		FOR BHF USE					

LL1

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

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

I. IDPH License ID Number: 0017996

Facility Name: Southgate Health Care Center

Address: 900 E. 9th Street P.O.Box 843 (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: 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		

In the event there are further questions about this report, please contact:
Name: Andrew B. Cutler **Telephone Number:** (847) 374-0400
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/18 to 12/31/18 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) _____
(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) 374-0400 Fax # (847) 374-4020

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

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 1/1/18 Ending: 12/31/18

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	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	23,207	11,949	9,751	44,907	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,207	11,949	9,751	44,907	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.88%

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 number of beds certified 106 and days of care provided 3,388

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 Fiscal Year: 12/31

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

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 1/1/18 Ending: 12/31/18

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	282,287	25,737	7,545	315,569		315,569		315,569			1
2	Food Purchase		260,303		260,303		260,303		260,303			2
3	Housekeeping	217,958	39,252		257,210		257,210		257,210			3
4	Laundry	133,281	21,367		154,648		154,648		154,648			4
5	Heat and Other Utilities			207,297	207,297		207,297		207,297			5
6	Maintenance	82,940	47,902	79,861	210,703		210,703		210,703			6
7	Other (specify):*											7
8	TOTAL General Services	716,466	394,561	294,703	1,405,730		1,405,730		1,405,730			8
	B. Health Care and Programs											
9	Medical Director			7,300	7,300		7,300		7,300			9
10	Nursing and Medical Records	2,322,551	235,150	486,497	3,044,198		3,044,198		3,044,198			10
10a	Therapy			12,000	12,000		12,000		12,000			10a
11	Activities	81,562	11,902		93,464		93,464		93,464			11
12	Social Services	36,964			36,964		36,964		36,964			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,441,077	247,052	505,797	3,193,926		3,193,926		3,193,926			16
	C. General Administration											
17	Administrative	335,279			335,279		335,279		335,279			17
18	Directors Fees			9,000	9,000		9,000		9,000			18
19	Professional Services			56,542	56,542		56,542	(8,172)	48,370			19
20	Dues, Fees, Subscriptions & Promotions			87,683	87,683		87,683	(51,422)	36,261			20
21	Clerical & General Office Expenses	131,599	18,093	347,882	497,574		497,574	(202,711)	294,863			21
22	Employee Benefits & Payroll Taxes			514,492	514,492		514,492		514,492			22
23	Inservice Training & Education			11,876	11,876		11,876		11,876			23
24	Travel and Seminar			9,140	9,140		9,140	(4,292)	4,848			24
25	Other Admin. Staff Transportation			21,472	21,472		21,472	(204)	21,268			25
26	Insurance-Prop.Liab.Malpractice			80,542	80,542		80,542		80,542			26
27	Other (specify):*											27
28	TOTAL General Administration	466,878	18,093	1,138,629	1,623,600		1,623,600	(266,801)	1,356,799			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,624,421	659,706	1,939,129	6,223,256		6,223,256	(266,801)	5,956,455			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: 1/1/18 Ending: 12/31/18

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			284,831	284,831		284,831	(107,434)	177,397			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			56,263	56,263		56,263	(9,876)	46,387			32
33	Real Estate Taxes			45,033	45,033		45,033		45,033			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			51,534	51,534		51,534		51,534			35
36	Other (specify):*											36
37	TOTAL Ownership			437,661	437,661		437,661	(117,310)	320,351			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation		205,782	822,888	1,028,670		1,028,670		1,028,670			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			306,035	306,035		306,035		306,035			42
43	Other (specify):*	74,288		55,580	129,868		129,868	(129,868)				43
44	TOTAL Special Cost Centers	74,288	205,782	1,184,503	1,464,573		1,464,573	(129,868)	1,334,705			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,698,709	865,488	3,561,293	8,125,490		8,125,490	(513,979)	7,611,511			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: 1/1/18 Ending: 12/31/18

