

Facility Name & ID Number Southgate Health Care Center

0017996 Report Period Beginning: 1/1/10 Ending: 12/31/10

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 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	11,384	7,308	5,906	24,598	8
9	SNF/PED					9
10	ICF	13,138	2,719	1,217	17,074	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,522	10,027	7,123	41,672	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.55%

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 4,220

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/10 Fiscal Year: 12/31/10

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

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 1/1/10 Ending: 12/31/10

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	204,265	21,525	7,780	233,570		233,570		233,570		1
2	Food Purchase		196,200		196,200		196,200		196,200		2
3	Housekeeping	154,883	21,994		176,877		176,877		176,877		3
4	Laundry	101,841	17,169		119,010		119,010		119,010		4
5	Heat and Other Utilities			126,810	126,810		126,810		126,810		5
6	Maintenance	79,670	35,998	53,066	168,734		168,734		168,734		6
7	Other (specify):*										7
8	TOTAL General Services	540,659	292,886	187,656	1,021,201		1,021,201		1,021,201		8
	B. Health Care and Programs										
9	Medical Director			7,429	7,429		7,429		7,429		9
10	Nursing and Medical Records	1,565,848	190,392	3,242	1,759,482		1,759,482		1,759,482		10
10a	Therapy	93,478		252,396	345,874		345,874		345,874		10a
11	Activities	60,128	5,475		65,603		65,603		65,603		11
12	Social Services	64,150			64,150		64,150		64,150		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,783,604	195,867	263,067	2,242,538		2,242,538		2,242,538		16
	C. General Administration										
17	Administrative	384,368			384,368		384,368		384,368		17
18	Directors Fees			8,268	8,268		8,268		8,268		18
19	Professional Services			28,981	28,981		28,981	(1,528)	27,453		19
20	Dues, Fees, Subscriptions & Promotions			72,657	72,657		72,657	(49,968)	22,689		20
21	Clerical & General Office Expenses	107,631	20,891	46,056	174,578		174,578	9,139	183,717		21
22	Employee Benefits & Payroll Taxes			495,104	495,104		495,104		495,104		22
23	Inservice Training & Education										23
24	Travel and Seminar			19,642	19,642		19,642	(11,961)	7,681		24
25	Other Admin. Staff Transportation			22,307	22,307		22,307		22,307		25
26	Insurance-Prop.Liab.Malpractice			96,031	96,031		96,031		96,031		26
27	Other (specify):*										27
28	TOTAL General Administration	491,999	20,891	789,046	1,301,936		1,301,936	(54,318)	1,247,618		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,816,262	509,644	1,239,769	4,565,675		4,565,675	(54,318)	4,511,357		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
12/31/2010

Supplementary Information
Schedule 3A

Other Administration Staff Transportation

Van and Truck Expense (a/c 01-462)	5,888
Gas and Car Expense (a/c 04-468)	16,419

TOTAL Schedule V C 25

22,307

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Southgate Health Care Center

#0017996

Report Period Beginning:

1/1/10

Ending:

12/31/10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			89,746	89,746		89,746	11,291	101,037			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			327	327		327	(327)				32
33	Real Estate Taxes			25,036	25,036		25,036		25,036			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			20,078	20,078		20,078		20,078			35
36	Other (specify):*											36
37	TOTAL Ownership			135,187	135,187		135,187	10,964	146,151			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		117,626	14,537	132,163		132,163		132,163			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	36,362		117,685	154,047		154,046	(154,046)				43
44	TOTAL Special Cost Centers	36,362	117,626	208,872	362,860		362,859	(154,046)	208,813			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,852,624	627,270	1,583,828	5,063,722		5,063,721	(197,400)	4,866,321			45

*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

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	11,291	30		9
10	Interest and Other Investment Income	(327)	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)	(3,800)	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	(46,168)	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 Pg 5A	(158,396)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (197,400)		\$	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))	\$ (197,400)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Southgate Health Care Center

