



Facility Name & ID Number Southgate Health Care Center

# 0017996 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	66	Intermediate (ICF)	66	24,090	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	140	TOTALS	140	51,100	7

B. Census-For the entire report period.

	1 Level of Care	2 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	8,131	257	4,857	13,245	8
9	SNF/PED					9
10	ICF	19,907	6,161	542	26,610	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,038	6,418	5,399	39,855	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.99%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES  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 08/25/72

J. Was the facility purchased or leased after January 1, 1978?

YES  Date N/A NO

K. Was the facility certified for Medicare during the reporting year?

YES  NO  If YES, enter number of beds certified 38 and days of care provided 4,130

Medicare Intermediary National Government Services (Louisville, KY)

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

**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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	172,225	13,588	8,608	194,421		194,421		194,421	1	
2	Food Purchase		180,238		180,238		180,238	(1,044)	179,194	2	
3	Housekeeping	132,012	19,878		151,890		151,890		151,890	3	
4	Laundry	86,542	12,615	2,092	101,249		101,249		101,249	4	
5	Heat and Other Utilities			77,894	77,894		77,894		77,894	5	
6	Maintenance	75,969	35,355	38,485	149,809		149,809		149,809	6	
7	Other (specify):*									7	
8	<b>TOTAL General Services</b>	<b>466,748</b>	<b>261,674</b>	<b>127,079</b>	<b>855,501</b>		<b>855,501</b>	<b>(1,044)</b>	<b>854,457</b>	<b>8</b>	
	<b>B. Health Care and Programs</b>										
9	Medical Director			5,700	5,700		5,700		5,700	9	
10	Nursing and Medical Records	1,068,719	120,865	60,262	1,249,846		1,249,846		1,249,846	10	
10a	Therapy			456,300	456,300		456,300		456,300	10a	
11	Activities	49,096	1,238		50,334		50,334		50,334	11	
12	Social Services	46,387			46,387		46,387		46,387	12	
13	CNA Training									13	
14	Program Transportation									14	
15	Other (specify):*									15	
16	<b>TOTAL Health Care and Programs</b>	<b>1,164,202</b>	<b>122,103</b>	<b>522,262</b>	<b>1,808,567</b>		<b>1,808,567</b>		<b>1,808,567</b>	<b>16</b>	
	<b>C. General Administration</b>										
17	Administrative	318,378			318,378		318,378		318,378	17	
18	Directors Fees			8,000	8,000		8,000		8,000	18	
19	Professional Services			15,107	15,107		15,107		15,107	19	
20	Dues, Fees, Subscriptions & Promotions			61,356	61,356		61,356	(39,735)	21,621	20	
21	Clerical & General Office Expenses	97,877	15,268	50,584	163,729		163,729	(1,063)	162,666	21	
22	Employee Benefits & Payroll Taxes			348,464	348,464		348,464		348,464	22	
23	Inservice Training & Education			302	302		302		302	23	
24	Travel and Seminar			11,877	11,877		11,877	(4,034)	7,843	24	
25	Other Admin. Staff Transportation			15,707	15,707		15,707		15,707	25	
26	Insurance-Prop.Liab.Malpractice			116,625	116,625		116,625		116,625	26	
27	Other (specify):*									27	
28	<b>TOTAL General Administration</b>	<b>416,255</b>	<b>15,268</b>	<b>628,022</b>	<b>1,059,545</b>		<b>1,059,545</b>	<b>(44,832)</b>	<b>1,014,713</b>	<b>28</b>	
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,047,205</b>	<b>399,045</b>	<b>1,277,363</b>	<b>3,723,613</b>		<b>3,723,613</b>	<b>(45,876)</b>	<b>3,677,737</b>	<b>29</b>	

SEE ACCOUNTANTS' COMPILATION REPORT

\*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.

\*\*See schedule of adjustments attached at end of cost report.