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(107,434)	30		9
10	Interest and Other Investment Income	(9,876)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(47,584)	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	(349,085)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (513,979)		$	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))**	$ (513,979)		37

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

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

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

Southgate Health Care Center

ID# 0017996

Report Period Beginning: 1/1/18

Ending: 12/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Personal Portion of Travel Expense	$ (204)	25	1
2	Non-Allowable Marketing Salaries	(74,288)	43	2
3	Bad Debt Expense	(196,345)	21	3
4	Non-Allowable Charitable Cont.	(2,175)	43	4
5	Non-Allowable Marketing Expense	(7,739)	43	5
6	Non-Allowable Tax Expense	(32,228)	43	6
7	Non-Allowable Health Insurance Dir.	(1,555)	43	7
8	Non-Allowable IHCA PAC	(7,810)	43	8
9	Non-Allowable Auto Expense	(4,073)	43	9
10	Non-Allowable Chamber of Comerce Dues	(188)	20	10
11	Non-Allowable IHCA Lobbying Expense	(3,650)	20	11
12	Offset Other Income	(6,366)	21	12
13	Out of State Travel	(3,242)	24	13
14	Non-Allowable Seminar Fees	(1,050)	24	14
15	Non-Allowable Legal Fees	(8,172)	19	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**	(349,085)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Southgate Health Care Center # 0017996 **Report Period Beginning:** 1/1/18 **Ending:** 12/31/18

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

	Operating Expenses	PAGES 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	(8,172)	0	0	0	0	0	0	0	0	0	0	(8,172)	19
20	Fees, Subscriptions & Promotions	(51,422)	0	0	0	0	0	0	0	0	0	0	(51,422)	20
21	Clerical & General Office Expenses	(202,711)	0	0	0	0	0	0	0	0	0	0	(202,711)	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	(4,292)	0	0	0	0	0	0	0	0	0	0	(4,292)	24
25	Other Admin. Staff Transportation	(204)	0	0	0	0	0	0	0	0	0	0	(204)	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**	(266,801)	0	0	0	0	0	0	0	0	0	0	(266,801)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(266,801)	0	0	0	0	0	0	0	0	0	0	(266,801)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Southgate Health Care Center # 0017996 **Report Period Beginning:** 1/1/18 **Ending:** 12/31/18

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(107,434)	0	0	0	0	0	0	0	0	0	0	(107,434)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(9,876)	0	0	0	0	0	0	0	0	0	0	(9,876)	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**	(117,310)	0	0	0	0	0	0	0	0	0	0	(117,310)	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):*	(129,868)	0	0	0	0	0	0	0	0	0	0	(129,868)	43
44	**TOTAL Special Cost Centers**	(129,868)	0	0	0	0	0	0	0	0	0	0	(129,868)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(513,979)	0	0	0	0	0	0	0	0	0	0	(513,979)	45

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 1/1/18 Ending: 12/31/18

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Jane 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			$			$	$	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: 1/1/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Sam Thompson	Operations	Administrative	6.25	None	40+	100.00	Salary	$ 260,919	17-1	1
2	Jeff Thompson	Maintenance	Maintenance	6.25	None	40+	100.00	Salary	33,280	6-1	2
3											3
4	Sam Thompson	Director	Administrative	6.25	None	40+	100.00	Dir. Fees (A)	2,250	18-3	4
5	Jeff Thompson	Director	Administrative	6.25	None	40+	100.00	Dir. Fees (A)	2,250	18-3	5
6	Shelly Bell	Director	Administrative	6.25	None	<1	<2%	Dir. Fees (A)	2,250	18-3	6
7	William Parker	Director	Administrative	0.00	None	<1	<2%	Dir. Fees (A)	2,250	18-3	7
8											8
9	William Parker	Consultant	Administrative	0.00	None			Consulting Fee	12,000	10-3	9
10											10
11											11
12	(A) Director Fees - Board Meetin Expenses Reimbursed										12
13								TOTAL	$ 315,199		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: 1/1/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 1/1/18 Ending: 12/31/18