ID# 0017996

Report Period Beginning: 1/1/10

Ending: 12/31/10

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Offset Other Income revenue	\$ (450)	21	1
2	Reclass assets to repairs/supplies per regs.		1	2
3	Reclass assets to repairs/supplies per regs.	9,589	21	3
4	Reclass assets to repairs/supplies per regs.		6	4
5	Out of state travel, meals & entertainment	(10,362)	24	5
6	Out of state travel, meals & entertainment	(1,599)	24	6
7	Out of state travel, meals & entertainment		24	7
8	Marketing salaries	(36,362)	43	8
9	Nonallowable marketing evenets	(22,136)	43	9
10	Contributions	(24,543)	43	10
11	Tax expense	(33,457)	43	11
12	Nonallowable auto expense	(7,121)	43	12
13	Medicare Lab	(8,383)	43	13
14	Medicare X-Ray	(4,482)	43	14
15	Directors' health, disability & life insurance	(3,817)	43	15
16	PAC contributions	(1,847)	43	16
17	Nonallowable legal fees	(1,528)	19	17
18	Penalties	(945)	43	18
19	Medicare Prosthetics	(243)	43	19
20	Bad Debt	(10,710)	43	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	(158,396)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Southgate Health Care Center# 0017996

Report Period Beginning:

1/1/10

Ending:

12/31/10

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	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	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	0	0	0	0	0	0	0	0	0	0	0	0	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	(1,528)	0	0	0	0	0	0	0	0	0	0	(1,528)	19
20	Fees, Subscriptions & Promotions	(49,968)	0	0	0	0	0	0	0	0	0	0	(49,968)	20
21	Clerical & General Office Expenses	9,139	0	0	0	0	0	0	0	0	0	0	9,139	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	(11,961)	0	0	0	0	0	0	0	0	0	0	(11,961)	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	(54,318)	0	(54,318)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(54,318)	0	(54,318)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Southgate Health Care Center# 0017996

Report Period Beginning:

1/1/10

Ending:

12/31/10

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	11,291	0	0	0	0	0	0	0	0	0	0	11,291	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(327)	0	0	0	0	0	0	0	0	0	0	(327)	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	10,964	0	0	0	0	0	0	0	0	0	0	10,964	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):*	(154,046)	0	0	0	0	0	0	0	0	0	0	(154,046)	43
44	TOTAL Special Cost Centers	(154,046)	0	0	0	0	0	0	0	0	0	0	(154,046)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(197,400)	0	0	0	0	0	0	0	0	0	0	(197,400)	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							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.

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 1/1/10 Ending: 12/31/10

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	\$ 282,600	17(1)	1
2	Jeff Thompson	Maintenance	Maintenance	6.25	None	40+	100.00	Salary	32,112	6(1)	2
3	Mary Lynn Thompson	Accountant	Accountant	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	Dir. Fees (A)	2,067	18(3)	5
6	Jeff Thompson	Director	Administrative	6.25	None	40+	100.00	Dir. Fees (A)	2,067	18(3)	6
7	Shelly MacCauley	Director	Administrative	6.25	None	<1	<2%	Dir. Fees (A)	2,067	18(3)	7
8	William Parker	Director	Administrative	0.00	None	<1	<2%	Dir. Fees (A)	2,067	18(3)	8
9											9
10	William Parker	Consultant	Administrative	0.00	None			Consulting Fees	11,000	6(3)	10
11											11
12	(A) - Director fees \$1,000; board meeting expenses reimbursed \$956.										
13								TOTAL	\$ 374,020		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:

1/1/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization N/A

Street Address _____

City / State / Zip Code _____

Phone Number ()

Fax Number ()

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.