Facility Name & ID Number Southgate Health Care Center

#0017996

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			178,376	178,376		178,376	(53,141)	125,235			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			5,075	5,075		5,075	(5,075)				32
33	Real Estate Taxes			88,346	88,346		88,346		88,346			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			21,453	21,453		21,453		21,453			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			293,250	293,250		293,250	(58,216)	235,034			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	186,130	151,190	25,841	363,161		363,161		363,161			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			76,650	76,650		76,650		76,650			42
43	Other (specify):* <b>Nonallowable Cost</b>	26,422		96,890	123,312		123,312	(123,312)				43
44	<b>TOTAL Special Cost Centers</b>	212,552	151,190	199,381	563,123		563,123	(123,312)	439,811			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	2,259,757	550,235	1,769,994	4,579,986		4,579,986	(227,404)	4,352,582			45

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

\*\*See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION 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	OHF 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	(53,141)	30		9
10	Interest and Other Investment Income	(5,075)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(5,031)	43		20
21	Owner or Key-Man Insurance	(26,360)	43		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(18,964)	43		24
25	Fund Raising, Advertising and Promotional	(33,603)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(4,439)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,838)	20		28
29	Other-Attach Schedule (See Pg 5A)	(77,953)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (227,404)		\$	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)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (227,404)		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	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY					
48	49	50	51	52	

SEE ACCOUNTANTS' COMPILATION REPORT

Southgate Health Care Center

ID# 0017996

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Medicare Prosthetics	\$ (634)	43	1
2	Medicare Lab Expense	(8,756)	43	2
3	Medicare Xray Expense	(2,894)	43	3
4	Marketing Expense	(48,075)	43	4
5	PAC Contributions	(1,622)	43	5
6	Out of State Travel	(4,034)	24	6
7	Chamber of Commerce Dues	(925)	20	7
8	Automobile Expense	(6,099)	43	8
9	Cable TV Expense	(377)	21	9
10	Offset Vending Income	(1,044)	2	10
11	Medicare Support Services	(438)	43	11
12	Miscellaneous Expense	(686)	21	12
13	Disallow lobbying dues	(2,369)	20	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	<b>Total</b>	(77,953)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Southgate Health Care Center# 0017996 Report Period Beginning:

01/01/2006

Ending: 12/31/2006

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,044)	0	0	0	0	0	0	0	0	0	0	(1,044)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(1,044)</b>	<b>0</b>	<b>(1,044)</b>	<b>8</b>									
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(39,735)	0	0	0	0	0	0	0	0	0	0	(39,735)	20
21	Clerical & General Office Expenses	(1,063)	0	0	0	0	0	0	0	0	0	0	(1,063)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(4,034)	0	0	0	0	0	0	0	0	0	0	(4,034)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	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	<b>TOTAL General Administration</b>	<b>(44,832)</b>	<b>0</b>	<b>(44,832)</b>	<b>28</b>									
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(45,876)</b>	<b>0</b>	<b>(45,876)</b>	<b>29</b>									

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Southgate Health Care Center# 0017996

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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

	Capital Expense	PAGES	PAGE	SUMMARY									
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS
													(to Sch V, col.7)
30	Depreciation	(53,141)	0	0	0	0	0	0	0	0	0	0	(53,141) 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(5,075)	0	0	0	0	0	0	0	0	0	0	(5,075) 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	<b>TOTAL Ownership</b>	<b>(58,216)</b>	<b>0</b>	<b>(58,216) 37</b>									
	<b>Ancillary Expense</b>												
	<b>E. Special Cost Centers</b>												
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):*	(123,312)	0	0	0	0	0	0	0	0	0	0	(123,312) 43
44	<b>TOTAL Special Cost Centers</b>	<b>(123,312)</b>	<b>0</b>	<b>(123,312) 44</b>									
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(227,404)</b>	<b>0</b>	<b>(227,404) 45</b>									

**VII. RELATED PARTIES**

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Jane A Parker	81.25					
Sam Thompson	6.25					
Jeff Thompson	6.25	N/A		N/A		
Shelly MacCauley	6.25					

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.**  YES  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		\$			\$	\$	1
2	V			N/A				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 &amp; ID Number

