

Facility Name & ID Number Southgate Health Care Center

0017996 Report Period Beginning: 1/1/09 Ending: 12/31/09

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	10,984	7,881	5,407	24,272	8
9	SNF/PED					9
10	ICF	13,141	1,863	1,478	16,482	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,125	9,744	6,885	40,754	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.75%

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

None (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 8/25/72

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 3,899

Medicare Intermediary National Government Services (Syracuse, NY)

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/09 Fiscal Year: 12/31/09

* 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: 1/1/09 Ending: 12/31/09

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	200,880	20,054	7,829	228,763		228,763	3,985	232,748		1
2	Food Purchase		192,639		192,639		192,639		192,639		2
3	Housekeeping	159,205	22,614		181,819		181,819		181,819		3
4	Laundry	100,275	21,561		121,836		121,836		121,836		4
5	Heat and Other Utilities			123,156	123,156		123,156		123,156		5
6	Maintenance	77,756	26,033	66,424	170,213		170,213	3,013	173,226		6
7	Other (specify):*										7
8	TOTAL General Services	538,116	282,901	197,409	1,018,426		1,018,426	6,998	1,025,424		8
	B. Health Care and Programs										
9	Medical Director			5,350	5,350		5,350		5,350		9
10	Nursing and Medical Records	1,528,126	182,716	1,725	1,712,567		1,712,567		1,712,567		10
10a	Therapy			298,988	298,988		298,988		298,988		10a
11	Activities	55,329	2,742		58,071		58,071		58,071		11
12	Social Services	60,624			60,624		60,624		60,624		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,644,079	185,458	306,063	2,135,600		2,135,600		2,135,600		16
	C. General Administration										
17	Administrative	337,907			337,907		337,907		337,907		17
18	Directors Fees			7,822	7,822		7,822		7,822		18
19	Professional Services			25,744	25,744		25,744	(1,202)	24,542		19
20	Dues, Fees, Subscriptions & Promotions			73,226	73,226		73,226	(53,868)	19,358		20
21	Clerical & General Office Expenses	89,361	16,516	42,816	148,693		148,693	2,542	151,235		21
22	Employee Benefits & Payroll Taxes			432,323	432,323		432,323		432,323		22
23	Inservice Training & Education										23
24	Travel and Seminar			15,224	15,224		15,224	(6,595)	8,629		24
25	Other Admin. Staf See Sch 3A			13,431	13,431		13,431		13,431		25
26	Insurance-Prop.Liab.Malpractice			120,126	120,126		120,126		120,126		26
27	Other (specify):*										27
28	TOTAL General Administration	427,268	16,516	730,712	1,174,496		1,174,496	(59,123)	1,115,373		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,609,463	484,875	1,234,184	4,328,522		4,328,522	(52,125)	4,276,397		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.

Southgate Health Care
Facility ID: 0017996
12/31/2009

Supplementary Information
Schedule 3A

Other Administration Staff Transportation

Van and Truck Expense (a/c 01-462)	4,203
Gas and Car Expense (a/c 04-468)	9,229

TOTAL Schedule V C 25	<u>13,432</u>
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Southgate Health Care Center

#0017996

Report Period Beginning:

1/1/09

Ending:

12/31/09

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			73,795	73,795		73,795	13,735	87,530			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			774	774		774	(774)				32
33	Real Estate Taxes			48,000	48,000		48,000		48,000			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			21,971	21,971		21,971		21,971			35
36	Other (specify):*											36
37	TOTAL Ownership			144,540	144,540		144,540	12,961	157,501			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		131,659	25,717	157,376		157,376		157,376			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 cost	38,424		101,496	139,920		139,920	(139,920)				43
44	TOTAL Special Cost Centers	38,424	131,659	203,863	373,946		373,946	(139,920)	234,026			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,647,887	616,534	1,582,587	4,847,008		4,847,008	(179,084)	4,667,924			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	13,735	30		9
10	Interest and Other Investment Income	(774)	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)	(4,150)	20		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(49,718)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG5A	(138,177)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (179,084)		\$	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	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (179,084)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Southgate Health Care Center