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

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 1/1/10 Ending: 12/31/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1					\$	\$			\$	1									
2										2									
3										3									
4										4									
5										5									
Working Capital																			
6										6									
7										7									
8										8									
9	TOTAL Facility Related				\$	\$			\$	9									
B. Non-Facility Related*																			
10										10									
11	BMW Credit	X	Vehicle Purchase	\$971.96	8/1/08	57,004	29,739	7/1/13	0.0090	327									
12										12									
13							Disallowed non-care related interest			(327)									
14	TOTAL Non-Facility Related			\$971.96		\$ 57,004	\$ 29,739			14									
15	TOTALS (line 9+line14)					\$ 57,004	\$ 29,739			15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

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 2009 report.			\$ 50,037	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.)	2009		\$ 37,073	2																				
3. Under or (over) accrual (line 2 minus line 1).			\$ (12,964)	3																				
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)			\$ 38,000	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.			\$ 25,036	7																				
Real Estate Tax History:																								
Real Estate Tax Bill for Calendar Year:	2005	<u>54,470</u>	8	<table border="1"> <tr> <td colspan="3">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2009</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">16</td> </tr> </table>		FOR BHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2009	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
FOR BHF USE ONLY																								
13	FROM R. E. TAX STATEMENT FOR 2009	\$	13																					
14	PLUS APPEAL COST FROM LINE 5	\$	14																					
15	LESS REFUND FROM LINE 6	\$	15																					
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																					
	2006	<u>46,830</u>	9																					
	2007	<u>48,255</u>	10																					
	2008	<u>45,848</u>	11																					
	2009	<u>37,073</u>	12																					
<u>Accrual based on prior year real estate tax bill.</u>																								

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

Facility Name & ID Number Southgate Health Care Center

0017996

Report Period Beginning:

1/1/10

Ending:

12/31/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 42,622 B. General Construction Type: Exterior Brick Frame Concrete Number of Stories 1

C. Does the Operating Entity? (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	417,617	6
7	5		1993	598,429	15,344	30	19,948	4,604	349,090	7
8			1994	13,658	350	30	455	105	7,715	8
Improvement Type**										
9	Land improvements		1975	7,341		10-30			7,341	9
10	Land improvements		1976	2,886		20			2,886	10
11	Building improvements		1977	1,098		28			1,098	11
12	Land and building improvements		1980	1,014		20			1,014	12
13	Building improvements		1981	57,891		15			57,891	13
14	Land & building improvements		1982	17,279		5-20			17,279	14
15	Building improvements		1983	675		10			675	15
16	Bushes & gravel		1984	888		10			888	16
17	Patio, Med room & improvements		1984	13,078		15			13,078	17
18	Building addition		1984	100,925		20			100,925	18
19	Gravel road & painting		1985	7,365		3-20			7,365	19
20	Improvements		1985	17,960		15			17,960	20
21	Fire alarm & barn		1985	3,568		20			3,568	21
22	Improvements		1986	13,163		15			13,163	22
23	Kitchen remodeling		1988	32,477	1,031	30	1,084	53	24,378	23
24	Overhead door/kitchen		1989	852		15			852	24
25	Flooring		1990	729		10			729	25
26	Fire alarm		1990	9,537	303	20	236	(67)	9,537	26
27	Dining room improvements		1992	1,824	58	10		(58)	1,824	27
28	Warehouse storage building		1993	17,802	565	30	593	28	10,674	28
29	100 gal lime tank		1995	3,742		15	117	117	3,742	29
30	Drywall resident rooms & bathrooms		1996	2,240	57	10		(57)	2,240	30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total
SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Southgate Health Care Center

0017996

Report Period Beginning:

1/1/10

Ending:

