

Facility Name & ID Number Southgate Health Care Center

0017996 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	<u>74</u>	Skilled (SNF)	<u>74</u>	<u>27,010</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>66</u>	Intermediate (ICF)	<u>66</u>	<u>24,090</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>140</u>	TOTALS	<u>140</u>	<u>51,100</u>	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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>7,911</u>	<u>251</u>	<u>6,445</u>	<u>14,607</u>	8
9	SNF/PED					9
10	ICF	<u>19,365</u>	<u>5,993</u>	<u>329</u>	<u>25,687</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>27,276</u>	<u>6,244</u>	<u>6,774</u>	<u>40,294</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.85%

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 Note: Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
 YES 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 5,259

Medicare Intermediary National Government Services (Louisville, KY)

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/07 Fiscal Year: 12/31/07

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	182,893	14,463		197,356		197,356	7,022	204,378		1
2	Food Purchase		192,470		192,470		192,470	(893)	191,577		2
3	Housekeeping	143,152	20,554		163,706		163,706		163,706		3
4	Laundry	91,548	15,799		107,347		107,347		107,347		4
5	Heat and Other Utilities			93,415	93,415		93,415		93,415		5
6	Maintenance	79,426	33,070	43,920	156,416		156,416		156,416		6
7	Other (specify):*										7
8	TOTAL General Services	497,019	276,356	137,335	910,710		910,710	6,129	916,839		8
	B. Health Care and Programs										
9	Medical Director			5,700	5,700		5,700		5,700		9
10	Nursing and Medical Records	1,232,951	133,490	92,248	1,458,689		1,458,689	(7,022)	1,451,667		10
10a	Therapy			429,740	429,740		429,740		429,740		10a
11	Activities	53,207	4,934		58,141		58,141		58,141		11
12	Social Services	59,738			59,738		59,738		59,738		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,345,896	138,424	527,688	2,012,008		2,012,008	(7,022)	2,004,986		16
	C. General Administration										
17	Administrative	304,838			304,838		304,838		304,838		17
18	Directors Fees			4,000	4,000		4,000		4,000		18
19	Professional Services			24,216	24,216		24,216	(2,777)	21,439		19
20	Dues, Fees, Subscriptions & Promotions			71,476	71,476		71,476	(45,785)	25,691		20
21	Clerical & General Office Expenses	100,577	17,318	43,899	161,794		161,794	(1,116)	160,678		21
22	Employee Benefits & Payroll Taxes			348,534	348,534		348,534		348,534		22
23	Inservice Training & Education			3,208	3,208		3,208		3,208		23
24	Travel and Seminar			15,033	15,033		15,033	(7,209)	7,824		24
25	Other Admin. Staff Transportation			22,996	22,996		22,996		22,996		25
26	Insurance-Prop.Liab.Malpractice			92,476	92,476		92,476		92,476		26
27	Other (specify):*										27
28	TOTAL General Administration	405,415	17,318	625,838	1,048,571		1,048,571	(56,887)	991,684		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,248,330	432,098	1,290,861	3,971,289		3,971,289	(57,780)	3,913,509		29

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

SEE ACCOUNTANTS' COMPILATION 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 Southgate Health Care Center

#0017996

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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			117,786	117,786		117,786	17,027	134,813			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,493	1,493		1,493	(1,493)				32
33	Real Estate Taxes			32,202	32,202		32,202	2,777	34,979			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			16,847	16,847		16,847		16,847			35
36	Other (specify):* Non-Care Depr			6,230	6,230		6,230	(6,230)				36
37	TOTAL Ownership			174,558	174,558		174,558	12,081	186,639			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	17,850	120,265	1,442	139,557		139,557		139,557			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):* Non-allowable Cos	37,386		143,787	181,173		181,173	(181,173)				43
44	TOTAL Special Cost Centers	55,236	120,265	221,879	397,380		397,380	(181,173)	216,207			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,303,566	552,363	1,687,298	4,543,227		4,543,227	(226,872)	4,316,355			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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	17,027	30		9
10	Interest and Other Investment Income	(1,493)	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	(21,933)	43		20
21	Owner or Key-Man Insurance	(17,743)	43		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(40,103)	43		24
25	Fund Raising, Advertising and Promotional	(41,464)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(17,134)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(3,951)	20		28
29	Other-Attach Schedule <u>See Pg. 5A</u>	(100,078)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (226,872)		\$	30

