

Facility Name & ID Number Southview Manor Nursing Ctr

0051656 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	74	Skilled (SNF)	74	27,010	1
2		Skilled Pediatric (SNF/PED)			2
3	126	Intermediate (ICF)	126	45,990	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	200	TOTALS	200	73,000	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	12,421			12,421	8
9	SNF/PED					9
10	ICF	54,332		529	54,861	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	66,753		529	67,282	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.17%

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 NO Non-allowable costs have been eliminated in Schedule V, Column 7

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

I. On what date did you start providing long term care at this location?
Date started 6/27/2012

J. Was the facility purchased or leased after January 1, 1978?
YES Date 6/27/2012 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 42 and days of care provided 0

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/17 Fiscal Year: 12/31/17

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Southview Manor Nursing Ctr # 0051656 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	328,253	49,466	13,925	391,644		391,644		391,644		1
2	Food Purchase		366,818		366,818		366,818	(10,104)	356,714		2
3	Housekeeping	366,482	96,060		462,542		462,542		462,542		3
4	Laundry	104,707	15,244		119,951		119,951		119,951		4
5	Heat and Other Utilities			208,870	208,870		208,870		208,870		5
6	Maintenance	302,732	2,407	49,949	355,088		355,088	1,686	356,774		6
7	Other (specify):* Waste Disposal			57,877	57,877		57,877		57,877		7
8	TOTAL General Services	1,102,174	529,995	330,621	1,962,790		1,962,790	(8,418)	1,954,372		8
	B. Health Care and Programs										
9	Medical Director			30,000	30,000		30,000		30,000		9
10	Nursing and Medical Records	2,678,820	72,763	39,008	2,790,591		2,790,591	(177)	2,790,414		10
10a	Therapy	72,162			72,162		72,162		72,162		10a
11	Activities	179,541		14,548	194,089		194,089		194,089		11
12	Social Services	435,970		894	436,864		436,864		436,864		12
13	CNA Training										13
14	Program Transportation			1,288	1,288		1,288	(297)	991		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,366,493	72,763	85,738	3,524,994		3,524,994	(474)	3,524,520		16
	C. General Administration										
17	Administrative	105,539		408,391	513,930		513,930		513,930		17
18	Directors Fees										18
19	Professional Services			113,520	113,520		113,520	(6,429)	107,091		19
20	Dues, Fees, Subscriptions & Promotions			36,976	36,976		36,976	(12,704)	24,272		20
21	Clerical & General Office Expenses	177,288	14,924	63,069	255,281		255,281		255,281		21
22	Employee Benefits & Payroll Taxes			655,629	655,629		655,629		655,629		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,165	1,165		1,165		1,165		24
25	Other Admin. Staff Transportation			1,668	1,668		1,668		1,668		25
26	Insurance-Prop.Liab.Malpractice			179,729	179,729		179,729	14,753	194,482		26
27	Other (specify):*										27
28	TOTAL General Administration	282,827	14,924	1,460,147	1,757,898		1,757,898	(4,380)	1,753,518		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,751,494	617,682	1,876,506	7,245,682		7,245,682	(13,272)	7,232,410		29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Southview Manor Nursing Ctr

#0051656

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation							247,385	247,385			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			156,089	156,089		156,089	323,716	479,805			32
33	Real Estate Taxes							341,267	341,267			33
34	Rent-Facility & Grounds			1,288,896	1,288,896		1,288,896	(1,281,376)	7,520			34
35	Rent-Equipment & Vehicles			20,936	20,936		20,936		20,936			35
36	Other (specify):*											36
37	TOTAL Ownership			1,465,921	1,465,921		1,465,921	(369,008)	1,096,913			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		41,887	99,402	141,289		141,289		141,289			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			507,238	507,238		507,238		507,238			42
43	Other (specify):* Disallowed Costs			238,152	238,152		238,152	(238,152)				43
44	TOTAL Special Cost Centers		41,887	844,792	886,679		886,679	(238,152)	648,527			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,751,494	659,569	4,187,219	9,598,282		9,598,282	(620,432)	8,977,850			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	(5,968)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	247,385	30		9
10	Interest and Other Investment Income	(11,026)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(12,434)	43		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	(1,500)	19		17
18	Fines and Penalties	(55,394)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(4,929)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(161,078)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(389,763)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (394,707)		\$	30

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	2	
		Amount	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)	(225,725)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (225,725)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (620,432)		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	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.		X	\$	38
39					39
40	Gift and Coffee Shops		X		40
41	Barber and Beauty Shops		X		41
42	Laboratory and Radiology		X		42
43	Prescription Drugs		X		43
44					44
45	Other-Attach Schedule		X		45
46	Other-Attach Schedule		X		46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' PREPARATION REPORT

Southview Manor Nursing Ctr

ID# 0051656

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Medical Records Income	\$ (177)	10	1
2	Vending Income	(10,104)	2	2
3	Resident Needs/Charity	(3,278)	43	3
4	PAC Dues	(13,654)	20	4
5	Building Co. - Admin Expenses	(781)	21	5
6	Building Co. - Amortization of Goodwill	(335,525)	36	6
7	Building Co. - Other Financing Costs	(28,333)	36	7
8	Building Co. - Licenses & Fees	(250)	20	8
9	Offset Resident Transportation Income	(297)	14	9
10	Capitalized Licenses and Fees Expensed	950	20	10
11	Capitalized Repair Expensed	1,686	6	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	(389,763)		49

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
See Page 6 Supplemental		See Page 6 Supplemental		See Page 6 Supplemental		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	20 Licenses & Fees	\$	SV Chicago LLC	100.00%	\$ 250	\$ 250	1
2	V	21 Bank Charges		SV Chicago LLC	100.00%	781	781	2
3	V	26 Property Insurance		SV Chicago LLC	100.00%	14,753	14,753	3
4	V	32 Interest		SV Chicago LLC	100.00%	334,742	334,742	4
5	V	33 Real Estate Taxes		SV Chicago LLC	100.00%	341,267	341,267	5
6	V	34 Rent	1,281,376	SV Chicago LLC	100.00%		(1,281,376)	6
7	V	36 Amortization Exp-Goodwill		SV Chicago LLC	100.00%	335,525	335,525	7
8	V	36 Finance Costs		SV Chicago LLC	100.00%	28,333	28,333	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,281,376			\$ 1,055,651	\$ * (225,725)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Southview Manor Nursing Ctr

0051656

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Jimmy Nassour	50	Bourbonnais Terrace NH	Bourbonnais	SV Chicago LLC	Chicago	Lessor	1
2	Carl Meyer	50	Community Care Center	Chicago				2
3			Crestwood Terrace Nursing Ctr	Crestwood				3
4			Frankfort Terrace Nursing Center	Frankfort				4
5			Joliet Terrace Nursing Center	Joliet				5
6			Kankakee Terrace Nursing Center	Bourbonnais				6
7			Sycamore Healthcare Center	Quincy				7
8			Terrace Nursing Home, The	Waukegan				8
9			West Chicago Terrace NH	West Chicago				9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Southview Manor Nursing Ctr # 0051656 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	N/A								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Southview Manor Nursing Ctr

0051656

Report Period Beginning:

1/1/2017

Ending: 2/31/2017

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' PREPARATION REPORT

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Southview Manor Nursing Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0051656

CONTACT PERSON REGARDING THIS REPORT Jerry Harris

TELEPHONE (630) 501-0996 FAX #: (630) 501-0987

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2016 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 2016.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>17-34-116-003-0000</u>	<u>Long Term Care Property</u>	\$ <u>118,143.43</u>	\$ <u>118,143.43</u>
2. <u>17-34-116-004-0000</u>	<u>Long Term Care Property</u>	\$ <u>67,124.13</u>	\$ <u>67,124.13</u>
3. <u>17-34-116-005-0000</u>	<u>Long Term Care Property</u>	\$ <u>51,019.16</u>	\$ <u>51,019.16</u>
4. <u>17-34-116-006-0000</u>	<u>Long Term Care Property</u>	\$ <u>51,019.16</u>	\$ <u>51,019.16</u>
5. <u>17-34-116-007-0000</u>	<u>Long Term Care Property</u>	\$ <u>51,019.16</u>	\$ <u>51,019.16</u>
6. <u>17-34-116-008-0000</u>	<u>Long Term Care Property</u>	\$ <u>2,942.45</u>	\$ <u>2,942.45</u>
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>341,267.49</u></u>	\$ <u><u>341,267.49</u></u>

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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 Southview Manor Nursing Ctr

0051656 Report Period Beginning:

1/1/2017 Ending:

12/31/2017

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 61,960 B. General Construction Type: Exterior Frame Number of Stories

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

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

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	Facility		2012	\$ 550,000	1
2					2
3	TOTALS			\$ 550,000	3

SEE ACCOUNTANTS' PREPARATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
200	2012	1980	\$ 4,215,182	\$	35	\$ 120,434	\$ 120,434	\$ 722,604	4
									5
									6
									7
									8
Improvement Type**									
Single Door		2012	2,770		20	139	139	1,155	9
Cables For Clocks		2013	3,900		20	195	195	1,300	10
Parkway Elevators		2013	5,476		20	274	274	1,689	11
Installed Sprinklers		2013	5,250		20	263	263	1,204	12
Doors		2014	3,145		20	157	157	486	13
Remote Fire Pump Controllers Alarm		2014	3,389		20	169	169	492	14
Doors		2014	3,479		20	174	174	485	15
Rangeguard Hood Repair		2014	3,891		20	195	195	698	16
Nova Fire Protectors - Repairs		2015	5,150		20	258	258	726	17
Nova Fire Protectors - Replace 6# Osy Valve		2015	3,685		20	184	184	456	18
Leaking Boiler # 1 Repair		2015	3,007		20	150	150	450	19
Replace Parkway Elevator Gasket		2016	5,710		20	286	286	572	20
Elevator Repair		2017	2,737		20	137	137	137	21
Replace In-Line Pump		2017	5,115		20	256	256	256	22
									23
									24
									25
									26
									27
									28
									29
									30
									31
									32
									33
									34
									35
									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
SEE ACCOUNTANTS' PREPARATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37						\$	\$	37
38	2012	3,860		20	193	193	1,158	38
39	2012	2,575		20	129	129	838	39
40	2012	2,770		20	139	139	888	40
41	2013	32,846		20	1,642	1,642	8,210	41
42	2013	4,400		20	220	220	1,100	42
43	2013	3,022		20	151	151	755	43
44	2013	5,560		20	278	278	1,390	44
45	2013	3,490		20	175	175	875	45
46	2014	6,381		20	319	319	1,276	46
47	2015	4,800		20	240	240	720	47
48	2015	4,274		20	214	214	642	48
49	2016	2,580		20	129	129	258	49
50	2016	18,490		20	925	925	1,850	50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70		\$ 4,366,934	\$		\$ 128,025	\$ 128,025	\$ 752,670	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,177,647	\$	\$ 117,765	\$ 117,765	10 Yrs	\$ 687,975	71
72	Current Year Purchases	15,946		1,595	1,595	10 Yrs	1,595	72
73	Fully Depreciated Assets	2,913					2,913	73
74								74
75	TOTALS	\$ 1,196,506	\$	\$ 119,360	\$ 119,360		\$ 692,483	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				\$	\$	\$	\$		\$	76
77	N/A									77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 6,113,440	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 247,385	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 247,385	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,445,153	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		\$	\$	\$	86
87	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Southview Manor Nursing Ctr

0051656

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

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	Storage				7,520			5
6								6
7	TOTAL				\$ 7,520			7

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.	_____ /2018	\$ _____
13.	_____ /2019	\$ _____
14.	_____ /2020	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 20,936 Description: See Attached Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name: Southview Manor Nursing Ctr
IDPH License ID Number: 0051656
Fiscal Year End: 12/31/2017

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Copier	2,588
Postage Machine	2,227
Air Cleaner	150
Dishwasher	13,551
Ice Machine	2,420
Total - Line 16	<u>20,936</u>

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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.
- SEE ACCOUNTANTS' PREPARATION REPORT**

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

	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	\$		\$ 52,564	\$		\$ 52,564	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs			4,065			4,065	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs			42,773			42,773	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 prescripts				25,623		25,623	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>See Attached Schedule 16A</u>						16,264		16,264	13
14	TOTAL			\$		\$ 99,402	\$ 41,887		\$ 141,289	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.

SEE ACCOUNTANTS' PREPARATION REPORT

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Urological Supplies	39(2)	hrs	\$		\$	\$	506		\$	506	1
2	Oxygen Rental/Cost	39(2)	hrs					5,432			5,432	2
3	Respiratory Rental/Cost	39(2)	hrs					10,326			10,326	3
4			hrs									4
5			visits									5
6			visits									6
7			hrs									7
8			hrs									8
9			# of prescrpts									9
10			hrs									10
11			hrs									11
12												12
13												13
14	TOTAL			\$		\$	\$	16,264		\$	16,264	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.

