FOR BHF USE

LL1

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

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

I. IDPH License ID Number: 0017996

Facility Name: Southgate Health Care Center

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

County: Massac

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

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Andrew B. Cutler **Telephone Number:** (847) 940-3269
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 1/1/2020 to 12/31/2020 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name)
(Title)

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Andrew B. Cutler, Managing Director, Healthcare
(Firm Name & Address) FGMK, LLC, 2801 Lakeside Dr., 3rd Floor, Bannockburn, IL 60015
(Telephone) (847) 940-3269 Fax # (847)964-5469

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: 1/1/2020 Ending: 12/31/2020

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	38,796	1
2		Skilled Pediatric (SNF/PED)			2
3	34	Intermediate (ICF)	34	12,444	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	140	TOTALS	140	51,240	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	19,973	8,856	12,074	40,903	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,973	8,856	12,074	40,903	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.83%

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 4,471

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: 1/1/2020 Ending: 12/31/2020

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	284,678	25,353	6,881	316,912		316,912		316,912			1
2	Food Purchase		312,759		312,759		312,759		312,759			2
3	Housekeeping	305,743	30,465		336,208		336,208		336,208			3
4	Laundry	156,970	14,855		171,825		171,825		171,825			4
5	Heat and Other Utilities			238,076	238,076		238,076		238,076			5
6	Maintenance	86,584	19,826	133,191	239,601		239,601	(4,135)	235,466			6
7	Other (specify):*											7
8	TOTAL General Services	833,975	403,258	378,148	1,615,381		1,615,381	(4,135)	1,611,246			8
	B. Health Care and Programs											
9	Medical Director			18,900	18,900		18,900		18,900			9
10	Nursing and Medical Records	2,531,774	328,935	435,852	3,296,561		3,296,561	(3,574)	3,292,987			10
10a	Therapy			15,000	15,000		15,000		15,000			10a
11	Activities	61,121	4,700		65,821		65,821		65,821			11
12	Social Services	42,706			42,706		42,706		42,706			12
13	CNA Training	66,731		19,859	86,590		86,590		86,590			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,702,332	333,635	489,611	3,525,578		3,525,578	(3,574)	3,522,004			16
	C. General Administration											
17	Administrative	341,865			341,865		341,865		341,865			17
18	Directors Fees			5,000	5,000		5,000		5,000			18
19	Professional Services			124,545	124,545		124,545	(60,523)	64,022			19
20	Dues, Fees, Subscriptions & Promotions			86,890	86,890		86,890	(65,876)	21,014			20
21	Clerical & General Office Expenses	125,759	23,969	583,539	733,267		733,267	(442,805)	290,462			21
22	Employee Benefits & Payroll Taxes			615,273	615,273		615,273		615,273			22
23	Inservice Training & Education			11,299	11,299		11,299		11,299			23
24	Travel and Seminar			1,366	1,366		1,366		1,366			24
25	Other Admin. Staff Transportation			53,887	53,887		53,887	(4,966)	48,921			25
26	Insurance-Prop.Liab.Malpractice			165,455	165,455		165,455		165,455			26
27	Other (specify):*											27
28	TOTAL General Administration	467,624	23,969	1,647,254	2,138,847		2,138,847	(574,170)	1,564,677			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,003,931	760,862	2,515,013	7,279,806		7,279,806	(581,879)	6,697,927			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: 1/1/2020 Ending: 12/31/2020

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			174,727	174,727		174,727		174,727			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			46,455	46,455		46,455	(46,455)				32
33	Real Estate Taxes			48,219	48,219		48,219		48,219			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			13,146	13,146		13,146		13,146			35
36	Other (specify):*											36
37	**TOTAL Ownership**			282,547	282,547		282,547	(46,455)	236,092			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		229,515	1,228,228	1,457,743		1,457,743		1,457,743			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			297,996	297,996		297,996		297,996			42
43	Other (specify):*	91,590		73,760	165,350		165,350	(165,350)				43
44	**TOTAL Special Cost Centers**	91,590	229,515	1,599,984	1,921,089		1,921,089	(165,350)	1,755,739			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,095,521	990,377	4,397,544	9,483,442		9,483,442	(793,684)	8,689,758			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: 1/1/2020 Ending: 12/31/2020