BHF USE ONLY					
48		49		50	
				51	
					52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	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	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (226,872)		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	TOTAL (C): (sum of lines 38-46)			\$	47

SEE ACCOUNTANTS' COMPILATION REPORT

Southgate Health Care Center

ID# 0017996

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Medicare Lab Expenses	\$ (8,146)	43	1
2	Medicare Xray Expense	(3,009)	43	2
3	Marketing Salary	(37,386)	43	3
4	PAC Contributions	(1,053)	43	4
5	Out of State Travel	(6,614)	24	5
6	Chamber of Commerce Dues	(370)	20	6
7	Automobile Expense	(11,453)	43	7
8	Penalties	(966)	43	8
9	Offset Vending Income	(893)	2	9
10	Medicare Support Services	(199)	43	10
11	Miscellaneous Expense	(1,116)	21	11
12	Relay for Life	200	43	12
13	Medicare Urology	155	43	13
14	Marketing Expense	(22,403)	43	14
15	Non-Care Asset Depreciation	(6,230)	36	15
16	Non-Allowable Seminar	(595)	24	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	(100,078)		49

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Summary A

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

01/01/2007

Ending: 12/31/2007

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	(893)	0	0	0	0	0	0	0	0	0	0	(893)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(893)	0	(893)	8									
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(45,785)	0	0	0	0	0	0	0	0	0	0	(45,785)	20
21	Clerical & General Office Expenses	(1,116)	0	0	0	0	0	0	0	0	0	0	(1,116)	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	(7,209)	0	0	0	0	0	0	0	0	0	0	(7,209)	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	TOTAL General Administration	(54,110)	0	(54,110)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(55,003)	0	(55,003)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Southgate Health Care Center# 0017996

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	17,027	0	0	0	0	0	0	0	0	0	0	17,027	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,493)	0	0	0	0	0	0	0	0	0	0	(1,493)	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):*	(6,230)	0	0	0	0	0	0	0	0	0	0	(6,230)	36
37	TOTAL Ownership	9,304	0	0	0	0	0	0	0	0	0	0	9,304	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(181,173)	0	0	0	0	0	0	0	0	0	0	(181,173)	43
44	TOTAL Special Cost Centers	(181,173)	0	0	0	0	0	0	0	0	0	0	(181,173)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(226,872)	0	0	0	0	0	0	0	0	0	0	(226,872)	45

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 Ann 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							2
3	V							3
4	V			N/A				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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	\$ 212,268	17(1)	1
2	Jeff Thompson	Maintenance	Maintenance	6.25	None	40+	100.00	Salary	29,606	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 Fees	1,000	18(3)	5
6	Jeff Thompson	Director	Administrative	6.25	None	40+	100.00	Director Fees	1,000	18(3)	6
7	Shelly MacCauley	Director	Administrative	6.25	None	<1	<2%	Director Fees	1,000	18(3)	7
8	William Parker	Director	Administrative	0.00	None	<1	<2%	Director Fees	1,000	18(3)	8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 285,914		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: 01/01/2007 Ending: 2/31/2007

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 N/A

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				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

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2006 report.		\$	54,470	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2006	\$	46,830	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(7,640)	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	48,140	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	2,777	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ <u>8,298</u> For <u>2005</u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	(8,298)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	34,979	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2002	<u>18,755</u>	8	
	2003	<u>19,464</u>	9	
	2004	<u>20,594</u>	10	
	2005	<u>54,470</u>	11	
	2006	<u>46,830</u>	12	
Appeal is for a reduction of the 2005 real estate assessment amount.				
Accrual based on prior year real estate tax bill taking into account the reduction of appraised valuation from appeal.				
FOR BHF USE ONLY				
	13	FROM R. E. TAX STATEMENT FOR 2006	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 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 2006 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 2006.