ID# 0017996

Report Period Beginning: 1/1/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Offset Other Income revenue	\$ (418)	21	1
2	Reclass assets to repairs/supplies per regs.	3,985	1	2
3	Reclass assets to repairs/supplies per regs.	2,960	21	3
4	Reclass assets to repairs/supplies per regs.	3,013	6	4
5	Out of state travel, meals & entertainment	(2,043)	24	5
6	Out of state travel, meals & entertainment	(3,752)	24	6
7	Out of state travel, meals & entertainment	(800)	24	7
8	Marketing salaries	(38,424)	43	8
9	Nonallowable marketing evenets	(21,620)	43	9
10	Contributions	(12,857)	43	10
11	Tax expense	(37,421)	43	11
12	Nonallowable auto expense	(8,829)	43	12
13	Medicare Lab	(6,425)	43	13
14	Medicare X-Ray	(2,673)	43	14
15	Directors' health, disability & life insurance	(10,768)	43	15
16	PAC contributions	(903)	43	16
17	Nonallowable legal fees	(1,202)	19	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	(138,177)		49

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Southgate Health Care Center

0017996

Report Period Beginning:

1/1/09

Ending:

12/31/09

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	3,985	0	0	0	0	0	0	0	0	0	0	3,985	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	3,013	0	0	0	0	0	0	0	0	0	0	3,013	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	6,998	0	6,998	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	(1,202)	0	0	0	0	0	0	0	0	0	0	(1,202)	19
20	Fees, Subscriptions & Promotions	(53,868)	0	0	0	0	0	0	0	0	0	0	(53,868)	20
21	Clerical & General Office Expenses	2,542	0	0	0	0	0	0	0	0	0	0	2,542	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	(6,595)	0	0	0	0	0	0	0	0	0	0	(6,595)	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	(59,123)	0	(59,123)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(52,125)	0	(52,125)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Southgate Health Care Center

0017996

Report Period Beginning:

1/1/09

Ending:

12/31/09

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

	Capital Expense	PAGES	PAGE	SUMMARY TOTALS										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	13,735	0	0	0	0	0	0	0	0	0	0	13,735	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(774)	0	0	0	0	0	0	0	0	0	0	(774)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	12,961	0	12,961	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):*	(139,920)	0	0	0	0	0	0	0	0	0	0	(139,920)	43
44	TOTAL Special Cost Centers	(139,920)	0	(139,920)	44									
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(179,084)	0	(179,084)	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	N/A		N/A		
Sam Thompson	6.25					
Jeff Thompson	6.25					
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			N/A				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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 1/1/09 Ending: 12/31/09

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	6.26	None	40+	100.00	Salary	\$ 233,200	17(1)	1
2	Jeff Thompson	Maintenance	Maintenance	6.25	None	40+	100.00	Salary	32,400	6(1)	2
3	Mary Lynn Thompson	Accountant	Accountant	0.00	None	40+	100.00	Salary	41,580	21(1)	3
4											4
5	Sam Thompson	Director	Administrative	6.25	None	40+	100.00	Dir. Fees (A)	1,956	18(3)	5
6	Jeff Thompson	Director	Administrative	6.25	None	40+	100.00	Dir. Fees (A)	1,956	18(3)	6
7	Shelly MacCauley	Director	Administrative	6.25	None	<1	<2%	Dir. Fees (A)	1,955	18(3)	7
8	William Parker	Director	Administrative	0.00	None	<1	<2%	Dir. Fees (A)	1,955	18(3)	8
9											9
10	William Parker	Consultant	Administrative	0.00	None			Consulting Fees	10,000	6(3)	10
11											11
12	(A) - Director fees \$1,000; board meeting expenses reimbursed \$956.										
13								TOTAL	\$ 325,002		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:

1/1/09

Ending: 12/31/09

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			N/A						4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' 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

1. Real Estate Tax accrual used on 2008 report.		\$	47,885	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.)	2008	\$	45,848	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(2,037)	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	50,037	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	48,000	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2004	20,594	8	
	2005	54,470	9	
	2006	46,830	10	
	2007	48,255	11	
	2008	45,848	12	
Accrual based on prior year real estate tax bill.				

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2008	\$	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:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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

Facility Name & ID Number Southgate Health Care Center

0017996 Report Period Beginning:

1/1/09 Ending:

12/31/09

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? [X] (a) Own the Facility [] (b) Rent from a Related Organization. [] (c) Rent from Completely Unrelated Organization.