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(46,455)	32		10
11	Discounts, Allowances, Rebates & Refunds	(3,574)	10		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(16,900)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(425,719)	21		24
25	Fund Raising, Advertising and Promotional	(62,952)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(39,845)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(198,239)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (793,684)		$	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))**	$ (793,684)		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: 1/1/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Personal Portion of Travel Expense	$ (4,966)	25	1
2	Non-Allowable Maeketing Salaries	(91,590)	43	2
3	Non-Allowable Marketing Expense	(11,484)	43	3
4	Non-Allowable Health Insurance Directors	(8,361)	43	4
5	Non-Allowable IHCA PAC Expense	(1,249)	43	5
6	Non-Allowable Auto Expense	(12,821)	43	6
7	Non-Allowable Legal Fees	(60,523)	19	7
8	Non-Allowable IHCA Lobbyong Expense	(2,924)	20	8
9	Garnishment	(186)	21	9
10	Capitalized R&M	(4,135)	6	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(198,239)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(4,135)	0	0	0	0	0	0	0	0	0	0	(4,135)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(4,135)	0	0	0	0	0	0	0	0	0	0	(4,135)	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	(3,574)	0	0	0	0	0	0	0	0	0	0	(3,574)	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**	(3,574)	0	0	0	0	0	0	0	0	0	0	(3,574)	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	(60,523)	0	0	0	0	0	0	0	0	0	0	(60,523)	19
20	Fees, Subscriptions & Promotions	(65,876)	0	0	0	0	0	0	0	0	0	0	(65,876)	20
21	Clerical & General Office Expenses	(442,805)	0	0	0	0	0	0	0	0	0	0	(442,805)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(4,966)	0	0	0	0	0	0	0	0	0	0	(4,966)	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**	(574,170)	0	0	0	0	0	0	0	0	0	0	(574,170)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(581,879)	0	0	0	0	0	0	0	0	0	0	(581,879)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Southgate Health Care Center # 0017996 **Report Period Beginning:** 1/1/2020 **Ending:** 12/31/2020

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

	Capital Expense D. Ownership	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)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(46,455)	0	0	0	0	0	0	0	0	0	0	(46,455)	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**	(46,455)	0	0	0	0	0	0	0	0	0	0	(46,455)	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):*	(165,350)	0	0	0	0	0	0	0	0	0	0	(165,350)	43
44	**TOTAL Special Cost Centers**	(165,350)	0	0	0	0	0	0	0	0	0	0	(165,350)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(793,684)	0	0	0	0	0	0	0	0	0	0	(793,684)	45

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	82.5%	None		None		
Sam Thompson	6.25%	None		None		
Jeff Thompson	6.25%	None		None		
Shelly Bell	6.25%	None		None		

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: 1/1/2020 Ending: 12/31/2020

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	$ 260,000	17-1	1
2	Jeff Thompson	Maintenance	Maintenance	6.25	None	40+	100.00	Salary	35,510	6-1	2
3											3
4	Sam Thompson	Director	Administrative	6.25	None	40+	100.00	Dir. Fees (A)	2,000	18-3	4
5	Jeff Thompson	Director	Administrative	6.25	None	40+	100.00	Dir. Fees (A)	1,000	18-3	5
6	Shelly Bell	Director	Administrative	6.25	None	<1	<2%	Dir. Fees (A)	1,000	18-3	6
7	William Parker	Director	Administrative	0.00	None	<1	<2%	Dir. Fees (A)	1,000	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 Meeting Expense Reimbursed.										12
13								TOTAL	$ 312,510		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: 1/1/2020 Ending: 2/31/2020