12/31/10

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	1,310	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	1,121	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	10,236	46
47									47
48	Roof - Section B	2000	31,346	436	20	1,567	1,131	16,095	48
49									49
50	New laundry building	2001	179,249	4,596	20	8,962	4,366	85,600	50
51	Laundry building flooring	2001	1,219	80	10	121	41	1,151	51
52	Roof replacement	2001	84,500	2,167	20	4,225	2,058	40,168	52
53									53
54	Design & remodel dining room	2002	97,732	2,506	40	2,443	(63)	20,766	54
55	Flooring	2002	39,834		10	3,683	3,683	31,455	55
56	Blinds	2002	2,473		10	247	247	2,100	56
57	Awning	2002	996		10	100	100	850	57
58	Walk in cooler repair	2002	3,361	105	10	336	231	2,856	58
59	Lighting	2002	2,563		10	256	256	2,176	59
60									60
61	Flooring	2003	871	27	10	87	60	653	61
62	Entryway Carpeting	2003	2,367	74	10	237	163	1,777	62
63									63
64									64
65									65
66									66
67	Flooring	2004	18,000		10	1,800	1,800	11,700	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,499,386	\$ 46,819		\$ 66,977	\$ 20,158	\$ 1,808,418	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:

1/1/10

Ending:

12/31/10

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,499,386	\$ 46,819		\$ 66,977	\$ 20,158	\$ 1,808,418	1
2									2
3	Flooring	2005	22,140		10	2,214	2,214	9,963	3
4	Drywall Hallways in A&D Wings & Various Resident Rooms	2005	19,233		10	1,923	1,923	10,577	4
5									5
6	Shelving unit for kitchen	2006	2,377		7	340	340	1,530	6
7	Drywall	2006	3,325	230	15	222	(8)	999	7
8	Air conditioning unit	2006	5,091	636	7	727	91	3,272	8
9	Flooring	2006	2,572	321	7	367	46	1,651	9
10									10
11	Air Conditioners Unit	2007	8,325		7	1,190	1,190	4,165	11
12	New Flooring/Shelving Units	2007	4,616		7	659	659	2,306	12
13	Installation of new lighting fixtures	2007	2,966		7	424	424	1,484	13
14	Repair to Laundry and Dishwasher Equip	2007	3,784		7	540	540	1,890	14
15	Additions to wandreguard & alarm system	2007	5,618		7	804	804	2,454	15
16									16
17	New flooring	2008	4,318	377	7	617	240	969	17
18									18
19	Flooring	2009	6,993	1,713	7	999	(714)	1,605	19
20	Replacement Roof	2009	40,000	2,667	15	2,667		4,000	20
21	HVAC Units	2009	2,591	634	7	370	(264)	555	21
22									22
23	Installation Exp for Electric & Gas Line for Generator	2010	8,165	778	7	583	(195)	583	23
24	Flooring	2010	4,191	135	7	300	165	300	24
25	Replacement Roof	2010	25,392	1,552	15	846	(706)	846	25
26									26
27									27
28									28
29									29
30									30
31	Adjustment to Agree to Current Depreciation								31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,671,083	\$ 55,862		\$ 82,769	\$ 26,907	\$ 1,857,567	34

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:

1/1/10

Ending:

12/31/10

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	\$ 667,597	\$ 31,062	\$ 15,446	\$ (15,616)	5-10	\$ 590,368	71
72	Current Year Purchases	37,522	2,822	2,822		7	2,822	72
73	Fully Depreciated Assets	190,589					190,589	73
74								74
75	TOTALS	\$ 895,708	\$ 33,884	\$ 18,268	\$ (15,616)		\$ 783,779	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	2	
	Reference	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)	\$ 3,699,795 81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 89,746 82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 101,037 83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 11,291 84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,674,350 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			87
88	BMW	57,504	16,698		88
89	Jeep Cherokee	40,164			89
90	Land	67,912			90
91	TOTALS	\$ 241,684	\$ 16,698	\$	91

G. Construction-in-Progress

	Description	Cost	
92	New facility design &	\$	92
93	construction. Not yet in	484,703	93
94	service.		94
95		\$ 484,703	95

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			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: \$ 20,078 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. _____ /2011 \$ _____

13. _____ /2012 \$ _____

14. _____ /2013 \$ _____

* 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.