Southgate Health Care Center

# 0017996

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

## 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	Sam Thompson	Operations	Administrative	6.25	None	40+	100.00	Salary	\$ 197,600	17(1)	1
2	Jeff Thompson	Maintenance	Maintenance	6.25	None	40+	100.00	Salary	28,080	6(1)	2
3	Mary Lynn Thompson	Accountant	Clerical	0.00	None	40+	100.00	Salary	40,040	21(1)	3
4											4
5	Sam Thompson	Director	Administrative	6.25	None	40+	100.00	Director Fee	2,000	18(3)	5
6	Jeff Thompson	Director	Administrative	6.25	None	40+	100.00	Director Fee	2,000	18(3)	6
7	Shelly MacCauley	Director	Administrative	6.25	None	<1	< 2%	Director Fee	2,000	18(3)	7
8	William Parker	Director	Administrative	0.00	None	<1	< 2%	Director Fee	2,000	18(3)	8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 273,720		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' COMPILATION REPORT

Facility Name & ID Number Southgate Health Care Center

# 0017996 Report Period Beginning: 01/01/2006 Ending: 2/31/2006

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

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

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

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				N/A					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' COMPILATION REPORT





**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2005 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 Sam Thompson

TELEPHONE (618) 524-2863 FAX #: (618) 524-3048

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

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>08-01-448-002</u>	<u>BK 148- W 80 ft except N 26 ft</u>	\$ <u>251.86</u>	\$ <u>251.86</u>
2. _____	<u>Addition to Metropolis</u>	\$ _____	\$ _____
3. <u>08-01-449-001</u>	<u>BK 149- All Bld 149 except N 26 ft</u>	\$ <u>1,417.16</u>	\$ <u>1,417.16</u>
4. _____	<u>Addition to Metropolis</u>	\$ _____	\$ _____
5. <u>08-01-450-001</u>	<u>BK 150</u>	\$ <u>52,213.46</u>	\$ <u>52,213.46</u>
6. _____	<u>All blk 150 ex triangular portion</u>	\$ _____	\$ _____
7. _____	<u>parcel n pt of :</u>	\$ _____	\$ _____
8. _____	<u>Addition to Metropolis</u>	\$ _____	\$ _____
9. <u>08-01-451-001</u>	<u>BK 151</u>	\$ <u>587.46</u>	\$ <u>587.46</u>
10. _____	<u>Addition to Metropolis</u>	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>54,469.94</u>	\$ <u>54,469.94</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 & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

Facility Name & ID Number Southgate Health Care Center

# 0017996

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

**X. BUILDING AND GENERAL INFORMATION:**

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

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

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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: \_\_\_\_\_ 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:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>	<u>185,500</u>	<u>1972</u>	<u>\$ 5,000</u>	<u>1</u>
2	<u>Resident Care</u>	<u>193,500</u>	<u>2002</u>	<u>95,000</u>	<u>2</u>
3	<b>TOTALS</b>	<b>379,000</b>		<b>\$ 100,000</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Southgate Health Care Center

# 0017996

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	88	1972	1976	\$ 207,276	\$	30	\$	\$	\$ 207,276	4
5	37		1976	289,344		30	14,461	14,461	289,344	5
6	10		1989	583,147	18,513	30	19,438	925	339,865	6
7	5		1993	598,429	15,344	30	19,948	4,604	269,298	7
8			1994	13,658	350	30	455	105	5,895	8
	<b>Improvement Type**</b>									
9	Land improvements		1975	7,341		10-30			7,341	9
10	Land improvements		1976	2,886		20			2,886	10
11	Building improvements		1977	1,098		28			1,098	11
12	Land and building improvements		1980	1,014		20			1,014	12
13	Building improvements		1981	57,891		15			57,891	13
14	Land & building improvements		1982	17,279		5-20			17,279	14
15	Building improvements		1983	675		10			675	15
16	Bushes & gravel		1984	888		10			888	16
17	Patio, Med room & improvements		1984	13,078		15			13,078	17
18	Building addition		1984	100,925		20			100,925	18
19	Gravel road & painting		1985	7,365		3-20			7,365	19
20	Improvements		1985	17,960		15			17,960	20
21	Fire alarm & barn		1985	3,568		20			3,568	21
22	Improvements		1986	13,163		15			13,163	22
23	Kitchen remodeling		1988	32,477	1,031	30	1,084	53	20,042	23
24	Overhead door/kitchen		1989	852		15			852	24
25	Flooring		1990	729		10			729	25
26	Fire alarm		1990	9,537	303	20	477	174	7,870	26
27	Dining room improvements		1992	1,824	58	10		(58)	1,824	27
28	Warehouse storage building		1993	17,802	565	30	593	28	8,302	28
29	100 gal lime tank		1995	3,742		15	250	250	2,875	29
30	Drywall resident rooms & bathrooms		1996	2,240	57	10	106	49	2,240	30
31										31
32										32
33										33
34										34
35										35
36										36

