	24	3
4	Marketing salaries	(30,720)	43	4
5	Nonallowable marketing events	(15,429)	43	5
6	Contributions	(3,940)	43	6
7	Tax expense	(20,734)	43	7
8	Nonallowable auto expense	(1,885)	43	8
9	Medicare Lab	(13,724)	43	9
10	Medicare X-Ray	(6,898)	43	10
11	Directors' health, disability & life insurance	(3,212)	43	11
12	IHCA PAC Expenses	(12,639)	43	12
13	Bad Debt	(26,703)	43	13
14	Penatlties	(25)	43	14
15	Medicare Support Services	(6)	43	15
16	Non-allowable Legal fees	(1,605)	19	16
17	Offset Chamber of Commerce and Passport Fees	(300)	20	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**	(164,732)		49

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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 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			$	N/A		$	$	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			$			$	$ * 0	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: 01/01/2015 Ending: 12/31/2015

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	$ 263,000	17(1)	1
2	Jeff Thompson	Maintenance	Maintenance	6.25	None	40+	100.00	Salary	33,280	6(1)	2
3	Mary Lynn Thompson	Accountant	Accountant	0.00	None	40+	100.00	Salary	23,100	21(1)	3
4											4
5	Sam Thompson	Director	Administrative	6.25	None	40+	100.00	Dir. Fees (A)	1,000	18(3)	5
6	Jeff Thompson	Director	Administrative	6.25	None	40+	100.00	Dir. Fees (A)	1,000	18(3)	6
7	Shelly Bell	Director	Administrative	6.25	None	<1	<2%	Dir. Fees (A)	1,000	18(3)	7
8	William Parker	Director	Administrative	0.00	None	<1	<2%	Dir. Fees (A)	1,000	18(3)	8
9											9
10	William Parker	Consultant	Administrative	0.00	None			Consulting Fees	12,000	10(3)	10
11											11
12	(A) - Director fees $; board meeting expenses reimbursed $.										12
13								TOTAL	$ 335,380		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: 01/01/2015 Ending: 2/31/2015

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 N/A
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		N/A								3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
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14										14
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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: 01/01/2015 Ending: 12/31/2015

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	City National Bank		X	Mortage Note Payable	$7,683.40	6/15/12	$ 1,000,000	$ 528,486	6/15/2027	0.0450	$ 26,120	1
2	Wells Fargo Dealer Services		X	Auto Loan	$548.80	10/24/12	39,513	18,659	10/24/2017			2
3	Chrysler Capital		X	Auto Loan	$719.12	5/25/15	43,147	37,394	4/25/2020			3
4												4
5												5
	Working Capital											
6	City National Bank		X	Working Capital	Monthly	3/20/14	337,000		3/19/15	0.0450	1,059	6
7												7
8												8
9	TOTAL Facility Related				$8,951.32		$ 1,419,660	$ 584,539			$ 27,179	9
	B. Non-Facility Related*											
10	TD Auto Finance		X	Vehicle Purchase	$622.19	12/18/12	40,189	21,187	12/18/17	0.0364	901	10
11								Interest income offset			(3,315)	11
12												12
13								Disallow non-care related interest			(901)	13
14	TOTAL Non-Facility Related				$622.19		$ 40,189	$ 21,187			$ (3,315)	14
15	TOTALS (line 9+line14)						$ 1,459,849	$ 605,726			$ 23,864	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:** 01/01/2015 **Ending:** 12/31/2015

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$ 43,390	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.)	2014	$ 44,652	2
3. Under or (over) accrual (line 2 minus line 1).		$ 1,262	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 44,652	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
	Allocated from Managment Co.		
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.		$ 45,914	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	38,776	8
	2011	40,631	9
	2012	40,461	10
	2013	43,379	11
	2014	44,652	12

Accrual based on prior year real estate tax bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Southgate Health Care Center, Inc. COUNTY Massac

FACILITY IDPH LICENSE NUMBER 0017996

CONTACT PERSON REGARDING THIS REPORT Sam Thompson

TELEPHONE (618) 524-2683 FAX #: (618) 524-3048

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

Enter the tax index number and real estate tax assessed for 2014 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-01-448-004	Nursing Facility	$ 307.84	$ 307.84
2.	08-01-448-005	Nursing Facility	$ 296.94	$ 296.94
3.	08-01-448-008	Nursing Facility	$ 1,293.54	$ 1,293.54
4.	08-01-450-999	Nursing Facility	$ 42,753.62	$ 42,753.62
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 44,651.94	$ 44,651.94