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** 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	Mortgage Note Payable	$7,683.40	6/15/12	$ 1,000,000	$ 420,507	6/15/27	0.0450	$ 24,892	1
2	Citizens One Bank		X	Auto Loan	$893.81	4/20/17	48,664	34,160	4/20/22	0.0389	2,033	2
3	Chrysler Capital		X	Auto Loan	$719.12	5/25/15	43,147	11,506	4/25/20			3
4												4
5												5
	Working Capital											
6	City National Bank		X	LOC	Int. Only			770,213	3/28/18	0.0450	29,338	6
7												7
8												8
9	TOTAL Facility Related				$9,296.33		$ 1,091,811	$ 1,236,386			$ 56,263	9
	B. Non-Facility Related*											
10	Interest Income										(9,876)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (9,876)	14
15	TOTALS (line 9+line14)						$ 1,091,811	$ 1,236,386			$ 46,387	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: 1/1/18 Ending: 12/31/18

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 45,852	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.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$ (45,852)	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 45,442	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.)		$ 45,443	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.		$ 45,033	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	43,379	8
	2014	44,652	9
	2015	45,999	10
	2016	45,748	11
	2017	45,442	12

Accrual based on prior year real estate tax bill

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATIO	$	16

NOTES:

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

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Southgate Health Care Center COUNTY Massac

FACILITY IDPH LICENSE NUMBER 0017996

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2017 on the lines provided below. Enter only the portion of th cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-01-440-001	Nursing Facility	$ 792.58	$ 792.58
2.	08-01-448-999	Nursing Facility	$ 44,649.76	$ 44,649.76
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 45,442.34	$ 45,442.34

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 1/1/18 Ending: 12/31/18

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:
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	Resident Care	185,500	1972	$ 5,000	1
2	Resident Care	193,500	2002	95,000	2
3	TOTALS	379,000		$ 100,000	3