\*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Southgate Health Care Center

# 0017996

Report Period Beginning:

01/01/2006 Ending: 12/31/2006

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	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	Parking lot	1997	\$ 5,000	\$ 299	10	\$ 500	\$ 201	\$ 4,750	37
38	Flooring	1997	674	17	10	68	51	614	38
39	Kitchen plumbing	1997	1,947	50	20	97	47	922	39
40	Tile floor	1997	784	20	10	78	58	741	40
41	Water softener	1997	667	17	10	67	50	636	41
42	Interior design	1997	1,245	32	15	83	51	789	42
43									43
44	Flooring	1998	1,130	29	10	113	84	960	44
45									45
46	Roofing	1999	17,240	442	20	862	420	6,788	46
47									47
48	Roof - Section B	2000	31,346	436	20	1,567	1,131	9,827	48
49									49
50	New laundry building	2001	179,249	4,596	20	8,962	4,366	49,752	50
51	Laundry building flooring	2001	1,219	90	10	121	31	667	51
52	Roof replacement	2001	84,500	2,167	20	4,225	2,058	23,238	52
53									53
54	Design & remodel dining room	2002	97,732	2,506	40	2,443	(63)	10,994	54
55	Flooring	2002	39,834	2,489	10	3,683	1,194	16,723	55
56	Blinds	2002	2,473	155	10	247	92	1,112	56
57	Awning	2002	996	62	10	100	38	450	57
58	Walk in cooler repair	2002	3,361	210	10	336	126	1,512	58
59	Lighting	2002	2,563	160	10	256	96	1,152	59
60									60
61	Flooring	2003	871	76	10	87	11	305	61
62	Entryway Carpeting	2003	2,367	207	10	237	30	829	62
63									63
64									64
65									65
66									66
67	Flooring	2004	18,000		10	1,800	1,800	4,500	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,499,386	\$ 50,281		\$ 82,744	\$ 32,463	\$ 1,538,804	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,499,386	\$ 50,281		\$ 82,744	\$ 32,463	\$ 1,538,804	1
2									2
3	Flooring	2005	22,140	3,163	10	2,214	(949)	3,321	3
4	Drywall Hallways in A&D Wings & Various Resident Rooms	2005	19,233	5,319	10	1,923	(3,396)	2,885	4
5									5
6	Shelving unit for kitchen	2006	2,377	2,377	7	170	(2,207)	170	6
7	Drywall	2006	3,325	166	15	111	(55)	111	7
8	Air conditioning unit	2006	5,091	727	7	364	(363)	364	8
9	Flooring	2006	2,572	367	7	183	(184)	183	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,554,124	\$ 62,400		\$ 87,709	\$ 25,309	\$ 1,545,838	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 470,670	\$ 6,534	\$ 11,567	\$ 5,033	5-10	\$ 469,149	71
72	Current Year Purchases	128,122	109,442	21,354	(88,088)	5-7	21,354	72
73	Fully Depreciated Assets	190,589					190,589	73
74								74
75	TOTALS	\$ 789,381	\$ 115,976	\$ 32,921	\$ (83,055)		\$ 681,092	75