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

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

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

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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. 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: N/A 2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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	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: 01/01/2015 Ending: 12/31/2015

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	1976	$ 496,620	$		$	$	$ 496,620	4
5	10			1989	583,147	18,513		19,438	925	514,807	5
6	5			1993	598,429	15,344	30	19,948	4,604	448,830	6
7				1994	13,658	350	30	455	105	9,990	7
8	32			2012	2,108,329	128,167	30	70,278	(57,890)	245,972	8
	Improvement Type**										
9	Land improvements			1975	7,341		10-30			7,341	9
10	Land improvements			1976	2,886		20			2,886	10
11	Building improvements			1977	1,098		28			1,098	11
12	Land and building improvements			1980	1,014		20			1,014	12
13	Building improvements			1981	57,891		15			57,891	13
14	Land & building improvements			1982	17,279		5-20			17,279	14
15	Building improvements			1983	675		10			675	15
16	Bushes & gravel			1984	888		10			888	16
17	Patio, Med room & improvements			1984	13,078		15			13,078	17
18	Building addition			1984	100,925		20			100,925	18
19	Gravel road & painting			1985	7,365		3-20			7,365	19
20	Improvements			1985	17,960		15			17,960	20
21	Fire alarm & barn			1985	3,568		20			3,568	21
22	Improvements			1986	13,163		15			13,163	22
23	Kitchen remodeling			1988	32,477	1,031	30	1,084	53	29,798	23
24	Overhead door/kitchen			1989	852		15			852	24
25	Flooring			1990	729		10			729	25
26	Fire alarm			1990	9,537		20			9,537	26
27	Dining room improvements			1992	1,824		10			1,824	27
28	Warehouse storage building			1993	17,802	565	30	593	28	13,639	28
29	100 gal lime tank			1995	3,742		15			3,742	29
30	Drywall resident rooms & bathrooms			1996	2,240		10			2,240	30
31											31
32											32
33											33
34											34
35											35
36											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: 01/01/2015 Ending: 12/31/2015

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	Parking lot	1997	$ 5,000	$	10	$	$	$ 5,000	37
38	Flooring	1997	674		10			674	38
39	Kitchen plumbing	1997	1,947	50	20	97	47	1,795	39
40	Tile floor	1997	784		10			784	40
41	Water softener	1997	667		10			667	41
42	Interior design	1997	1,245		15			1,245	42
43									43
44	Flooring	1998	1,130		10			1,130	44
45									45
46	Roofing	1999	17,240	442	20	862	420	14,546	46
47									47
48	Roof - Section B	2000	31,346	436	20	1,567	1,131	23,930	48
49									49
50	New laundry building	2001	179,249	4,596	20	8,962	4,366	130,410	50
51	Laundry building flooring	2001	1,219		10			1,219	51
52	Roof replacement	2001	84,500	2,167	20	4,225	2,058	61,293	52
53									53
54	Design & remodel dining room	2002	97,732	2,506	40	2,443	(63)	32,981	54
55	Flooring	2002	39,834		10			39,834	55
56	Blinds	2002	2,473		10			2,473	56
57	Awning	2002	996		10			996	57
58	Walk in cooler repair	2002	3,361		10			3,361	58
59	Lighting	2002	2,563		10			2,563	59
60									60
61	Flooring	2003	871	27	10		(27)	871	61
62	Entryway Carpeting	2003	2,367	74	10		(74)	2,367	62
63									63
64									64
65									65
66									66
67	Flooring	2004	18,000		10			18,000	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,607,715	$ 174,268		$ 129,952	$ (44,317)	$ 2,369,850	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: 01/01/2015 Ending: 12/31/2015

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,607,715	$ 174,268		$ 129,952	$ (44,317)	$ 2,369,850	1
2	Flooring	2005	22,140		10	2,214	2,214	21,033	2
3	Drywall Hallways in A&D Wings & Various Resident Rooms	2005	19,233		10	964	964	19,233	3
4									4
5	Shelving unit for kitchen	2006	2,377		7			2,377	5
6	Drywall	2006	3,325	230	15	222	(8)	2,109	6
7	Air condtioning unit	2006	5,091	636	7		(636)	5,091	7
8	Flooring	2006	2,572	321	7		(321)	2,572	8
9									9
10	Air Conditioners Unit	2007	8,325		7			8,325	10
11	New Flooring/Shelving Units	2007	4,616		7			4,616	11
12	Instalation of new lighting fixtures	2007	2,966		7			2,966	12
13	Repair to Laundry and Dishwasher Equip	2007	3,784		7			3,784	13
14	Additions to wandreguard & alarm system	2007	5,618		7			5,618	14
15									15
16	New flooring	2008	4,318	377	7	617	240	4,054	16
17									17
18	Flooring	2009	6,993	1,713	7	999	(714)	6,600	18
19	Replacement Roof	2009	40,000	2,667	15	2,667		17,335	19
20	HVAC Units	2009	2,591	634	7	370	(264)	2,405	20
21									21
22	Installation Exp for Electric & Gas Line for Generator	2010	8,165	1,693	7	1,166	(527)	5,887	22
23	Flooring	2010	4,191	599	7	599		3,295	23
24	Replacement Roof	2010	25,392	1,166	15	1,693	527	9,837	24
25									25
26	Water Heater	2011	12,126	726	5	2,426	1,700	10,917	26
27	Mechanical Lifts	2011	7,623	181	7	1,088	907	4,896	27
28	Flooring	2011	2,700	32	7	286	254	1,337	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,801,861	$ 185,243		$ 145,263	$ (39,981)	$ 2,514,137	34