(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 80ft except N 26 ft</u>	\$ <u>269.48</u>	\$ <u>269.48</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>1,516.56</u>	\$ <u>1,516.56</u>
4. _____	<u>Addition to Metropolis</u>	\$ _____	\$ _____
5. <u>08-01-450-001</u>	<u>BK 150</u>	\$ <u>44,415.38</u>	\$ <u>44,415.38</u>
6. _____	<u>All blk 150 ex triangular portion</u>	\$ _____	\$ _____
7. _____	<u>Addition to Metropolis</u>	\$ _____	\$ _____
8. <u>08-01-451-001</u>	<u>BK 151</u>	\$ <u>628.56</u>	\$ <u>628.56</u>
9. _____	<u>Addition to Metropolis</u>	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>46,829.98</u>	\$ <u>46,829.98</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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:

01/01/2007 Ending:

12/31/2007

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

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	TOTALS	379,000		\$ 100,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

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			289,344	5
6	10		1989	583,147	18,513	30	19,438	925	359,303	6
7	5		1993	598,429	15,344	30	19,948	4,604	289,246	7
8			1994	13,658	350	30	455	105	6,350	8
Improvement Type**										
9										9
10	Land improvements		1975	7,341		10-30			7,341	10
11	Land improvements		1976	2,886		20			2,886	11
12	Building improvements		1977	1,098		28			1,098	12
13	Land and building improvements		1980	1,014		20			1,014	13
14	Building improvements		1981	57,891		15			57,891	14
15	Land & building improvements		1982	17,279		5-20			17,279	15
16	Building improvements		1983	675		10			675	16
17	Bushes & gravel		1984	888		10			888	17
18	Patio, Med room & improvements		1984	13,078		15			13,078	18
19	Building addition		1984	100,925		20			100,925	19
20	Gravel road & painting		1985	7,365		3-20			7,365	20
21	Improvements		1985	17,960		15			17,960	21
22	Fire alarm & barn		1985	3,568		20			3,568	22
23	Improvements		1986	13,163		15			13,163	23
24	Kitchen remodeling		1988	32,477	1,031	30	1,084	53	21,126	24
25	Overhead door/kitchen		1989	852		15			852	25
26	Flooring		1990	729		10			729	26
27	Fire alarm		1990	9,537	303	20	477	174	8,347	27
28	Dining room improvements		1992	1,824	58	10		(58)	1,824	28
29	Warehouse storage building		1993	17,802	565	30	593	28	8,895	29
30	100 gal lime tank		1995	3,742		15	250	250	3,125	30
31	Drywall resident rooms & bathrooms		1996	2,240	57	10	106	49	2,346	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 & ID Number Southgate Health Care Center