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: 1/1/2020 Ending: 12/31/2020

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	$7,683.40	6/15/2012	$ 1,000,000	$ 940,598	6/15/2027	0.0450	$ 29,950	1
2	Citizens One Auto Finance		X	Auto Loan	$893.81	4/20/2017	48,664	11,533	4/20/2022	0.0389		2
3				Construction Loan				145,000				3
4												4
5												5
	Working Capital											
6	City National Bank		X	Working Capital LOC	Int. Only			1,014,583		0.0450	16,505	6
7				due to HFS Pmt Delays & lack of processing applications								7
8												8
9	TOTAL Facility Related				$8,577.21		$ 1,048,664	$ 2,111,714			$ 46,455	9
	B. Non-Facility Related*											
10	Interest Income		X	Offset Expense							(46,455)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (46,455)	14
15	TOTALS (line 9+line14)						$ 1,048,664	$ 2,111,714			$	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: 1/1/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 46,536	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.)		$ 47,377	2
3. Under or (over) accrual (line 2 minus line 1).		$ 841	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 47,377	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 48,218	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	45,999	8
	2016	45,748	9
	2017	45,442	10
	2018	46,536	11
	2019	47,359	12

Accrual based on prior year real estate tax bills

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Southgate Health Care Center COUNTY Massac

FACILITY IDPH LICENSE NUMBER 0017996

CONTACT PERSON REGARDING THIS REPORT Andrew B. Cutler

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

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

Enter the tax index number and real estate tax assessed for 2019 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2019.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-01-448-009	Long-Term Care Property	$ 424.10	$ 424.10
2.	08-01-440-001	Long-Term Care Property	$ 818.60	$ 818.60
3.	08-01-448-999	Long-Term Care Property	$ 46,116.20	$ 46,116.12
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 47,358.90	$ 47,358.82

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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: 1/1/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	93		1972	1972	$ 202,276	$		$	$	$	4
5	10		1976	1976	292,230						5
6	5		1989	1989	583,147						6
7			1993	1993	629,889		30	20,996	20,996	563,800	7
8	32		2012	2012	2,124,783		30	70,826	70,826	599,922	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			32,477	18
19	Various			1989	852		15			82	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			17,240	26
27	Various			2000	17,005		20	850	850	16,575	27
28	Various			2001	259,580		20	13,187	13,187	258,857	28
29	Various			2002	145,221		40	2,443	2,443	58,523	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	1,213	1,213	54,191	32
33	Various			2006	13,365		15	328	328	13,365	33
34	Various			2007	25,309		7			25,309	34
35	Various			2008	4,318		7			4,318	35
36	Book Depreciation					174,727					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: 1/1/2020 Ending: 12/31/2020

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	$		$	$	$ 49,584	37
38	Various	2010	37,748					37,748	38
39	Various	2011	22,449					22,449	39
40	Various	2013	36,890		15	2,728	2,728	20,463	40
41	Various	2014	192,136		20	6,661	6,661	43,396	41
42	Various	2015	42,915		15	3,585	3,585	19,718	42
43	Various	2016	7,021		7	1,003	1,003	4,513	43
44	Flooring - Resident Rooms on Intermediate B Hall	2017	14,947		7	2,135	2,135	7,473	44
45	New Air Conditioner for Patient Rooms	2017	3,702		7	529	529	1,851	45
46	Generator Repairs (Facility)	2018	10,088		5	2,018	2,018	5,045	46
47	Flooring Hallways	2018	8,741		7	1,249	1,249	3,122	47
48	Exit Door Glass	2018	3,000		39	77	77	192	48
49	Laundry Roof Reapirs	2018	5,320		39	136	136	404	49
50	Parking Lot Upgrades	2018	2,000		15	133	133	333	50
51	Electrical Panel Upgrades	2018	2,455		7	351	351	877	51
52	Air Conditioner	2018	8,142		7	1,163	1,163	2,908	52
53	Remodel - Administrator Office	2019	7,132		20	357	357	448	53
54	Roof Maintenance Building	2019	2,180		20	109	109	164	54
55	Air Conditioner Unit - Patient Rooms	2019	3,398		15	227	227	340	55
56	Boiler	2019	18,500		20	925	925	1,162	56
57	Water Heater	2019	5,713		10	571	571	857	57
58	Glass Doors	2020	2,087		20	104	104	104	58
59	Water Heater	2020	4,135		10	414	414	414	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)		$ 5,185,170	$ 174,727		$ 134,317	$ 134,317	$ 2,161,270	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: 1/1/2020 Ending: 12/31/2020