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

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

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

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

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [] YES [X] NO

If so, please complete the following:

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

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

XI. OWNERSHIP COSTS:

A. Land.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Rows include Resident Care and TOTALS.

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	398,179	6
7	5		1993	598,429	15,344	30	19,948	4,604	329,142	7
8			1994	13,658	350	30	455	105	7,260	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	23,294	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	9,301	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	10,081	29
30	100 gal lime tank		1995	3,742		15	250	250	3,625	30
31	Drywall resident rooms & bathrooms		1996	2,240	57	10		(57)	2,240	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:

1/1/09

Ending:

12/31/09

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	\$	10	\$	\$	\$ 5,000	37
38	Flooring	1997	674	17	10		(17)	674	38
39	Kitchen plumbing	1997	1,947	50	20	97	47	1,213	39
40	Tile floor	1997	784	20	10		(20)	784	40
41	Water softener	1997	667	17	10		(17)	667	41
42	Interior design	1997	1,245	32	15	83	51	1,038	42
43									43
44	Flooring	1998	1,130	29	10		(29)	1,130	44
45									45
46	Roofing	1999	17,240	442	20	862	420	9,374	46
47									47
48	Roof - Section B	2000	31,346	436	20	1,567	1,131	14,528	48
49									49
50	New laundry building	2001	179,249	4,596	20	8,962	4,366	76,638	50
51	Laundry building flooring	2001	1,219	80	10	121	41	1,030	51
52	Roof replacement	2001	84,500	2,167	20	4,225	2,058	35,943	52
53									53
54	Design & remodel dining room	2002	97,732	2,506	40	2,443	(63)	18,323	54
55	Flooring	2002	39,834	1,244	10	3,683	2,439	27,772	55
56	Blinds	2002	2,473	77	10	247	170	1,853	56
57	Awning	2002	996	31	10	100	69	750	57
58	Walk in cooler repair	2002	3,361	105	10	336	231	2,520	58
59	Lighting	2002	2,563	80	10	256	176	1,920	59
60									60
61	Flooring	2003	871	54	10	87	33	566	61
62	Entryway Carpeting	2003	2,367	148	10	237	89	1,540	62
63									63
64									64
65									65
66									66
67	Flooring	2004	18,000		10	1,800	1,800	9,900	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,499,386	\$ 48,352		\$ 67,351	\$ 18,999	\$ 1,741,441	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Southgate Health Care Center

0017996

Report Period Beginning:

1/1/09

Ending:

12/31/09

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	\$ 48,352		\$ 67,351	\$ 18,999	\$ 1,741,441	1
2									2
3	Flooring	2005	22,140		10	2,214	2,214	7,749	3
4	Drywall Hallways in A&D Wings & Various Resident Rooms	2005	19,233		10	1,923	1,923	8,654	4
5									5
6	Shelving unit for kitchen	2006	2,377		7	340	340	1,190	6
7	Drywall	2006	3,325	256	15	222	(34)	777	7
8	Air conditioning unit	2006	5,091	636	7	727	91	2,545	8
9	Flooring	2006	2,572	321	7	367	46	1,284	9
10									10
11	Air Conditioners Unit	2007	8,325		7	1,190	1,190	2,975	11
12	New Flooring/Shelving Units	2007	4,616		7	659	659	1,647	12
13	Instalation of new lighting fixtures	2007	2,966		7	424	424	1,060	13
14	Repair to Laundry and Dishwasher Equip	2007	3,784		7	540	540	1,350	14
15	Additions to wandreguard & alarm system	2007	5,618		7	804	804	1,650	15
16									16
17	New flooring	2008	4,318	529	7	176	(353)	352	17
18									18
19	Flooring	2009	6,993	999	7	606	(393)	606	19
20	Replacement Roof	2009	40,000	1,333	15	1,333		1,333	20
21	HVAC Units	2009	2,591	370	7	185	(185)	185	21
22									22
23									23
24	Adjustment to Agree to Current Depreciation			(538)			538		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)		\$ 2,633,335	\$ 52,258		\$ 79,061	\$ 26,803	\$ 1,774,798	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	\$ 642,694	\$ 16,571	\$ 6,234	\$ (10,337)	5-10	\$ 572,755	71
72	Current Year Purchases	24,903	4,899	2,167	(2,732)	7	2,167	72
73	Fully Depreciated Assets	190,589					190,589	73
74								74
75	TOTALS	\$ 858,186	\$ 21,470	\$ 8,401	\$ (13,069)		\$ 765,511	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	Dodge Dakota	2000	14,504				5	14,504	77
78										78
79										79
80	TOTALS			\$ 33,004	\$	\$	\$		\$ 33,004	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)		\$ 3,624,525	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 73,728	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 87,462	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 13,734	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 2,573,313	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	\$	\$	\$	86
87	2005 Mercedes Benz	76,104	1,775	25,660	87
88	BMW	57,504	4,800	15,760	88
89	Jeep Cherokee	40,164	1,923	40,164	89
90	Land	67,912			90
91	TOTALS	\$ 241,684	\$ 8,498	\$ 81,584	91