**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: 01/01/2015 Ending: 12/31/2015

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 4,801,861	$ 185,243		$ 145,263	$ (39,981)	$ 2,514,137	1
2									2
3	Remodeling & Rewiring - final payment for phone	2013	9,874	658	15	658		1,645	3
4	and cable wiring completed on the 300 Wing Addition								4
5	Remodeling & Rewiring - B Hall - Nurse call system	2013	3,058	204	15	204		510	5
6	(Micro Vision 200Z) Skilled Portion of Facility								6
7	Remodeling - 100 & 200 Hall Resident Room bathrooms,	2013	6,955	464	15	464		1,160	7
8	new sinks, countertops, and wall board. New handrails								8
9	installed and painted in hallways.								9
10	Rewiring B Hall - Electric rewiring for entire B Hall	2013	13,478	899	15	899		2,247	10
11									11
12									12
13	Hot Water Heater	2013	3,525	504	7	504		1,260	13
14									14
15	Remodeling of B/C Hall - installing, finishing, and painting	2014	171,980	2,205	39	4,410	2,205	6,615	15
16	sheetrock in resident rooms and hallway. New handrails								16
17	in hallways. New flooring in resident rooms and hallways.								17
18	HVAC Unit by dining room	2014	5,643		7	806	806	1,209	18
19	Pellett Heater - Kitchen	2014	6,264	447	7	895	448	1,342	19
20	Engineering work for parking lot renovation	2014	8,249	275	15	550	275	825	20
21									21
22	Water Heater - Laundry	2015	9,504	679	7	679		679	22
23	Parking Lot Improvements	2015	22,007	734	15	734		734	23
24	Flooring - Resident rooms on Intermediate A Hall	2015	11,404	380	15	380		380	24
25									25
26									26
27									27
28									28
29									29
30	Adjustment to tie to financials			46,529			(46,529)		30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,073,802	$ 239,221		$ 156,445	$ (82,776)	$ 2,532,742	34

**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: 01/01/2015 Ending: 12/31/2015

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	$ 316,360	$ 53,737	$ 53,737	$	6	$ 147,481	71
72	Current Year Purchases	31,226	3,138	3,138		3-7	3,138	72
73	Fully Depreciated Assets	870,435					870,435	73
74								74
75	TOTALS	$ 1,218,021	$ 56,875	$ 56,875	$		$ 1,021,054	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	Chevy Truck	2011	10,977		2,195	2,195	5	9,878	78
79	See Sch 13A			89,246		11,417	11,417	5	31,644	79
80	TOTALS			$ 133,227	$	$ 13,612	$ 13,612		$ 74,526	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)	$ 6,525,050	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 296,096	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 226,932	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (69,164)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,628,322	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	BMW	57,504		57,504	87
88	Jeep Cherokee	40,164		40,164	88
89	Jeep	40,189	8,038	28,133	89
90	See SCH 13A	85,178		1,727	90
91	TOTALS	$ 299,139	$ 8,038	$ 203,632	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93	N/A		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: Southgate Health Care Center
IDPH License ID Number: 0017996
Fiscal Year End: 12/31/2015

Schedule 13A

XI. Ownership Costs
Line 79 - Vehicle Depreciation

Use	Model, Make & Year	Year Acquired	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustments	Life in Years	Accumulated Depreciation
Resident Care	Buick Enclave	2012	39,513	6,161	6,161	-	5	25,918
Resident Care	Lawn Tractor	2014	6,586	941	941	-	7	1,411
Resident Care	Dodge Caravan	2015	43,147	4,315	4,315	-	5	4,315
						-		-
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
TOTAL			**89,246**	**11,417**	**11,417**	**-**		**31,644**