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	$ 508,281	$	$ 18,374	$ 18,374	various	$ 331,400	71
72	Current Year Purchases	4,013		191	191	7	191	72
73	Fully Depreciated Assets	870,435						73
74								74
75	TOTALS	$ 1,382,729	$	$ 18,565	$ 18,565		$ 331,591	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	Bucik Enclave	2012	$ 30,805	$	$	$		$ 30,805	76
77	Resident Care	Dodge Caravan	2015	43,147		4,316	4,316	5	43,147	77
78	Resident Care	Pick Up Truck	2016	17,266		1,727	1,727	5	17,266	78
79	Resident Care	Dodge Durango	2017	48,664		9,733	9,733	5	34,065	79
80	TOTALS			$ 139,882	$	$ 15,776	$ 15,776		$ 125,283	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)	$ 6,807,781	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 174,727	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 168,658	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (6,069)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,618,144	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: 1/1/2020 Ending: 12/31/2020

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

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

	Fiscal Year Ending	Annual Rent
12.	/2021	$
13.	/2022	$
14.	/2023	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ 13,146 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
Nursing Equipment Rental	318
Phone System	6,000
Oxygen Rental/Supplies	6,828
	13,146

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

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

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

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

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER CNA 80

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER CNA 40

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)	2,597	41,890		44,487
4	Clinical Wages	(b)	1,299	20,945		22,244
5	In-House Trainer Wages	(c)	1,192	18,667		19,859
6	Transportation					
7	Contractual Payments					
8	CNA Competency Tests					
9	TOTALS		$ 5,088	$ 81,502	$	$ 86,590
10	SUM OF line 9, col. 1 and 2	(e)	$ 86,590			

C. CONTRACTUAL INCOME

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

$ N/A

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	23
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	7
2. From other facilities (f)	
TOTAL TRAINED	30

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

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff 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	39-3	hrs	$		$ 412,504	$		$ 412,504	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			205,952			205,952	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			435,071			435,071	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				106,062		106,062	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Attached	39-2					123,453		123,453	12
13	Other (specify): See Attached	39-3				174,701			174,701	13
14	TOTAL			$		$ 1,228,228	$ 229,515		$ 1,457,743	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	9,742
13	VA Pharmacy	97,492
13	VA Supplies	-
13	Medicare Medical Supplies	2,512
13	VA X-Ray	13,707
		123,453
	Special Services - Services (Column 5 - Other)	
13	Medicare Lab	41,660
13	Medicare Support Services	1,054
13	VA Lab	29,929
13	VA Physician	10,223
13	VA Rehab	89,624
13	VA Podiatrist	2,211
		174,701

STATE OF ILLINOIS

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2020 (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	$ (572,117)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	4,810,765		3
4	Supply Inventory (priced at)	3,541		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	11,805		7
8	Accounts Receivable (owners or related parties)	62,500		8
9	Other(specify): See Attached	5,598		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,322,092	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	196,014		13
14	Buildings, at Historical Cost	4,579,540		14
15	Leasehold Improvements, at Historical Cost	2,604,903		15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(5,105,442)		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)**	$ 2,275,015	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,597,107	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 259,124	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,014,583		29
30	Accrued Salaries Payable	263,640		30
31	Accrued Taxes Payable (excluding real estate taxes)	21,493		31
32	Accrued Real Estate Taxes(Sch.IX-B)	47,377		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	472,890		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,079,107	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	11,533		39
40	Mortgage Payable	940,598		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	752,210		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,704,341	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,783,448	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,813,659	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,597,107	$	48