G. Construction-in-Progress

	Description	Cost	
92	New facility design &	\$	92
93	construction. Not yet in	225,606	93
94	service.		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? YES NO

If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions				N/A			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: \$ 21,971 Description: See attached Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18			N/A		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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* 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

Southgate Health Care
Facility ID: 0017996
12/31/2009

Supplementary Information
Schedule 14A

Equipment Rental Lease

<u>Rent a/c 01-456</u>	<u>Amount</u>
Propane Gas Tanks	112
Maint equip rental	32
12 months rent on phone system	<u>6,000</u>
Total per General Ledger	<u><u>6,144</u></u>
<u>Dietary Equip Rental a/c 03-552</u>	
Dish Machine	<u><u>2,863</u></u>
<u>Nursing Equip Rental a/c 06-712</u>	
Genesis Medical - Positioning Pads	<u>4,386</u>
	<u><u>4,386</u></u>
<u>Nursing Oxygen and Rental a/c 06-722</u>	
American Homepatient	<u><u>8,578</u></u>
TOTAL Schedule XII B 16	<u><u>21,971</u></u>

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			
		1	2	3	4
		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	\$	1,856	\$ 133,649	\$	1,856	\$ 133,649	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		526	37,897		526	37,897	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		1,770	127,442		1,770	127,442	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				131,659		131,659	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>VA Rehab</u>	39(3)				19,903			19,903	12
13	Other (specify): <u>Other VA Ancillaries</u>	39(3)				5,814			5,814	13
14	TOTAL			\$	4,152	\$ 324,705	\$ 131,659	4,152	\$ 456,364	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

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/09**

(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	\$ 778,588	\$ 778,588	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>-0-</u>)	763,157	763,157	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	23,808	23,808	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>A/R Employees</u>	1,010	1,010	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,566,563	\$ 1,566,563	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	3,520,314	3,431,949	14
15	Leasehold Improvements, at Historical Cost	118,657	92,576	15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(2,606,339)	(2,573,313)	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>	321,929	321,929	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,522,473	\$ 1,373,141	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,089,036	\$ 2,939,704	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 115,449	\$ 115,449	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	54,386	54,386	30
31	Accrued Taxes Payable (excluding real estate taxes)	20,274	20,274	31
32	Accrued Real Estate Taxes(Sch.IX-B)	50,037	50,037	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>	178,326	178,326	36
37	<u>Deferred Income-Resident Liability</u>	130,188	130,188	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 548,660	\$ 548,660	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	41,076	41,076	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)	\$ 41,076	\$ 41,076	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 589,736	\$ 589,736	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,499,300	\$ 2,349,968	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,089,036	\$ 2,939,704	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Schedule 17A

XV. Balance Sheet

Line 23 (Other)

	<u>Operating</u>	<u>After Consolidation</u>
Capitalized License Cost	2,000	2,000
Accum. Amortization - Capitalized License	(2,000)	(2,000)
Unamortized Loan Cost	21,684	21,684
Accum. Amortization - Loan Cost	(21,684)	(21,684)
Construction in Progress	321,929	321,929
	<u>321,929</u>	<u>321,929</u>

Line 36 (Other Current Liabilities)

Payroll withholdings	9,804	9,804
Due to DHFS - Coinsurance	168,522	168,522
	<u>178,326</u>	<u>178,326</u>

See Accountant's Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,283,289	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,283,289	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	619,436	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	(403,422)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Rounding	(3)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 216,011	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)	\$ 2,499,300	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	\$ 4,292,877	1
2	Discounts and Allowances for all Levels	646,348	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,939,225	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients	2,644	5
6	Therapy	299,948	6
7	Oxygen	993	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 303,585	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	183,153	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	8,702	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 191,855	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	16,205	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 16,205	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Inc (\$418); Bad Debt Recoveries (\$14,547)	14,964	28
28a	Vending Income	610	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 15,574	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,466,444	30

2

Expenses		Amount	
A. Operating Expenses			
31	General Services	1,018,426	31
32	Health Care	2,135,600	32
33	General Administration	1,174,496	33
B. Capital Expense			
34	Ownership	144,540	34
C. Ancillary Expense			
35	Special Cost Centers	297,296	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)*	\$ 4,847,008	40
41	Income before Income Taxes (line 30 minus line 40)**	619,436	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 619,436	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:

1/1/09

Ending:

12/31/09

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	2,320	2,320	\$ 64,140	\$ 27.65	1
2	Assistant Director of Nursing	2,129	2,129	48,630	22.84	2
3	Registered Nurses	12,359	12,359	246,147	19.92	3
4	Licensed Practical Nurses	22,856	22,856	380,807	16.66	4
5	CNAs & Orderlies	92,991	92,991	788,402	8.48	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,160	2,160	26,148	12.11	9
10	Activity Assistants	3,710	3,710	29,181	7.87	10
11	Social Service Workers	4,559	4,559	60,624	13.30	11
12	Dietician					12
13	Food Service Supervisor	2,160	2,160	33,333	15.43	13
14	Head Cook	6,930	6,930	57,791	8.34	14
15	Cook Helpers/Assistants	6,151	6,151	48,715	7.92	15
16	Dishwashers	8,469	8,469	61,041	7.21	16
17	Maintenance Workers	4,320	4,320	77,756	18.00	17
18	Housekeepers	19,952	19,952	159,205	7.98	18
19	Laundry	11,961	11,961	100,275	8.38	19
20	Administrator					20
21	Assistant Administrator	2,160	2,160	104,707	48.48	21
22	Other Administrative	2,160	2,160	233,200	107.96	22
23	Office Manager	2,160	2,160	41,580	19.25	23
24	Clerical	5,666	5,666	47,781	8.43	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>Marketing Directo</u>	2,160	2,160	38,424	17.79	33
34	TOTAL (lines 1 - 33)	217,333	217,333	\$ 2,647,887 *	\$ 12.18	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	Monthly	\$ 7,829	1(3)	35
36	Medical Director	Monthly	5,350	9(3)	36
37	Medical Records Consultant	Quarterly	262	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,463	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) <u>Mech Eng. Consult.</u>	Monthly	436	6(3)	46
47	<u>Maintenance Consultant</u>	Monthly	10,000	6(3)	47
48					48
49	TOTAL (lines 35 - 48)		\$ 25,340		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Southgate Health Care Center

0017996

Report Period Beginning: 1/1/09

Ending: 12/31/09

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	\$ 104,707	Workers' Compensation Insurance	\$ 59,679	IDPH License Fee	\$	
Sam Thompson	Administrative	6.25	233,200	Unemployment Compensation Insurance		Advertising: Employee Recruitment	53,820	
				FICA Taxes	211,411	Health Care Worker Background Check (Indicate # of checks performed <u>137</u>)	1,530	
				Employee Health Insurance	95,490	Patient Background Checks		
				Employee Meals	12,775	Miscellaneous License & Fees	2,804	
				Illinois Municipal Retirement Fund (IMRF)*		Misc. Dues & Subscriptions	860	
				Employee Relations & Morale	42,596	IHCA	10,612	
				Pension Contributions	10,372	SILO dues	3,600	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 337,907			Less: Public Relations Expense	(4,150)	
B. Administrative - Other						Non-allowable advertising	(49,718)	
Description			Amount			Yellow page advertising	()	
N/A			\$			TOTAL (agree to Sch. V, line 20, col. 8)	\$ 19,358	
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)	\$ 432,323			
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, Inc.	Accounting		\$ 10,679	N/A			Out-of-State Travel	\$
Williams, Williams, Lentz	Accounting		4,250					
Kemper CPA	Accounting		5,524				In-State Travel	
Duane Morris	Legal		1,582					
Lefkowitz and Associates	Legal		2,507				Seminar Expense	12,024
Whitlow Roberts	Legal		1,202				Less: Nonallowable out of state travel, meals & entertainment	(3,395)
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 25,744	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 8,629

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Southgate Health Care Center, Inc.
Provider ID 0017996
12/31/2009

Schedule 21A

XIX.C. Professional Services

Total Professional Services	From PG21	25,744
Less: Nonallowable Legal Fees (Whitlow & Roberts)		<u>(1,202)</u>
		24,542
	Schedule V, Line 19, Column 8	<u>24,542</u>
	Variance	<u><u>-</u></u>

See Accountant's 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 FY2006	7 FY2007	8 FY2008	9 FY2009	10 FY2010	11 FY2011	12 FY2012	13 FY2013	14 FY2014
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3								N/A					
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# 0017996

Report Period Beginning:

1/1/09

Ending:

12/31/09**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 - \$10,612
- (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? NA
- (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? 7 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 33,433 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. NA
- (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.

- (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.
- (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. \$ 12,775 Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (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. \$ NA
c. What percent of all travel expense relates to transportation of nurses and patients? None
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? NA
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? NA
Indicate the amount of income earned from providing such transportation during this reporting period. \$ NA
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: NA
- (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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees

SEE ACCOUNTANTS' COMPILATION REPORT