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 1/1/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	93		1972	1972	$ 202,276	$		$	$	$ 202,276	4
5	10		1976	1976	292,230					292,230	5
6	5		1989	1989	583,147					583,147	6
7			1993	1993	629,889		30	20,996	20,996	521,808	7
8	32		2012	2012	2,124,783		30	70,826	70,826	458,270	8
	Improvement Type**										
9	Various			1975	7,341		30			7,341	9
10	Various			1977	1,098		28			1,098	10
11	Various			1980	1,014		20			1,014	11
12	Various			1981	57,891		15			57,891	12
13	Various			1982	17,279		20			17,279	13
14	Various			1983	675		10			675	14
15	Various			1984	114,893		20			114,893	15
16	Various			1985	28,893		20			28,893	16
17	Various			1986	13,163		15			13,163	17
18	Various			1988	32,477		30	511	511	32,477	18
19	Various			1989	852		15			852	19
20	Various			1990	10,266		20			10,266	20
21	Various			1992	1,824		10			1,824	21
22	Various			1995	3,742		15			3,742	22
23	Various			1996	2,240		10			2,240	23
24	Various			1997	10,317		20			10,359	24
25	Various			1998	1,130		10			1,130	25
26	Various			1999	17,240		20	862	862	17,132	26
27	Various			2000	17,005		20	850	850	14,875	27
28	Various			2001	259,580		20	13,187	13,187	232,483	28
29	Various			2002	145,221		40	2,443	2,443	53,637	29
30	Various			2003	3,238		10			3,238	30
31	Various			2004	18,000		10			18,000	31
32	Various			2005	54,191		10	3,178	3,178	49,800	32
33	Various			2006	13,365		15	222	222	12,815	33
34	Various			2007	25,309		7			25,309	34
35	Various			2008	4,318		7			4,582	35
36	Book Depreciation					284,831					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: 1/1/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Various	2009	$ 49,584	$		$ 4,036	$ 4,036	$ 49,584	37
38	Various	2010	37,748			3,458	3,458	37,748	38
39	Various	2011	22,449			3,800	3,800	22,449	39
40	Various	2013	36,890		15	2,728	2,728	15,007	40
41	Various	2014	192,136		20	6,661	6,661	30,074	41
42	Water heater - Laundry	2015	9,504		7	1,358	1,358	4,753	42
43	Parking Lot Improvements	2015	22,007		15	1,467	1,467	5,135	43
44	Flooring - Resident Rooms on Intermediate A Hall	2015	11,404		15	760	760	2,660	44
45	Hot Water Heater	2016	7,021		7	1,003	1,003	2,507	45
46	Flooring - Resident Rooms on Intermediate B Hall	2017	14,947		7	2,135	2,135	3,203	46
47	New Air Conditioner for Patient Rooms	2017	3,702		7	529	529	793	47
48	Generator Repairs (Facility)	2018	10,088		5	1,009	1,009	1,009	48
49	Flooring Hallways	2018	8,741		7	624	624	624	49
50	Exit Door Glass	2018	3,000		39	38	38	38	50
51	Laundry Roof Reapirs	2018	5,320		39	68	68	68	51
52	Parking Lot Upgrades	2018	2,000		15	67	67	67	52
53	Electrical Panel Upgrades	2018	2,455		7	175	175	175	53
54	Air Conditioner	2018	8,142		7	582	582	582	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)		$ 5,142,025	$ 284,831		$ 143,573	$ 143,573	$ 2,971,216	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: 1/1/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 394,194	$	$ 8,838	$ 8,838	5	$ 303,490	71
72	Current Year Purchases	39,254		3,171	3,171	5-7	3,171	72
73	Fully Depreciated Assets	870,435					870,435	73
74								74
75	TOTALS	$ 1,303,883	$	$ 12,009	$ 12,009		$ 1,177,096	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	Buick Enclave	2012	$ 30,805	$	$	$	5	$ 30,805	76
77	Resident Care	Dodge Caravan	2015	43,147		8,629	8,629	5	30,202	77
78	Resident Care	Pick Up Truck	2016	17,266		3,453	3,453	5	12,086	78
79	Resident Care	Dodge Durango	2017	48,664		9,733	9,733	5	14,599	79
80	TOTALS			$ 139,882	$	$ 21,815	$ 21,815		$ 87,692	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)	$ 6,685,790	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 284,831	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 177,397	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (107,434)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,236,003	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	$ 198,550	$	$ 198,550	86
87	Land	93,196			87
88					88
89					89
90					90
91	TOTALS	$ 291,746	$	$ 198,550	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: 1/1/18 Ending: 12/31/18

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2019	$
13.	/2020	$
14.	/2021	$

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

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

16. Rental Amount for movable equipment: $ 51,534 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	6,000
Propane Gas Tanks	108
Storage	37,500
Oxygen Rental/Supplies	7,926
	51,534

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 1/1/18 Ending: 12/31/18

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 1/1/18 Ending: 12/31/18

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 271,029	$		$ 271,029	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			92,729			92,729	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			337,038			337,038	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				130,337		130,337	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached	39-2/39-3				122,092	75,445		197,537	13
14	TOTAL			$		$ 822,888	$ 205,782		$ 1,028,670	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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	Special Services - Supplies (Column 6 - Other)	Amount
13	Medicare X-Ray	3304
13	VA Pharmacy	72101
13	VA Supplies	40
13		
13		
		75445
	Special Services - Services (Column 5 - Other)	
13	Medicare Lab	12490
13	VA Lab	1573
13	VA Physician	7902
13	VA Rehab	100127
13		
		122092