***(See instructions.)**

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	Other Current Assets:	Amount	Amount
9	A/R Employee	5,598	
9			
9			
9			
9			
9			
	Total Line 9	5,598	-

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

	Other Current Liabilities:	Amount	Amount
36	Insurance - W/H Life Ins	(979)	
36	Insurance - W/H Health Ins	-	
36	Construction Loan	145,000	
36	Garnishment W/H	-	
36	Other Accrued Expenses	260,452	
36	Relay for Life	675	
36	Accrued Licensed Bed Tax	64,627	
36	Due To DPA Audit	3,115	
36	Due to Coinsurance	-	
	Total Line 36	472,890	-

	Other Non-Current Liabilities:	Amount	Amount
43	SBA Loan	752,210	
43			
43			
43			
43			
43			
43			
43			
	Total Line 43	752,210	0

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,851,588	1
2	Restatements (describe):		2
3	Equity adjustment	13,287	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,864,875	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	84,686	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	(135,902)	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)**	$ (51,216)	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)**	$ 2,813,659	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	$ 7,328,680	1
2	Discounts and Allowances for all Levels	(1,518,699)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,809,981	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	7,557	5
6	Therapy	2,713,005	6
7	Oxygen	12,416	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,732,978	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	201,161	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	135,707	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 336,868	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	67,662	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 67,662	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**SBA Loan**	616,879	28
28a	**Rebate/Garnishment Fees (Adj P. 5)**	3,760	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 620,639	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,568,128	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,615,381	31
32	Health Care	3,525,578	32
33	General Administration	2,138,847	33
	B. Capital Expense		
34	Ownership	282,547	34
	C. Ancillary Expense		
35	Special Cost Centers	1,623,093	35
36	Provider Participation Fee	297,996	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,483,442	40
41	**Income before Income Taxes (line 30 minus line 40)****	84,686	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 84,686	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,207,649	44
45	Private Pay - Net Inpatient Revenue	1,495,676	45
46	Medicare - Net Inpatient Revenue	409,710	46
47	Other-(specify) **VA Inpatient**	1,221,813	47
48	Other-(specify) **Medicare Replacement/Insurance**	(524,867)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,809,981	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	2,080	2,080	$ 61,401	$ 29.52	1
2	Assistant Director of Nursing	2,208	2,208	65,056	29.46	2
3	Registered Nurses	9,655	9,655	354,878	36.76	3
4	Licensed Practical Nurses	34,806	34,806	867,814	24.93	4
5	CNAs & Orderlies	94,765	94,765	1,212,884	12.80	5
6	CNA Trainees	9,762	9,762	101,548	10.40	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,016	2,016	27,856	13.82	9
10	Activity Assistants	1,926	1,926	33,265	17.27	10
11	Social Service Workers	2,000	2,000	42,706	21.35	11
12	Dietician					12
13	Food Service Supervisor	4,000	4,000	45,191	11.30	13
14	Head Cook	3,822	3,822	44,867	11.74	14
15	Cook Helpers/Assistants	10,191	10,191	84,677	8.31	15
16	Dishwashers	6,926	6,926	44,867	6.48	16
17	Maintenance Workers	4,116	4,116	86,584	21.04	17
18	Housekeepers	24,423	24,423	305,743	12.52	18
19	Laundry	15,722	15,722	156,970	9.98	19
20	Administrator	2,080	2,080	81,865	39.36	20
21	Assistant Administrator					21
22	Other Administrative	2,080	2,080	260,000	125.00	22
23	Office Manager					23
24	Clerical	7,671	7,671	125,759	16.39	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	3,224	3,224	91,590	28.41	33
34	TOTAL (lines 1 - 33)	243,473	243,473	$ 4,095,521 *	$ 16.82	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	178	$ 6,881	1-3	35
36	Medical Director	36	18,000	9-3	36
37	Medical Records Consultant	Quarterly	1,687	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,085	10-3	39
40	Physical Therapy Consultant	Monthly	15,000	10-3	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	Consultant Physicians	Monthly	12,000	10-3	47
48					48
49	TOTAL (lines 35 - 48)	214	$ 60,653		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	5,311	$ 185,879	10-3	50
51	Licensed Practical Nurses	4,957	148,703	10-3	51
52	Certified Nurse Assistants/Aides	1,239	37,176	10-3	52
53	TOTAL (lines 50 - 52)	11,507	$ 371,758		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sam Thompson	Administrative	6.25%	$ 260,000
Rebekah Mahonet	Administrator	0	81,865
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 341,865