Continued from PG13

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	Land	$ 67,912	$	$ 0	86
87	Chevrolet Silverado Pick Up Truck	17,266	1,727	1,727	87
88					88
89					89
90					90
91	TOTALS	$ 85,178	$	$ 1,727	91

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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:				$ N/A			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2016	$
13.	/2017	$
14.	/2018	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 22,208 Description: See attached Schedule 14A
(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			$ N/A	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name: **Southgate Health Care Center**
IDPH License ID Number: **0017996**
Fiscal Year End: **12/31/2015**

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Phone System	6,000
Post Office Box Rental	144
Ice machine rental	688
Office space	2,000
Safety deposit box rental	40
Propane Gas Tanks	380
Dish Machine	923
CPAP Machine	1,580
Wound Vac Machine	8,218
Oxygen Supplies	2,235
Total - Line 16	**22,208**

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [ ] YES [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39(1)	1737	hrs	$ 110,771		$	$	1,737	$ 110,771	1
2	Licensed Speech and Language Development Therapist	39(1)	953	hrs	65,823				953	65,823	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	39(1)	2067	hrs	137,501				2,067	137,501	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				151,104		151,104	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): See Sch 16A	39(3)					28,028			28,028	12
13	Other (specify):										13
14	TOTAL				$ 314,095		$ 28,028	$ 151,104	4,757	$ 493,227	14

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

Facility Name: **Southgate Health Care Center**
IDPH License ID Number: **0017996**
Fiscal Year End: **12/31/2015**

Schedule 16A

XIV. Special Services (Direct Cost)
Line 12 Other (specify)

Description	Units	Amount
VA lab		2,438
VA physcian		6,774
VA rehab		18,816
Total - Line 12	**-**	**28,028**

STATE OF ILLINOIS

Facility Name & ID Number Southgate Health Care Center **#** 0017996 **Report Period Beginning:** 01/01/2015 **Ending:** 12/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2015 **(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	$ 3,000	$ 3,000	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (1,093))	1,059,595	1,059,595	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	12,461	12,461	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): A/R Employee	5,457	5,457	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,080,513	$ 1,080,513	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	4,275,349	3,800,183	14
15	Leasehold Improvements, at Historical Cost	2,598,225	1,273,619	15
16	Equipment, at Historical Cost		1,351,248	16
17	Accumulated Depreciation (book methods)	(3,828,372)	(3,628,322)	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 (spe			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,238,398	$ 2,896,728	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,318,911	$ 3,977,241	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 278,663	$ 278,663	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	37,394	37,394	29
30	Accrued Salaries Payable	144,403	144,403	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,778	5,778	31
32	Accrued Real Estate Taxes(Sch.IX-B)	44,652	44,652	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Sch 17A	93,505	93,505	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 604,395	$ 604,395	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	39,846	39,846	39
40	Mortgage Payable	528,486	528,486	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)**	$ 568,332	$ 568,332	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,172,727	$ 1,172,727	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,146,184	$ 2,804,514	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,318,911	$ 3,977,241	48

***(See instructions.)**

Facility Name: **Southgate Health Care Center**
IDPH License ID Number: **0017996**
Fiscal Year End: **12/31/2015**

Schedule 17A

XV. Balance Sheet
Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
Insurance - W/H Life Ins	614	614
Insurance - W/H Health Ins	-	-
Garnishment W/H	1	1
Other Accrued Expenses	(14,701)	(14,701)
Accrued Licensed Bed Tax	107,591	107,591
Total - Line 36	**93,505**	**93,505**

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,219,243	1
2	Restatements (describe):		2
3	**Prior Period Adjustment**	(15,154)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,204,089	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	174,573	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	(232,478)	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)**	$ (57,905)	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)**	$ 3,146,184	24 *

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

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	$ 6,307,765	1
2	Discounts and Allowances for all Levels	(841,842)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,465,923	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	17,773	5
6	Therapy	1,052,826	6
7	Oxygen	3,273	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,073,872	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	180,759	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	12,068	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 192,827	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,315	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,315	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Other Income	6,879	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 6,879	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,742,816	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,285,919	31
32	Health Care	2,614,804	32
33	General Administration	1,321,446	33
	B. Capital Expense		
34	Ownership	392,298	34
	C. Ancillary Expense		
35	Special Cost Centers	629,142	35
36	Provider Participation Fee	324,634	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,568,243	40
41	**Income before Income Taxes (line 30 minus line 40)****	174,573	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 174,573	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,524,230	44
45	Private Pay - Net Inpatient Revenue	2,371,231	45
46	Medicare - Net Inpatient Revenue	200,100	46
47	Other-(specify) Net VA Inpatient Revenue	370,362	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,465,923	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.**