Southgate Health Care
Facility ID: 0017996
12/31/2010

Supplementary Information
Schedule 14A

Equipment Rental Lease

<u>Rent a/c 01-456</u>	<u>Amount</u>
Phone System	6,000
Propane Gas Tanks	<u>72</u>
Total per General Ledger	<u><u>6,072</u></u>

Dietary Equip Rental a/c 03-552

Dish Machine	<u><u>1,787</u></u>
--------------	---------------------

Nursing Equip Rental a/c 06-712

Genesis Medical	1,330
Alpha Home Health	<u>652</u>
	<u><u>1,982</u></u>

Nursing Oxygen and Rental a/c 06-722

American Homepatient	<u><u>10,237</u></u>
----------------------	----------------------

TOTAL Schedule XII B 16 20,078

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)	1183 hrs	\$ 44,930	1,536	\$ 110,570		2,719	\$ 155,500	1
2	Licensed Speech and Language Development Therapist	10A(3)	463 hrs	13,990	578	41,630		1,041	55,620	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	878 hrs	34,558	1,392	100,196		2,270	134,754	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				117,626		117,626	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)				9,794			9,794	12
13	Other (specify): <u>Other VA Ancillaries</u>	39(3)				4,743			4,743	13
14	TOTAL			\$ 93,478	3,506	\$ 266,933	\$ 117,626	6,030	\$ 478,037	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: 1/1/10

Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/10

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 1,079,454	\$ 1,079,454	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>-0-</u>)	519,254	519,254	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	37,969	37,969	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>A/R Employees</u>	350	350	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,637,027	\$ 1,637,027	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	3,605,172	2,540,759	14
15	Leasehold Improvements, at Historical Cost	118,657	130,324	15
16	Equipment, at Historical Cost		928,712	16
17	Accumulated Depreciation (book methods)	(2,696,085)	(2,674,284)	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>	484,703	484,703	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,680,359	\$ 1,510,214	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,317,386	\$ 3,147,241	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 79,479	\$ 79,479	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	52,993	52,993	30
31	Accrued Taxes Payable (excluding real estate taxes)	27,137	27,137	31
32	Accrued Real Estate Taxes(Sch.IX-B)	38,000	38,000	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>	180,666	180,666	36
37	<u>Deferred Income-Resident Liability</u>	159,975	159,975	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 538,250	\$ 538,250	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	29,739	29,739	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)	\$ 29,739	\$ 29,739	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 567,990	\$ 567,989	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,749,396	\$ 2,579,252	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,317,386	\$ 3,147,241	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Southgate Health Care Center, Inc.
Provider ID #: 0017996
12/31/2010

Schedule 17A

	<u>Operating</u>	<u>After Consolidation</u>
XV. Balance Sheet		
Line 23 (Other)		
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	484,703	484,703
	<u>484,703</u>	<u>484,703</u>
Line 36 (Other Current Liabilities)		
Payroll withholdings	12,098	12,098
Due to DHFS - Coinsurance	168,522	168,522
Credit Union Withheld	46	46
	<u>180,666</u>	<u>180,666</u>

See Accountant's Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,499,300	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,499,300	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	556,004	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	(305,908)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Rounding		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 250,096	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)	\$ 2,749,396	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Southgate Health Care Center# 0017996Report Period Beginning: 1/1/10Ending: 12/31/10

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	\$ 4,313,216	1
2	Discounts and Allowances for all Levels	724,438	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,037,654	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients	1,633	5
6	Therapy	350,594	6
7	Oxygen	1,138	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 353,365	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	197,489	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	16,256	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 213,745	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	14,309	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 14,309	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Other Inc (\$450)</u>	450	28
28a	<u>Vending Income</u>	203	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 653	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,619,726	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,021,201	31
32	Health Care	2,242,538	32
33	General Administration	1,301,936	33
B. Capital Expense			
34	Ownership	135,187	34
C. Ancillary Expense			
35	Special Cost Centers	286,210	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)*	\$ 5,063,722	40
41	Income before Income Taxes (line 30 minus line 40)**	556,004	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 556,004	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:

1/1/10

Ending:

12/31/10

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	\$ 56,261	\$ 27.05	1
2	Assistant Director of Nursing	2,080	2,080	32,262	15.51	2
3	Registered Nurses	9,028	9,028	189,498	20.99	3
4	Licensed Practical Nurses	26,051	26,051	421,525	16.18	4
5	CNAs & Orderlies	93,670	93,670	866,302	9.25	5
6	CNA Trainees					6
7	Licensed Therapist	2,524	2,524	93,478	37.04	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,080	2,080	26,427	12.71	9
10	Activity Assistants	3,941	3,941	33,701	8.55	10
11	Social Service Workers	4,459	4,459	64,150	14.39	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	34,081	16.39	13
14	Head Cook	6,318	6,318	53,877	8.53	14
15	Cook Helpers/Assistants	9,039	9,039	74,594	8.25	15
16	Dishwashers	5,192	5,192	41,713	8.03	16
17	Maintenance Workers	4,160	4,160	79,670	19.15	17
18	Housekeepers	18,123	18,123	154,883	8.55	18
19	Laundry	11,367	11,367	101,841	8.96	19
20	Administrator					20
21	Assistant Administrator	2,080	2,080	101,768	48.93	21
22	Other Administrative	2,080	2,080	282,600	135.87	22
23	Office Manager	2,080	2,080	40,040	19.25	23
24	Clerical	5,617	5,617	67,591	12.03	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 Director</u>	1,944	1,944	36,362	18.70	33
34	TOTAL (lines 1 - 33)	215,993	215,993	\$ 2,852,624 *	\$ 13.21	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	\$ 7,780	1(3)	35
36	Medical Director	Monthly	7,429	9(3)	36
37	Medical Records Consultant	Quarterly	1,892	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,350	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	23	6(3)	46
47	<u>Maintenance Consultant</u>	Monthly	12,000	6(3)	47
48					48
49	TOTAL (lines 35 - 48)		\$ 30,474		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

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	\$ 101,768	Workers' Compensation Insurance	\$ 75,588	IDPH License Fee	\$	
Sam Thompson	Administrative	6.25	282,600	Unemployment Compensation Insurance		Advertising: Employee Recruitment	54,498	
				FICA Taxes	234,715	Health Care Worker Background Check		
				Employee Health Insurance	121,743	(Indicate # of checks performed <u>209</u>)	2,509	
				Employee Meals	13,140	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous License & Fees	3,723	
				Employee Relations & Morale	40,718	Misc. Dues & Subscriptions	599	
				Pension Contributions	8,781	IHCA	7,728	
				Personnel Expenses	419	SILO dues	3,600	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 384,368					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)				
Description			Amount					
N/A			\$					
TOTAL (agree to Schedule V, line 17, col. 3)			\$					
(Attach a copy of any management service agreement)								
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		\$ 10,675	N/A			Out-of-State Travel	\$
Williams, Williams, Lentz	Accounting		4,000					
Kemper CPA	Accounting		4,105					
Duane Morris	Legal		5,017				In-State Travel	
Lefkovitz and Associates	Legal		3,746					
Whitlow Roberts	Legal		1,528					
Refund County Clerk Filing	Legal		(90)				Seminar Expense	17,589
							Less: Nonallowable out of state travel, meals & entertainment	(9,908)
							Entertainment Expense	(
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 28,981				TOTAL	\$ 7,681

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Southgate Health Care Center, Inc.
Provider ID #: 0017996
12/31/2010

Schedule 21A

XIX.C. Professional Services

Total Professional Services	From PG21	28,981
Less: Nonallowable Legal Fees (Whitlow & Robe)		<u>(1,528)</u>
		27,453
	Schedule V, Line 19, Column	<u>27,453</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	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3								N/A					
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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