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
SB2	Legal	$ 60,523
Whitlow Roberts Houston and Straul	Legal	2,363
Williams Williams Lentz	Accounting/Tax	15,600
FGMK, LLC	Accounting/Consulting	12,395
Kemper CPA	401K Admin.	6,938
American Funds	401K Administration	1,248
NRC	Survey	1,736
Smartlinx	Payroll	23,742
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 124,545

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 90,072
Unemployment Compensation Insurance	
FICA Taxes	341,423
Employee Health Insurance	99,803
Employee Meals	2,360
Illinois Municipal Retirement Fund (IMRF)*	
401 K Match	56,989
Other Employee Benefits	24,626
TOTAL (agree to Schedule V, line 22, col.8)	$ 615,273

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 62)	1,923
Patient Background Checks 44	1,358
Subscriptions	7,367
Licenses	660
Association Dues	7,716
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 21,014

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,366
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,366

**See instructions.

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Legal Fees	Amount	
SB2	4,025.52	ADJ
SB2	4,000.00	ADJ
SB2	4,000.00	ADJ
SB2	4,098.48	ADJ
SB2	4,000.00	ADJ
SB2	4,000.00	ADJ
SB2	4,000.00	ADJ
SB2	4,000.00	ADJ
SB2	4,000.00	ADJ
SB2	4,000.00	ADJ
SB2	4,000.00	ADJ
SB2	4,000.00	ADJ
SB2	4,399.21	ADJ
SB2	4,000.00	ADJ
SB2 year end accrual	8,000.00	ADJ
Whitlow Roberts Houston Straub	87.50	
Whitlow Roberts Houston Straub	490.00	
Whitlow Roberts Houston Straub	542.50	
Whitlow Roberts Houston Straub	52.50	
Whitlow Roberts Houston Straub	665.00	
Whitlow Roberts Houston Straub	140.00	
Whitlow Roberts Houston Straub	122.50	
Whitlow Roberts Houston Straub	262.50	
Total Legal Fees	62,885.71	
Legal Adjustment	-60,523.00	
Allowable Legal Fees	2,362.71	

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Persons Attending	Title	Date Attended	Location	Cost	Total
Jolynn Williams	Clerical	1/17/2020	Local	Mileage	13.20
Sam Thompson	Administrative	4/29/2020	Local	Mileage	800.00
Sherry Johnson	Clerical	10/5/2020	Local	Mileage	129.37
Sherry Johnson	Clerical	10/23/2020	Local	Mileage	64.40
Sherry Johnson	Clerical	11/6/2020	Local	Mileage	116.14
Sherry Johnson	Clerical	11/13/2020	Local	Mileage	58.65
Sherry Johnson	Clerical	11/18/2020	Local	Mileage	58.65
Sherry Johnson	Clerical	11/20/2020	Local	Mileage	60.69
Sherry Johnson	Clerical	12/11/2020	Local	Mileage	64.86
				Total	1,365.96

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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 -$7716**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **49,176** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **297,996**
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. $ **2,360** 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? **LN 14**
d. Have vehicle usage logs been maintained? **records available**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **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.