STATE OF ILLINOIS

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 1/1/18 Ending: 12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/18 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (456,277)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 52,569)	2,618,399		3
4	Supply Inventory (priced at)	3,541		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	15,283		7
8	Accounts Receivable (owners or related parties)	62,500		8
9	Other(specify):	5,693		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,249,139	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	193,196		13
14	Buildings, at Historical Cost	4,467,785		14
15	Leasehold Improvements, at Historical Cost	2,604,903		15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(4,723,769)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,542,115	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,791,254	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 297,489	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	770,216		29
30	Accrued Salaries Payable	217,355		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,630		31
32	Accrued Real Estate Taxes(Sch.IX-B)	45,442		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	87,618		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,423,750	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	45,666		39
40	Mortgage Payable	420,507		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)**	$ 466,173	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,889,923	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,901,331	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,791,254	$	48

*(See instructions.)

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	Other Current Assets:	Amount	Amount
9	A/R Employee	5,693	
9			
9			
9			
9			
9			
	Total Line 9	5,693	-

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

	Other Current Liabilities:	Amount	Amount
36	Insurance - W/H Life Ins	(239)	
36	Insurance - W/H Health Ins	624	
36	VA Xray	(3,559)	
36	Garnishment W/H	157	
36	Other Accrued Expenses	(16,203)	
36	Relay for Life	675	
36	Accrued Licensed Bed Tax	21,245	
36	Due To DPA Audit	81,803	
36	Due to Coinsurance	3,115	
	Total Line 36	87,618	-

	Other Non-Current Liabilities:	Amount	Amount
43			
43			
43			
43			
43			
43			
43			
43			
	Total Line 43	0	0

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,057,316	1
2	Restatements (describe):		2
3	To Tie Equity to Current Adjust for Historical Adjustment	(279,815)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,777,501	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	123,830	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)**	$ 123,830	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)**	$ 2,901,331	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	$ 7,438,160	1
2	Discounts and Allowances for all Levels	(2,001,692)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,436,468	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	(16,150)	5
6	Therapy	2,598,735	6
7	Oxygen	(2,681)	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,579,904	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	204,385	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,321	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 216,706	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	9,876	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 9,876	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Other Income (Adjusted P 5)**	6,366	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 6,366	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,249,320	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,405,730	31
32	Health Care	3,193,926	32
33	General Administration	1,623,600	33
	B. Capital Expense		
34	Ownership	437,661	34
	C. Ancillary Expense		
35	Special Cost Centers	1,158,538	35
36	Provider Participation Fee	306,035	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,125,490	40
41	**Income before Income Taxes (line 30 minus line 40)****	123,830	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 123,830	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,910,560	44
45	Private Pay - Net Inpatient Revenue	2,065,357	45
46	Medicare - Net Inpatient Revenue	141,053	46
47	Other-(specify) **VA Inpatient**	565,558	47
48	Other-(specify) **Medicare Replacement/Ins.**	(246,060)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,436,468	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.**