0017996

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

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	\$ 5,250	37
38	Flooring	1997	674	17	10	68	51	682	38
39	Kitchen plumbing	1997	1,947	50	20	97	47	1,019	39
40	Tile floor	1997	784	20	10	78	58	819	40
41	Water softener	1997	667	17	10	67	50	703	41
42	Interior design	1997	1,245	32	15	83	51	872	42
43									43
44	Flooring	1998	1,130	29	10	113	84	1,073	44
45									45
46	Roofing	1999	17,240	442	20	862	420	7,650	46
47									47
48	Roof - Section B	2000	31,346	436	20	1,567	1,131	11,394	48
49									49
50	New laundry building	2001	179,249	4,596	20	8,962	4,366	58,714	50
51	Laundry building flooring	2001	1,219	80	10	121	41	788	51
52	Roof replacement	2001	84,500	2,167	20	4,225	2,058	27,463	52
53									53
54	Design & remodel dining room	2002	97,732	2,506	40	2,443	(63)	13,437	54
55	Flooring	2002	39,834	2,489	10	3,683	1,194	20,406	55
56	Blinds	2002	2,473	155	10	247	92	1,359	56
57	Awning	2002	996	62	10	100	38	550	57
58	Walk in cooler repair	2002	3,361	210	10	336	126	1,848	58
59	Lighting	2002	2,563	160	10	256	96	1,408	59
60									60
61	Flooring	2003	871	54	10	87	33	392	61
62	Entryway Carpeting	2003	2,367	148	10	237	89	1,066	62
63									63
64									64
65									65
66									66
67	Flooring	2004	18,000		10	1,800	1,800	6,300	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,499,386	\$ 50,190		\$ 68,283	\$ 18,093	\$ 1,607,087	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	\$ 50,190		\$ 68,283	\$ 18,093	\$ 1,607,087	1
2									2
3	Flooring	2005	22,140		10			3,321	3
4	Drywall Hallways in A&D Wings & Various Resident Rooms	2005	19,233		10	1,923	1,923	4,808	4
5									5
6	Shelving unit for kitchen	2006	2,377		7	340	340	510	6
7	Drywall	2006	3,325	316	15	222	(94)	333	7
8	Air conditioning unit	2006	5,091	1,247	7	727	(520)	1,091	8
9	Flooring	2006	2,572	630	7	367	(263)	550	9
10									10
11	Air Conditioners Unit	2007	8,325	8,325	7	595	(7,730)	595	11
12	New Flooring/Shelving Units	2007	4,616	4,616	7	329	(4,287)	329	12
13	Instalation of new lighting fixtures	2007	2,966	2,966	7	212	(2,754)	212	13
14	Repair to Laundry and Dishwasher Equip	2007	3,784	3,784	7	270	(3,514)	270	14
15	Additions to wandreguard & alarm system	2007	5,618	5,618	7	402	(5,216)	402	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)		\$ 2,579,433	\$ 77,692		\$ 73,670	\$ (4,022)	\$ 1,619,508	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	\$ 598,792	\$ 10,326	\$ 54,275	\$ 43,949	5-10	\$ 544,778	71
72	Current Year Purchases	29,768	29,768	2,263	(27,505)	5-7	2,263	72
73	Fully Depreciated Assets	190,589					190,589	73
74								74
75	TOTALS	\$ 819,149	\$ 40,094	\$ 56,538	\$ 16,444		\$ 737,630	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	11,512	79
80	TOTALS			\$ 60,728	\$	\$ 4,605	\$ 4,605		\$ 49,216	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)		\$ 3,559,310	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 117,786	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 134,813	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 17,027	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 2,406,354	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	2,747	24,260	87
88	1999 Suburban (2000)	29,810		29,810	88
89	2001 Envoy (2002)	40,686	1,640	40,586	89
90	See Page 13A	144,016	1,775	41,366	90
91	TOTALS	\$ 331,094	\$ 6,163	\$ 212,440	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

Southgate Health Care Center
FYE 12.31.07
Provider ID#: 0017996
Non Care Assets

<u>1</u> Description & Year Acquired	<u>2</u> Cost	<u>3</u> Current Book Depr	<u>4</u> Accumulated Depr
2004 Mercedes Benz	76,104	1,775	41,366
Land	67,912 N/A	N/A	
	<u>144,016</u>	<u>1,775</u>	<u>41,366</u>

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: \$ 16,847 Description: Rent- \$5,996, Dietary Equip- \$2,879, Nursing Equip- \$3,605, Oxygen- \$4,367