D. Vehicle Depreciation (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	1989 Chevrolet van	1989	\$ 18,500	\$	\$	\$	5	\$ 18,500	76
77	Resident Care	1983 Ford pickup	1987	4,700				5	4,700	77
78	Resident Care	1999 Dodge Dakota	2000	14,504				5	14,504	78
79	Resident Care	2004 Van	2004	23,024		4,605	4,605	5	6,907	79
80	TOTALS			\$ 60,728	\$	\$ 4,605	\$ 4,605		\$ 44,611	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)		\$ 3,504,233	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 178,376	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 125,235	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ (53,141)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 2,271,541	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	Fully Depreciated Non-Care Assets	\$ 76,418	\$	\$ 76,418	86
87	2005 Jeep Cherokee	40,164	4,579	16,227	87
88	1999 Suburban (2000)	29,810		29,810	88
89	2001 Envoy (2002)	40,686	3,280	32,449	89
90	2004 Mercedes Benz	76,104	1,775	26,145	90
91	TOTALS	\$ 263,182	\$ 9,634	\$ 181,049	91

G. Construction-in-Progress

	Description	Cost	
92	New facility - Design &	\$	92
93	construction. Not yet in		93
94	service	225,606	94
95		\$ 225,606	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' COMPILATION REPORT

**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:		<u>N/A</u>		\$			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: \_\_\_\_\_ \*

**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: \$ 21,453 Description: Dish machine- \$2578, Oxygen concentrators- \$6145, Nursing equipment- \$12,730

(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			\$ <u>N/A</u>	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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. \_\_\_\_\_ /2007 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2008 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2009 \$ \_\_\_\_\_

\* 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.

**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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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' COMPILATION 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	Licensed Occupational Therapist	10A(3)	hrs			2,872	\$ 163,545		2,872	\$ 163,545	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs			1,240	37,903		1,240	37,903	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	10A(3)	hrs			4,664	246,155		4,664	246,155	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					126,694		126,694	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program	39(1,2,3)	19,775 hrs		186,130	431	25,841	24,284	20,206	236,255	12
13	Other (specify): <b>VA Rehab &amp; Lab</b>	10A(3), 39(2)				139	8,347	212	139	8,559	13
14	<b>TOTAL</b>				\$ 186,130	9,346	\$ 481,791	\$ 151,190	29,121	\$ 819,111	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' COMPILATION REPORT

Facility Name &amp; ID Number Southgate Health Care Center

# 0017996

Report Period Beginning: 01/01/2006

Ending:

12/31/2006

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2006

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 240,226	\$ 240,226	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 5,809 )	987,762	987,762	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments	975	975	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	26,847	26,847	7
8	Accounts Receivable (owners or related parties)	5,000	5,000	8
9	Other(specify): <u>A/R Employees</u>	1,210	1,210	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,262,020	\$ 1,262,020	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	100,000	100,000	13
14	Buildings, at Historical Cost	3,445,427	2,540,759	14
15	Leasehold Improvements, at Historical Cost	118,657	13,365	15
16	Equipment, at Historical Cost		850,109	16
17	Accumulated Depreciation (book methods)	(2,471,638)	(2,271,541)	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): <u>See Schedule 17A</u>	227,660	227,660	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,420,106	\$ 1,460,352	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,682,126	\$ 2,722,372	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 231,360	\$ 231,360	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	113,320	113,320	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,797	8,797	31
32	Accrued Real Estate Taxes(Sch.IX-B)	54,470	54,470	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Schedule 17A</u>	167,793	167,793	36
37	<u>Deferred income- Patient Liability</u>	121,217	121,217	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 696,957	\$ 696,957	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	51,091	51,091	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 51,091	\$ 51,091	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 748,048	\$ 748,048	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,934,078	\$ 1,974,324	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,682,126	\$ 2,722,372	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

Southgate Health Care Center, Inc.  
Provider # 0017996  
01/01/06 to 12/31/06

**Schedule 17A**

XV. BALANCE SHEET

**Line 23 (Other)**

Employee Advances	2,054
Construction in Progress	<u>225,606</u>
<b>Total Line 23</b>	<u><u>227,660</u></u>