SEE ACCOUNTANTS' PREPARATION REPORT

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2017**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 310,465	\$ 310,487	1
2	Cash-Patient Deposits	(2,222)	(2,222)	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>624,264</u>)	2,365,807	2,365,807	3
4	Supply Inventory (priced at <u>Cost</u>)	5,100	5,100	4
5	Short-Term Investments			5
6	Prepaid Insurance	53,135	91,090	6
7	Other Prepaid Expenses	31,876	31,876	7
8	Accounts Receivable (owners or related parties)	156,145	156,145	8
9	Other(specify): <u>See Attached Schedule 17A</u>	83,589	455,880	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,003,895	\$ 3,414,163	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		550,000	13
14	Buildings, at Historical Cost	29,071	4,240,368	14
15	Leasehold Improvements, at Historical Cost		126,566	15
16	Equipment, at Historical Cost	126,203	1,196,506	16
17	Accumulated Depreciation (book methods)	(17,547)	(1,445,153)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe <u>Goodwill</u>)	842,415	2,520,040	22
23	Other(specify): <u>Loan Costs, Net</u>		25,468	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 980,142	\$ 7,213,795	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,984,037	\$ 10,627,958	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,864,991	\$ 4,094,078	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,711,395	1,711,395	29
30	Accrued Salaries Payable	545,723	545,723	30
31	Accrued Taxes Payable (excluding real estate taxes)	19,777	19,777	31
32	Accrued Real Estate Taxes(Sch.IX-B)		595,399	32
33	Accrued Interest Payable		466,892	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule 17A</u>	392,889	392,889	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,534,775	\$ 7,826,153	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		12,546,375	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule 17A</u>	3,324,727	(9,665)	43
44	<u>Mortgage Premium</u>		513,129	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,324,727	\$ 13,049,839	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 8,859,502	\$ 20,875,992	46
47	TOTAL EQUITY(page 18, line 24)	\$ (4,875,465)	\$ (10,248,034)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,984,037	\$ 10,627,958	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

Facility Name: Southview Manor Nursing Ctr
 IDPH License ID Number: 0051656
 Fiscal Year End: 12/31/2017

Schedule 17A

XV. Balance Sheet

Line 9 Other Assets (specify):

Description	Operating	After Consolidation
DUE FROM EKS	30,906	30,906
IMPOUND RESERVE	52,683	52,683
DUE TO MID CAP LINE OF CREDIT		
MORTGAGE ESCROWS		372,291
Total - Line 9	83,589	455,880

XV. Balance Sheet

Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
ACCRUED EXPENSES	72,483	72,483
ALLIED ACCRUAL	312,085	312,085
PAYROLL WITHHOLDINGS	(12,445)	(12,445)
DUE TO/FROM ALIEN RECIPIEN*	20,766	20,766
Total - Line 36	392,889	392,889

XV. Balance Sheet

Line 43 Long-Term Liabilities (specify):

Description	Operating	After Consolidation
ACCRUED RENT	654,152	13,479
DUE TO/FROM FACILITIES	(18,103)	(23,144)
DUE TO/FROM PROPERTY	2,688,678	
Total - Line 43	3,324,727	(9,665)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (3,737,186)	1
2	Restatements (describe):		2
3	Prior Period Adj-Cash Reconciliation	2,316	3
4	Rounding	2	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,734,868)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,269,377)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	128,780	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)	\$ (1,140,597)	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)	\$ (4,875,465)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Southview Manor Nursing Ctr

0051656

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

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		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 8,126,215	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,126,215	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	180,486	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 180,486	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		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	11,026	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 11,026	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)	600	27
28	<u>Miscellaneous Income</u>	474	28
28a	<u>Vending Income</u>	10,104	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 11,178	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,328,905	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,962,790	31
32	Health Care	3,524,994	32
33	General Administration	1,757,898	33
B. Capital Expense			
34	Ownership	1,465,921	34
C. Ancillary Expense			
35	Special Cost Centers	379,441	35
36	Provider Participation Fee	507,238	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,598,282	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,269,377)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,269,377)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 8,034,627	44
45	Private Pay - Net Inpatient Revenue	7,440	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) <u>Hospice</u>	21,476	47
48	Other-(specify) <u>Veterans</u>	62,672	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,126,215	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete 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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Southview Manor Nursing Ctr