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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	2,251	2,251	$ 75,492	$ 33.54	1
2	Assistant Director of Nursing	1,947	1,947	51,115	26.25	2
3	Registered Nurses	16,277	16,277	260,044	15.98	3
4	Licensed Practical Nurses	33,393	33,393	608,580	18.22	4
5	CNAs & Orderlies	125,723	125,723	1,327,320	10.56	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,080	2,080	25,300	12.16	9
10	Activity Assistants	4,189	4,189	56,262	13.43	10
11	Social Service Workers	2,120	4,120	36,964	8.97	11
12	Dietician					12
13	Food Service Supervisor	4,160	4,160	75,127	18.06	13
14	Head Cook	8,129	8,129	81,655	10.04	14
15	Cook Helpers/Assistants	5,436	5,436	55,556	10.22	15
16	Dishwashers	7,314	7,314	69,949	9.56	16
17	Maintenance Workers	4,280	4,280	82,940	19.38	17
18	Housekeepers	21,580	21,580	217,958	10.10	18
19	Laundry	14,287	14,287	133,281	9.33	19
20	Administrator	2,080	2,080	74,360	35.75	20
21	Assistant Administrator					21
22	Other Administrative	2,080	2,080	260,919	125.44	22
23	Office Manager					23
24	Clerical	7,899	7,899	131,599	16.66	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Marketing	3,352	3,352	74,288	22.16	33
34	TOTAL (lines 1 - 33)	268,577	270,577	$ 3,698,709 *	$ 13.67	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	$ 7,545	1-3	35
36	Medical Director	Monthly	7,300	9-3	36
37	Medical Records Consultant	39	1,945	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,927	10-3	39
40	Physical Therapy Consultant	Monthly	12,000	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	Physician Consultant	Monthly	12,000	10-3	47
48					48
49	TOTAL (lines 35 - 48)	39	$ 47,717		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	5,967	$ 208,856	10-3	50
51	Licensed Practical Nurses	5,569	167,085	10-3	51
52	Certified Nurse Assistants/Aides	2,785	41,771	10-3	52
53	TOTAL (lines 50 - 52)	14,321	$ 417,712		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sam Thompson	Administrative	6.25%	$ 260,919
Rebekah Mahoney	Administrator	0	74,360
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 335,279

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
Williams Williams Lentz	Accounting/Tax	$ 4,350
FGMK, LLC	Accounting/Consulting	10,782
Kemper CPA/American Funds	Accounting/401K	8,776
Whitlow Roberts Houston Straub	Legal	660
Duane Morris	Legal	303
SB2	Legal	31,671
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 56,542

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 78,282
Unemployment Compensation Insurance	
FICA Taxes	312,479
Employee Health Insurance	41,877
Employee Meals	7,005
Illinois Municipal Retirement Fund (IMRF)*	
401K Match	57,095
Other Employee Benefits	17,754
TOTAL (agree to Schedule V, line 22, col.8)	$ 514,492

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 99)	3,963
Patient Background Checks 52	1,600
Subscriptions	20,154
Licenses	974
Association Dues	5,590
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 36,261

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	3,831
Seminar Expense	1,017
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,848

* Attach copy of IMRF notifications

**See instructions.

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Legal Schedule
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Legal Fees	Amount	Invoice Date	
Whitlow Roberts Houston Straub	270.00	3/6/2018	
Whitlow Roberts Houston Straub	120.00	4/5/2018	
Whitlow Roberts Houston Straub	270.00	5/8/2018	
Duane Morris	121.50	8/13/2018	
SB2	4,000.00	5/3/2018	
SB2	4,000.00	6/1/2018	
SB2	3,500.00	5/25/2018	
SB2	4,000.00	7/2/2018	
SB2	4,000.00	8/1/2008	
SB2	4,000.00	9/4/2018	
SB2	4,135.81	10/4/2018	ADJ
SB2	4,034.82	11/4/2018	ADJ
	181.92	11/15/2018	
Total Legal Fees	32,634.05		
Legal Adjustment	-8,170.63		
Allowable Legal Fees	24,463.42		

Southgate Health Care Center
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Travel Schedule
1/1/18-12/31/18