^- This entity is a cash bais taxpayer

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,167	2,167	$ 68,428	$ 31.58	1
2	Assistant Director of Nursing	2,297	2,297	56,642	24.66	2
3	Registered Nurses	13,900	13,900	367,123	26.41	3
4	Licensed Practical Nurses	28,251	28,251	494,214	17.49	4
5	CNAs & Orderlies	118,835	118,835	1,232,294	10.37	5
6	CNA Trainees					6
7	Licensed Therapist	4,757	4,757	314,095	66.03	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,112	2,112	23,412	11.09	9
10	Activity Assistants	2,751	2,751	26,150	9.51	10
11	Social Service Workers	5,059	5,059	59,959	11.85	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	2,080	2,080	40,616	19.53	13
14	Head Cook	11,334	11,334	109,687	9.68	14
15	Cook Helpers/Assistants	7,516	7,516	67,696	9.01	15
16	Dishwashers	4,686	4,686	38,842	8.29	16
17	Maintenance Workers	5,248	5,248	90,532	17.25	17
18	Housekeepers	19,582	19,582	188,231	9.61	18
19	Laundry	13,824	13,824	137,739	9.96	19
20	Administrator	2,080	2,080	64,132	30.83	20
21	Assistant Administrator		0	0		21
22	Other Administrative	2,080	2,080	263,000	126.44	22
23	Office Manager	1,200	1,200	23,100	19.25	23
24	Clerical	5,995	5,995	95,528	15.94	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 Ca					32
33	Other(specify) Marketing Dir.	2,112	2,112	30,720	14.55	33
34	TOTAL (lines 1 - 33)	257,864	257,864	$ 3,792,140 *	$ 14.71	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 7,860	1(7)	35
36	Medical Director	Monthly	7,600	9(3)	36
37	Medical Records Consultant	Quarterly	1,871	10(3)	37
38	Nurse Consultant			10(3)	38
39	Pharmacist Consultant	Monthly	1,283	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	Orthopaedic Rehab Consultant	Monthly	397	10(3)	47
48	Physician Consultant	Monthly	12,000	10(3)	48
49	TOTAL (lines 35 - 48)		$ 31,011		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	24	$ 1,045	10(3)	50
51	Licensed Practical Nurses	437	14,149	10(3)	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	461	$ 15,194		53

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sam Thompson	Administrative	6.25	$ 263,000
Rebekah Mahoney	Administrator	0	64,132
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 327,132

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
RSM US LLP	Accounting	$ 11,340
Williams, Williams, Lentz	Accounting	4,250
Kemper CPA	Accounting	3,109
Duane Morris	Legal	1,547
Whitlow Roberts	Legal	1,605
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 21,851

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 81,179
Unemployment Compensation Insurance	
FICA Taxes	283,039
Employee Health Insurance	60,894
Employee Meals	15,000
Illinois Municipal Retirement Fund (IMRF)*	
Employee Retirement	
Employee Relations	28,255
Personnel Expenses	2,446
Pension Contribution Expense	8,648
TOTAL (agree to Schedule V, line 22, col.8)	$ 479,461

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

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,749
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 107)	1,344
Patient Background Checks	
Miscellaneous Licenses & Fees	6,272
Misc. Dues & Subscriptions	3,131
IHCA	8,400
Nonallowable Advertising	51,934
Less: Chamber Dues	(300)
Less: Public Relations Expense	(3,040)
Non-allowable advertising	(51,934)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,556

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 16,066
Out-of-State Seminars	1,940
In-State Travel	11,339
In-State Seminars	1,990
Marketing Mileage & Non Educational	2,027
Seminar Expense	
Less: Nonallowable out of state travel,	
meals & entertainment	(20,033)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 13,329

* Attach copy of IMRF notifications

**See instructions.

Facility Name: **Southgate Health Care Center**
IDPH License ID Number: **0017996**
Fiscal Year End: **12/31/2015**

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
Total Professional Fees from PG 21		21,851
	Total (agree to Schedule V, line 19, column 3)	21,851
Less: Non-Allowable Legal Fees		(1,605)
	Total (agree to Schedule V, line 19, column 8)	20,246

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													N/A
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA & AHCA - $8,400**

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

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **3-7 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **24,229** Line **10(2)**

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

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

(9) Are you presently operating under a sublease agreement? YES **X** NO

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **324,634**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **15,000** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
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? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

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