(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. _____ /2008 \$ _____

13. _____ /2009 \$ _____

14. _____ /2010 \$ _____

* 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' COMPILATION REPORT

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?</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>2. CLASSROOM PORTION:</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. CLINICAL PORTION:</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	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' COMPILATION 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	10A(3)	hrs	\$	3,121	\$ 187,269	\$	3,121	\$ 187,269	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		228	13,707		228	13,707	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		3,813	228,764		3,813	228,764	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				117,378		117,378	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39(1,2,3)	1950	17,850	5	300	2,887	1,955	21,037	12
13	Other (specify): VA Physician & Lab	39(3)			13	1,142		13	1,142	13
14	TOTAL			\$ 17,850	7,180	\$ 431,182	\$ 120,265	9,130	\$ 569,297	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 & ID Number Southgate Health Care Center

0017996

Report Period Beginning: 01/01/2007

Ending:

12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(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	\$ 528,127	\$ 528,127	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 5,809)	1,012,490	1,012,490	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	975	975	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	21,353	21,353	7
8	Accounts Receivable (owners or related parties)	11,245	11,245	8
9	Other(specify): <u>A/R Employees</u>	2,448	2,448	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,576,638	\$ 1,576,638	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	167,912	100,000	13
14	Buildings, at Historical Cost	3,500,506	2,540,759	14
15	Leasehold Improvements, at Historical Cost	118,657	38,674	15
16	Equipment, at Historical Cost		879,877	16
17	Accumulated Depreciation (book methods)	(2,595,654)	(2,406,354)	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>	225,606	225,606	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,417,027	\$ 1,378,562	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,993,665	\$ 2,955,200	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 126,063	\$ 126,063	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	113,620	113,620	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,506	3,506	31
32	Accrued Real Estate Taxes(Sch.IX-B)	48,140	48,140	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Schedule 17A</u>	177,417	177,417	36
37	<u>Defereed Inc-Patient Liability</u>	124,081	124,081	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 592,827	\$ 592,827	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	25,945	25,945	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 25,945	\$ 25,945	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 618,772	\$ 618,772	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,374,893	\$ 2,336,428	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,993,665	\$ 2,955,200	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Southgate Health Care Center, Inc.
Provider # 0017996
1/1/07 to 12/31/07

XV. Balance Sheet

Line 23 (Other)

Capitalized License Cost	2,000
Accum Amortization-Capitalized License	(2,000)
Unamortized Loan Cost	21,684
Accum Amortization-Loan Cost	(21,684)
Construction	225,606
	<u>225,606</u>

Line 36 (Other Current Liabilities)

Insurance-W/H Life Ins	25
Insurance-W/H Health Ins	2,502
401K Accrued	(1,430)
Due to DPA Coinsurance	161,313
Other Accrued Expenses	15,007
	<u>177,417</u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,934,078	1
2	Restatements (describe):		2
3	Adjustment subsequent to cost report preparation	232,301	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,166,379	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	724,100	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(515,586)	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)	\$ 208,514	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,374,893	24 *

* 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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,786,678	1
2	Discounts and Allowances for all Levels	835,199	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,621,877	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients	3,834	5
6	Therapy	417,276	6
7	Oxygen	1,712	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 422,822	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	188,256	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	16,706	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 204,962	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	15,277	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 15,277	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Other Income</u>	1,496	28
28a	<u>Vending Income</u>	893	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,389	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,267,327	30

2

Expenses		Amount	
A. Operating Expenses			
31	General Services	910,710	31
32	Health Care	2,012,008	32
33	General Administration	1,048,571	33
B. Capital Expense			
34	Ownership	174,558	34
C. Ancillary Expense			
35	Special Cost Centers	320,730	35
36	Provider Participation Fee	76,650	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,543,227	40
41	Income before Income Taxes (line 30 minus line 40)**	724,100	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 724,100	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: **01/01/2007**

Ending:

12/31/2007

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	\$ 51,416	\$ 24.72	1
2	Assistant Director of Nursing	1,747	1,747	37,151	21.27	2
3	Registered Nurses	11,413	11,413	221,322	19.39	3
4	Licensed Practical Nurses	17,834	17,834	262,880	14.74	4
5	CNAs & Orderlies	81,931	81,931	677,645	8.27	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,080	2,080	21,458	10.32	9
10	Activity Assistants	3,799	3,799	31,749	8.36	10
11	Social Service Workers	4,704	4,704	59,738	12.70	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	29,801	14.33	13
14	Head Cook	7,528	7,528	59,037	7.84	14
15	Cook Helpers/Assistants	7,737	7,737	57,870	7.48	15
16	Dishwashers	5,199	5,199	36,185	6.96	16
17	Maintenance Workers	4,499	4,499	79,426	17.65	17
18	Housekeepers	18,944	18,944	143,539	7.58	18
19	Laundry	11,595	11,595	91,548	7.90	19
20	Administrator	2,080	2,080	91,819	44.14	20
21	Assistant Administrator	38	38	751	19.76	21
22	Other Administrative	2,080	2,080	212,268	102.05	22
23	Office Manager					23
24	Clerical	7,730	7,730	100,577	13.01	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-allowa</u>	2,099	2,099	37,386	17.81	33
34	TOTAL (lines 1 - 33)	197,197	197,197	\$ 2,303,566 *	\$ 11.68	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	198	\$ 7,022	1(3)	35
36	Medical Director	Monthly	5,700	9(3)	36
37	Medical Records Consultant	32	1,886	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	1,213	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	242	\$ 15,821		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	2,699	\$ 82,127	10(3)	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	2,699	\$ 82,127		53

SEE ACCOUNTANTS' COMPILATION REPORT

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	
Michelle Cavitt	Administrator	0	\$ 91,819	Workers' Compensation Insurance	\$ 63,478	IDPH License Fee	\$	
Brandy Meadows	Asst. Administrator	0	751	Unemployment Compensation Insurance	23,171	Advertising: Employee Recruitment		
Sam Thompson	Administrative	6.25	212,268	FICA Taxes	193,311	Health Care Worker Background Check (Indicate # of checks performed <u>237</u>)	2,480	
				Employee Health Insurance	50,230	Patient Background Checks		
				Employee Meals	10,950	Illinois Health Care Association Dues	8,372	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Fees	2,642	
				Employee Retirement	7,394	Miscellaneous Dues & Subscriptions	4,924	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 304,838			Promotional Advertising	53,058	
B. Administrative - Other						Less: Public Relations Expense	(370)	
Description			Amount			Non-allowable advertising	(41,464)	
			\$			Yellow page advertising	(3,951)	
N/A						TOTAL (agree to Sch. V, line 20, col. 8)	\$ 25,691	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)			\$ 348,534	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
RSM McGladrey	Accounting		\$ 8,455				Out-of-State Travel	\$ 6,614
Williams, Williams, & Lentz	Accounting		3,750					
Kemper CPA	Accounting		8,209				In-State Travel	4,594
Duane Morris	Legal		930					
Denton Keuller	Legal		95	N/A			Seminar Expense	3,825
Allen Lefokovitz	Legal-Real Estate Tax Appeal		2,777				Less: Non-Allowable Seminar	(595)
See Schedule 21A								
							Entertainment Expense	(6,614)
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 24,216	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 7,824

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Southgate Health Care Center
Facility ID#: 0017996
FYE 9.30.07

Total Professional Fees per Schedule XIX(C)	\$ 24,216
Less: Legal fees related to real estate appeal	\$ (2,777)
Total agreeing with Schedule V, Line 19, Col. 8	<u>\$ 21,439</u>

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 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	5-13 Amount of Expense Amortized Per Year								
					6 FY2004	7 FY2005	8 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 FY2011	14 FY2012
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7					N/A								
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