0051656

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,856	2,176	\$ 104,353	\$ 47.96	1
2	Assistant Director of Nursing	1,648	1,832	73,858	40.32	2
3	Registered Nurses	4,303	4,536	128,119	28.24	3
4	Licensed Practical Nurses	41,481	45,573	1,164,213	25.55	4
5	CNAs & Orderlies	81,295	88,957	1,073,285	12.07	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,280	5,793	72,162	12.46	8
9	Activity Director					9
10	Activity Assistants	14,116	15,438	179,541	11.63	10
11	Social Service Workers	22,775	24,166	435,970	18.04	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,637	24,757	328,253	13.26	15
16	Dishwashers					16
17	Maintenance Workers	22,049	23,491	302,732	12.89	17
18	Housekeepers	29,967	33,788	366,482	10.85	18
19	Laundry	9,607	10,804	104,707	9.69	19
20	Administrator	2,048	2,096	105,539	50.35	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,694	9,297	177,288	19.07	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	2,014	2,240	24,859	11.10	31
32	Other Health C: MDS Coordinator	3,798	4,118	110,133	26.74	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	273,568	299,062	\$ 4,751,494 *	\$ 15.89	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	285	\$ 13,925	L1, C3	35
36	Medical Director	Monthly	12,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	368	17,756	L10, C3	38
39	Pharmacist Consultant	Monthly	15,600	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	Psychiatric Medical Director	Monthly	18,000	L9,C3	47
48	Administrative	152	7,785	L21,C3	48
49	TOTAL (lines 35 - 48)	805	\$ 85,066		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	16	\$ 696	L10,C3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	16	\$ 696		53

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Southview Manor Nursing Ctr

0051656

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Adeyomi Adebogun	Administrator	0	\$ 16,229	Workers' Compensation Insurance	\$ 101,521	IDPH License Fee	\$ 1,990		
Darnell Fortney	Administrator	0	57,310	Unemployment Compensation Insurance	36,647	Advertising: Employee Recruitment			
Addison Wilczak	Administrator	0	32,000	FICA Taxes	360,099	Health Care Worker Background Check			
				Employee Health Insurance	154,866	(Indicate # of checks performed 1)	85		
				Employee Meals		Patient Background Checks	238 5,974		
				Illinois Municipal Retirement Fund (IMRF)*		IL Council on LTC	27,308		
				Other Employee Benefits	2,253	Licenses & Fees	2,569		
				Employee Drug Screening	243				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 105,539	TOTAL (agree to Schedule V, line 22, col.8)		\$ 655,629	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 24,272
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
TM Healthcare Management - Management Fees			\$ 408,391	N/A			Out-of-State Travel	\$	
							In-State Travel		
							Seminar Expense	1,165	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 408,391	TOTAL		\$	Entertainment Expense	()	
C. Professional Services									
Vendor/Payee	Type		Amount						
See Attached Schedule	Legal		\$ 9,463						
Marcum LLP	Accounting		22,000						
Templin Healthcare Accounting Svc	Accounting		4,290						
Cohn Reznick	Accounting		5,535						
Ability Network	Data Processing		3,213						
Information Controls	Data Processing		5,719						
Change Healthcare	Data Processing		674						
Point Click Care	Data Processing		39,110						
Prospect Resources, Inc.	Benchmarking		500						
Personnel Planners	Unemployment Consulting		1,730						
Howard Simon & Associates	Payroll Processing		10,686						
See Attached Schedule 21A			10,600						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 113,520	TOTAL (agree to Sch. V, line 24, col. 8)					\$ 1,165

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

Southview Manor Nursing Ctr

Period Beginning **1/1/2017**
Period End **12/31/2017**

Schedule 21A

XIX. Support Schedules, Section C. Professional Services

Vendor/Payee	Type	Amount
S4 Group	Lobbying	1,500
US Trustee Payment Center	Trustee Fees	6,500
Relias & Tsonas	RE Tax Appeal	2,600
		<u>10,600</u>

Facility Name & ID Number Southview Manor Nursing Ctr

0051656

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. 27,308 IL Council on LTC
- (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? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,329 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. \$ 507,238
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. \$ 0 Has any meal income been offset against related costs? No 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? 100% of Line
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
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 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

SEE ACCOUNTANTS' PREPARATION REPORT