Persons Attending	Title	Date Attended	Location	Title Sponsor	Cost	Total	
Susan Parmley	Transport Aide	Jan-18	various	mileage reimb	10.01		
Leah White	Marketing Director	Jan-18	various	mileage reimb	102.48		
Cindy Dunevant	Social Serv Dir	Apr-18	various	mileage reimb	66.64		
Cindy Dunevant	Social Serv Dir	May-18	various	mileage reimb	291.76		
Sara DeJournet	Bookeeper	Jun-18	post office	mileage reimb	44.80		
Cindy Dunevant	Social Serv Dir	Jun-18	various	mileage reimb	353.92		
Sara DeJournet	Bookeeper	Jul-18	post office	mileage reimb	11.20		
Cindy Dunevant	Social Serv Dir	Aug-18	various	mileage reimb	53.76		
Sara DeJournet	Bookeeper	Aug-08	post office	mileage reimb	10.64		
Cindy Dunevant	Social Serv Dir	Sep-18	various	mileage reimb	339.36		
Cindy Dunevant	Social Serv Dir	Nov-18	various	mileage reimb	252.00		
Sara DeJournet	Bookeeper	Nov-18	post office	mileage reimb	20.72		
Susan Parmley	Transport Aide	Nov-18	various	mileage reimb	16.02		
Susan Parmley	Transport Aide	Dec-18	various	mileage reimb	28.06		
Vickey Herren	Transport Aide	Dec-18	various	mileage reimb	20.00		
Sam Thompson	President	Sep-18	Peoria, IL	IHCA Annual Conv			
Jane Parker	Chairman	Sep-18	Peoria, IL	IHCA Annual Conv			
Rebekah Mahoney	Administrator	Sep-18	Peoria, IL	IHCA Annual Conv			
Rhonda Johnson	Dir of Nurses	Sep-18	Peoria, IL	IHCA Annual Conv			
Cindy Dunevant	Social Serv Director	Sep-18	Peoria, IL	IHCA Annual Conv			
Norma Riley	Care Plan Coord	Sep-18	Peoria, IL	IHCA Annual Conv			
Deanna Varnum	Activity Dir	Sep-18	Peoria, IL	IHCA Annual Conv			
Cord Koch	Marketing Dir	Sep-18	Peoria, IL	IHCA Annual Conv			
Debbie Crim	Asst Dir of Nurses	Sep-18	Peoria, IL	IHCA Annual Conv	2,209.92		
Sam Thompson	President	Oct-18	San Diego, IL	AHCA Annual Conv	3,241.80		ADJ

Total	7,073.09
	-3,241.80
Adjusted Total	3,831.29

Southgate Health Care Center
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Seminar Schedule (LINES 23 & 24)
1/1/17-12/31/17

PAGE 23 EDUCATION & TRAINING

Persons Attending	Title	Date Attended	Location	Title Sponsor	Cost	Total	
Various	Various	Monthly	Metropolos	Relias Learning - Monthly	11,876	11,876	

PAGE 24 SEMINAR

Persons Attending	Title	Date Attended	Location	Title Sponsor	Cost	Total	
Norma Riley	Care Plan Coord	4/3/2018	on-line webir	AANCA			
Rebekah Mahoney	Administrator	4/3/2018	on-line webir	AANAC		217	
Sam Thompson	President	9/1/2018	Peoria, IL	IHCA Annual Conv			
Jane Parker	Chairman	9/1/2018	Peoria, IL	IHCA Annual Conv			
Rebekah Mahoney	Administrator	9/1/2018	Peoria, IL	IHCA Annual Conv			
Rhonda Johnson	Dir of Nurses	9/1/2018	Peoria, IL	IHCA Annual Conv			
Cindy Dunevant	Social Serv Director	9/1/2018	Peoria, IL	IHCA Annual Conv			
Norma Riley	Care Plan Coord	9/1/2018	Peoria, IL	IHCA Annual Conv			
Deanna Varnum	Activity Dir	9/1/2018	Peoria, IL	IHCA Annual Conv			
Cord Koch	Marketing Dir	9/1/2018	Peoria, IL	IHCA Annual Conv			
Debbie Crim	Asst Dir of Nurses	9/1/2018	Peoria, IL	IHCA Annual Conv		800	
Sam Thompson	President	Oct-18	San Diego, C	AHCA Annual Convention		1,050	ADJ
					Total	2,067	
						-1,050	
					Adjusted Total	1,017	

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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 $5,590**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **41,525** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen
during this cost report period. $ **306,035**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **7,005** Has any meal income been offset against
related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **Ln 14**
d. Have vehicle usage logs been maintained? **records available**
e. Are all vehicles stored at the nursing home during the night and all othe
times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **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**

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

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

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