**Line 36 (Other Current Liabilities)**

Federal Income Tax Withheld	4,385
Insurance W/H Life Insurance	387
Insurance W/H Health Insurance	1,708
Due to DPA Coinsurance	<u>161,313</u>
<b>Total Line 36</b>	<u><u>167,793</u></u>

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,962,057</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Adjustments subsequent to cost report preparation</b>	<b>(31,687)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>1,930,370</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>236,009</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(232,301)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>3,708</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,934,078</b>	<b>24</b> *

Operating Entity Only

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

SEE ACCOUNTANTS' COMPILATION REPORT

**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**

1

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 3,571,768	1
2	Discounts and Allowances for all Levels	582,060	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,153,828	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	442,737	6
7	Oxygen	963	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 443,700	8
	<b>C. Other Operating Revenue</b>		
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	192,930	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	19,584	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 212,514	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	4,558	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 4,558	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Miscellaneous Income</u>	351	28
28a	<u>Vending Income</u>	1,044	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,395	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,815,995	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	855,501	31
32	Health Care	1,808,567	32
33	General Administration	1,059,545	33
	<b>B. Capital Expense</b>		
34	Ownership	293,250	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	486,473	35
36	Provider Participation Fee	76,650	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,579,986	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	236,009	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 236,009	43

\* 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. SEE ACCOUNTANTS' COMPILATION REPORT

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **Southgate Health Care Center**

# **0017996**

Report Period Beginning:

**01/01/2006**

Ending:

**12/31/2006**

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,080	2,080	\$ 48,752	\$ 23.44	1
2	Assistant Director of Nursing	1,630	1,630	34,307	21.05	2
3	Registered Nurses	9,000	9,000	166,499	18.50	3
4	Licensed Practical Nurses	24,330	24,330	329,430	13.54	4
5	CNAs & Orderlies	84,167	84,167	667,447	7.93	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,080	2,080	20,046	9.64	9
10	Activity Assistants	3,617	3,617	29,050	8.03	10
11	Social Service Workers	3,770	3,770	46,387	12.30	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	28,590	13.75	13
14	Head Cook	5,710	5,710	43,562	7.63	14
15	Cook Helpers/Assistants	6,822	6,822	48,354	7.09	15
16	Dishwashers	7,781	7,781	51,719	6.65	16
17	Maintenance Workers	4,399	4,399	75,969	17.27	17
18	Housekeepers	18,112	18,112	140,426	7.75	18
19	Laundry	11,503	11,503	86,542	7.52	19
20	Administrator	2,080	2,080	101,963	49.02	20
21	Assistant Administrator	932	932	18,815	20.19	21
22	Other Administrative	2,080	2,080	197,600	95.00	22
23	Office Manager					23
24	Clerical	7,535	7,535	97,877	12.99	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) <u>Mktg Non-allowab</u>	2,080	2,080	26,422	12.70	33
34	TOTAL (lines 1 - 33)	201,788	201,788	\$ 2,259,757 *	\$ 11.20	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	242	\$ 8,608	1(3)	35
36	Medical Director	Monthly	5,700	9(3)	36
37	Medical Records Consultant	32	1,861	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	1,200	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	7	350	10A(3)	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Specialty Nursing</u>	10	1,000	10(3)	46
47					47
48					48
49	TOTAL (lines 35 - 48)	303	\$ 18,719		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,848	\$ 56,201	10(3)	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,848	\$ 56,201		53

SEE ACCOUNTANTS' COMPILATION REPORT



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

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2							N/A					
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Southgate Health Care Center# 0017996Report Period Beginning: 01/01/2006Ending: 12/31/2006**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. Illinois Health Care Assoc. \$7,728
- (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? 6 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 21,599 Line 10(2)
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 76,650  
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.

**SEE ACCOUNTANTS' COMPILATION REPORT**

- (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. \$ 10,904 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? 0  
d. Have vehicle usage logs been maintained? Adequate records have been maintained.  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? 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 The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. 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) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees