

Facility Name & ID Number Southgate Health Care Center

0017996 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	106	Skilled (SNF)	106	38,690	1
2		Skilled Pediatric (SNF/PED)			2
3	34	Intermediate (ICF)	34	12,410	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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	13,281	13,661	7,164	34,106	8
9	SNF/PED					9
10	ICF	8,260	1,787	1,576	11,623	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,541	15,448	8,740	45,729	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.49%

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 08/25/72

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

YES Date N/A NO

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

YES NO If YES, enter number of beds certified 106 and days of care provided 3,375

Medicare Intermediary Cigna Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/14 Fiscal Year: 12/31/14

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

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	257,849	32,372		290,221		290,221	8,303	298,524		1
2	Food Purchase		250,302		250,302		250,302	(15,000)	235,302		2
3	Housekeeping	201,533	44,978		246,511		246,511		246,511		3
4	Laundry	132,390	36,675		169,065		169,065		169,065		4
5	Heat and Other Utilities			153,670	153,670		153,670		153,670		5
6	Maintenance	93,912	50,211	52,781	196,904		196,904	(5,643)	191,261		6
7	Other (specify):*										7
8	TOTAL General Services	685,684	414,538	206,451	1,306,673		1,306,673	(12,340)	1,294,333		8
	B. Health Care and Programs										
9	Medical Director			7,200	7,200		7,200		7,200		9
10	Nursing and Medical Records	2,211,121	254,542	23,555	2,489,218		2,489,218	(8,303)	2,480,915		10
10a	Therapy										10a
11	Activities	56,625	8,912		65,537		65,537		65,537		11
12	Social Services	61,499			61,499		61,499		61,499		12
13	CNA Training										13
14	Program Transportation							210	210		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,329,245	263,454	30,755	2,623,454		2,623,454	(8,093)	2,615,361		16
	C. General Administration										
17	Administrative	306,538			306,538		306,538		306,538		17
18	Directors Fees			4,453	4,453		4,453		4,453		18
19	Professional Services			23,545	23,545		23,545		23,545		19
20	Dues, Fees, Subscriptions & Promotions			75,654	75,654		75,654	(51,401)	24,253		20
21	Clerical & General Office Expenses	112,608	21,564	114,114	248,286		248,286	(9,403)	238,883		21
22	Employee Benefits & Payroll Taxes			605,409	605,409		605,409	15,000	620,409		22
23	Inservice Training & Education			1,333	1,333		1,333		1,333		23
24	Travel and Seminar			37,905	37,905		37,905	(26,199)	11,706		24
25	Other Admin. Staff Transportation			32,906	32,906		32,906		32,906		25
26	Insurance-Prop.Liab.Malpractice			132,367	132,367		132,367		132,367		26
27	Other (specify):*										27
28	TOTAL General Administration	419,146	21,564	1,027,686	1,468,396		1,468,396	(72,003)	1,396,393		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,434,075	699,556	1,264,892	5,398,523		5,398,523	(92,436)	5,306,087		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Southgate Health Care Center

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Report Period Beginning:

01/01/14

Ending:

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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			294,722	294,722		294,722	(68,018)	226,704			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			37,080	37,080		37,080	(8,752)	28,328			32
33	Real Estate Taxes			45,800	45,800		45,800		45,800			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			17,696	17,696		17,696		17,696			35
36	Other (specify):*											36
37	TOTAL Ownership			395,298	395,298		395,298	(76,770)	318,528			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	327,178	116,803	6,922	450,903		450,903		450,903			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			333,727	333,727		333,727		333,727			42
43	Other (specify):* Non-Allowable Co	16,720		220,310	237,030		237,030	(237,030)				43
44	TOTAL Special Cost Centers	343,898	116,803	560,959	1,021,660		1,021,660	(237,030)	784,630			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,777,973	816,359	2,221,149	6,815,481		6,815,481	(406,236)	6,409,245			45

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

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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	(68,018)	30		9
10	Interest and Other Investment Income	(8,752)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(2,720)	20		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	(48,681)	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 Page 5A	(278,065)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (406,236)		\$	30

BHF USE ONLY						
48		49		50		51
						52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (406,236)		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

Southgate Health Care Center

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Offset Other Income revenue	\$ (9,403)	21	1
2	Out of state travel, meals & entertainment	(25,284)	24	2
3	Out of state travel, meals & entertainment	(705)	24	3
4	Marketing salaries	(16,720)	43	4
5	Nonallowable marketing evenets	(26,265)	43	5
6	Contributions	(4,817)	43	6
7	Tax expense	(15,052)	43	7
8	Nonallowable auto expense	(9,551)	43	8
9	Medicare Lab	(6,691)	43	9
10	Medicare X-Ray	(6,723)	43	10
11	Directors' health, disability & life insurance	(3,192)	43	11
12	IHCA PAC Expenses	(8,954)	43	12
13	Bad Debt	(135,787)	43	13
14	Penalties	(2,484)	43	14
15	Dietary Tax	(84)	43	15
16	Medicare Support Services	(589)	43	16
17	Medicare Prosthetics	(121)	43	17
18	Capitalize building improvement >\$2,500	(5,643)	6	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		(278,065)	49

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Jane Ann Parker	81.25	N/A		N/A		
Sam Thompson	6.25					
Jeff Thompson	6.25					
Shelly Bell	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		\$	N/A		\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ * 0	14

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

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VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Sam Thompson	Operations	Administrative	6.25	None	40+	100.00	Salary	\$ 242,200	17(1)	1
2	Jeff Thompson	Maintenance	Maintenance	6.25	None	40+	100.00	Salary	33,280	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)	1,113	18(3)	5
6	Jeff Thompson	Director	Administrative	6.25	None	40+	100.00	Dir. Fees (A)	1,113	18(3)	6
7	Shelly Bell	Director	Administrative	6.25	None	<1	<2%	Dir. Fees (A)	1,113	18(3)	7
8	William Parker	Director	Administrative	0.00	None	<1	<2%	Dir. Fees (A)	1,114	18(3)	8
9											9
10	William Parker	Consultant	Administrative	0.00	None			Consulting Fees	12,000	10(3)	10
11											11
12	(A) - Director fees \$; board meeting expenses reimbursed \$.										
13								TOTAL	\$ 331,973		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

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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		N/A							3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

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											
										Name of Lender	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	City National Bank		X	Mortgage Note Payable	\$7,683.40	6/15/12	\$ 1,000,000	\$ 632,983	6/15/27	0.0450	\$ 35,944	1								
2	Wells Fargo Dealer Services		X	Auto Loan	\$548.80	10/24/12	39,416	25,246	10/24/17			2								
3												3								
4												4								
5												5								
Working Capital																				
6	City National Bank		X	Working Capital	Monthly	3/20/13	337,000	145,000	3/19/15	0.0450		6								
7												7								
8												8								
9	TOTAL Facility Related				\$8,232.20		\$ 1,376,416	\$ 803,229			\$ 35,944	9								
B. Non-Facility Related*																				
10	TD Auto Finance		X	Vehicle Purchase	\$622.19	12/18/12	40,189	27,752	12/18/17	0.0364	1,136	10								
11											(7,616)	11								
12												12								
13											(1,136)	13								
14	TOTAL Non-Facility Related				\$622.19		\$ 40,189	\$ 27,752			\$ (7,616)	14								
15	TOTALS (line 9+line14)						\$ 1,416,605	\$ 830,981			\$ 28,328	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.)

** 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 2013 report.				\$	40,969 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.)	2013			\$	43,379 2
3. Under or (over) accrual (line 2 minus line 1).				\$	2,410 3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	43,390 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
		Allocated from Management Co.			
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.				\$	45,800 7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2009	<u>37,073</u>	8	FOR BHF USE ONLY	
	2010	<u>38,776</u>	9		
	2011	<u>40,631</u>	10		
	2012	<u>40,461</u>	11		
	2013	<u>43,379</u>	12		
Accrual based on prior year real estate tax bill.				13	FROM R. E. TAX STATEMENT FOR 2013 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

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

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Southgate Health Care Center COUNTY Massac
 FACILITY IDPH LICENSE NUMBER 0017996
 CONTACT PERSON REGARDING THIS REPORT Sam Thompson
 TELEPHONE (618) 524-2683 FAX #: (618) 524-3048

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2013 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2013.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>08-01-448-004</u>	<u>Nursing Facility</u>	\$ <u>299.08</u>	\$ <u>299.08</u>
2. <u>08-01-448-005</u>	<u>Nursing Facility</u>	\$ <u>288.44</u>	\$ <u>288.44</u>
3. <u>08-01-448-008</u>	<u>Nursing Facility</u>	\$ <u>1,256.68</u>	\$ <u>1,256.68</u>
4. <u>08-01-450-999</u>	<u>Nursing Facility</u>	\$ <u>41,534.96</u>	\$ <u>41,534.96</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>43,379.16</u></u>	\$ <u><u>43,379.16</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

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12/31/14

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

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

XI. OWNERSHIP COSTS:

A. Land.		1	2	3	4	
		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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	93	1972	1976	\$ 496,620	\$ <--See Attache		\$	\$	\$ 496,620	4
5	10		1989	583,147	18,513		19,438	925	495,369	5
6	5		1993	598,429	15,344	30	19,948	4,604	428,882	6
7			1994	13,658	350	30	455	105	9,535	7
8	32		2012	2,108,329	128,167	30	70,278	(57,890)	175,694	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	28,714	23
24	Overhead door/kitchen		1989	852		15			852	24
25	Flooring		1990	729		10			729	25
26	Fire alarm		1990	9,537		20			9,537	26
27	Dining room improvements		1992	1,824		10			1,824	27
28	Warehouse storage building		1993	17,802	565	30	593	28	13,046	28
29	100 gal lime tank		1995	3,742		15			3,742	29
30	Drywall resident rooms & bathrooms		1996	2,240		10			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

Facility Name & ID Number Southgate Health Care Center

0017996

Report Period Beginning:

01/01/14

Ending:

12/31/14

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

1	2	3	4	5	6	7	8	9	
	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		10			674	38
39	Kitchen plumbing	1997	1,947	50	20	97	47	1,698	39
40	Tile floor	1997	784		10			784	40
41	Water softener	1997	667		10			667	41
42	Interior design	1997	1,245		15			1,245	42
43									43
44	Flooring	1998	1,130		10			1,130	44
45									45
46	Roofing	1999	17,240	442	20	862	420	13,684	46
47									47
48	Roof - Section B	2000	31,346	436	20	1,567	1,131	22,363	48
49									49
50	New laundry building	2001	179,249	4,596	20	8,962	4,366	121,448	50
51	Laundry building flooring	2001	1,219		10			1,219	51
52	Roof replacement	2001	84,500	2,167	20	4,225	2,058	57,068	52
53									53
54	Design & remodel dining room	2002	97,732	2,506	40	2,443	(63)	30,538	54
55	Flooring	2002	39,834		10			39,834	55
56	Blinds	2002	2,473		10			2,473	56
57	Awning	2002	996		10			996	57
58	Walk in cooler repair	2002	3,361		10			3,361	58
59	Lighting	2002	2,563		10			2,563	59
60									60
61	Flooring	2003	871	27	10		(27)	871	61
62	Entryway Carpeting	2003	2,367	74	10		(74)	2,367	62
63									63
64									64
65									65
66									66
67	Flooring	2004	18,000		10	900	900	18,000	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,607,715	\$ 174,268		\$ 130,852	\$ (43,417)	\$ 2,239,898	70

**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:

01/01/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	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		\$ 4,607,715	\$ 174,268		\$ 130,852	\$ (43,417)	\$ 2,239,898	1
2	Flooring	2005	22,140		10	2,214	2,214	18,819	2
3	Drywall Hallways in A&D Wings & Various Resident Rooms	2005	19,233		10	1,923	1,923	18,269	3
4									4
5	Shelving unit for kitchen	2006	2,377		7			2,377	5
6	Drywall	2006	3,325	230	15	222	(8)	1,887	6
7	Air conditioning unit	2006	5,091	636	7		(636)	5,091	7
8	Flooring	2006	2,572	321	7		(321)	2,572	8
9									9
10	Air Conditioners Unit	2007	8,325		7	590	590	8,325	10
11	New Flooring/Shelving Units	2007	4,616		7	333	333	4,616	11
12	Installation of new lighting fixtures	2007	2,966		7	210	210	2,966	12
13	Repair to Laundry and Dishwasher Equip	2007	3,784		7	274	274	3,784	13
14	Additions to wandreguard & alarm system	2007	5,618		7	752	752	5,618	14
15									15
16	New flooring	2008	4,318	377	7	617	240	3,437	16
17									17
18	Flooring	2009	6,993	1,713	7	999	(714)	5,601	18
19	Replacement Roof	2009	40,000	2,667	15	2,667		14,668	19
20	HVAC Units	2009	2,591	634	7	370	(264)	2,035	20
21									21
22	Installation Exp for Electric & Gas Line for Generator	2010	8,165	1,693	7	1,166	(527)	4,721	22
23	Flooring	2010	4,191	599	7	599		2,696	23
24	Replacement Roof	2010	25,392	1,166	15	1,693	527	8,144	24
25									25
26	Water Heater	2011	12,126	726	5	2,426	1,700	8,491	26
27	Mechanical Lifts	2011	7,623	181	7	1,088	907	3,808	27
28	Flooring	2011	2,700	32	7	286	254	1,051	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,801,861	\$ 185,243		\$ 149,281	\$ (35,963)	\$ 2,368,874	34

**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:

01/01/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 4,801,861	\$ 185,243		\$ 149,281	\$ (35,963)	\$ 2,368,874	1
2									2
3	Remodeling & Rewiring - final payment for phone	2013	9,874	658	15	658		987	3
4	and cable wiring completed on the 300 Wing Addition								4
5	Remodeling & Rewiring - B Hall - Nurse call system	2013	3,058	204	15	204		306	5
6	(Micro Vision 200Z) Skilled Portion of Facility								6
7	Remodeling - 100 & 200 Hall Resident Room bathrooms,	2013	6,955	464	15	464		696	7
8	new sinks, countertops, and wall board. New handrails								8
9	installed and painted in hallways.								9
10	Rewiring B Hall - Electric rewiring for entire B Hall	2013	13,478	899	15	899		1,348	10
11									11
12									12
13	Hot Water Heater	2013	3,525	504	7	504		756	13
14									14
15	Remodeling of B/C Hall - installing, finishing, and painting	2014	171,980	2,205	39	2,205		2,205	15
16	sheetrock in resident rooms and hallway. New handrails								16
17	in hallways. New flooring in resident rooms and hallways.								17
18	HVAC Unit by dining room	2014	5,643		7	403	403	403	18
19	Pellett Heater - Kitchen	2014	6,264	447	7	447		447	19
20	Engineering work for parking lot renovation	2014	8,249	275	15	275		275	20
21									21
22	Adjustment to tie to financials			72,851			(72,851)		22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,030,887	\$ 263,750		\$ 155,340	\$ (108,411)	\$ 2,376,297	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 313,963	\$ 26,998	\$ 56,822	\$ 29,824	5-7	\$ 128,788	71
72	Current Year Purchases	41,415	3,974	3,974		5-7	3,974	72
73	Fully Depreciated Assets	831,417					831,417	73
74								74
75	TOTALS	\$ 1,186,795	\$ 30,972	\$ 60,796	\$ 29,824		\$ 964,179	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Care	Chevy Van	1989	\$ 18,500	\$	\$	\$		\$ 18,500	76
77	Resident Care	Dodge Dakota	2000	14,504					14,504	77
78	Resident Care	Chevy Truck	2011	10,977		2,195	2,195	5	7,683	78
79	See Sch 13A			46,099		8,373	8,373	5	20,227	79
80	TOTALS			\$ 90,080	\$	\$ 10,568	\$ 10,568		\$ 60,914	80

E. Summary of Care-Related Assets

	1	Reference	2	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)		\$ 6,407,762	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 294,722	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 226,704	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ (68,019)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 3,401,390	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	2005 Mercedes Benz	\$ 76,104	\$	\$ 76,104	86
87	BMW	57,504		57,504	87
88	Jeep Cherokee	40,164		40,164	88
89	Jeep	40,189	8,038	20,095	89
90	Land	67,912			90
91	TOTALS	\$ 281,873	\$ 8,038	\$ 193,867	91

G. Construction-in-Progress

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

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

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

Facility Name: Southgate Health Care Center
IDPH License ID Number: 0017996
Fiscal Year End: 12/31/14

Schedule 13A

XI. Ownership Costs

Line 79 - Vehicle Depreciation

Use	Model, Make & Year	Year Acquired	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustments	Life in Years	Accumulated Depreciation
Resident Care	Buick Enclave	2012	39,513	7,903	7,903	-	5	19,757
Resident Care	Lawn Tractor	2014	6,586	470	470	-	7	470
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
TOTAL			46,099	8,373	8,373	-		20,227

Facility Name & ID Number Southgate Health Care Center

0017996

Report Period Beginning: 01/01/14

Ending: 12/31/14

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ <u>N/A</u>			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

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. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

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: \$ 17,696 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			\$ <u>N/A</u>	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

Facility Name: Southgate Health Care Center
IDPH License ID Number: 0017996
Fiscal Year End: 12/31/14

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Phone System	6,000
Post Office Box Rental	140
Pitney Bowes Postage Machine Rental	159
Propane Gas Tanks	108
Dish Machine	1,007
CPAP Machine	2,250
Wound Vac Machine	4,930
Oxygen Rental	1,140
Oxygen Supplies	1,962
Total - Line 16	<u>17,696</u>

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</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.

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	39(1)	2451	hrs	\$ 145,824		\$	\$	2,451	\$ 145,824	1
2	Licensed Speech and Language Development Therapist	39(1)	1612	hrs	60,970				1,612	60,970	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	39(1)	4661	hrs	120,384				4,661	120,384	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				116,803		116,803	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): <u>See Sch 16A</u>	39(3)					6,922			6,922	12
13	Other (specify):										13
14	TOTAL				\$ 327,178		\$ 6,922	\$ 116,803	8,724	\$ 450,903	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.

Facility Name: Southgate Health Care Center
IDPH License ID Number: 0017996
Fiscal Year End: 12/31/14

Schedule 16A

XIV. Special Services (Direct Cost)

Line 12 Other (specify)

<u>Description</u>	<u>Units</u>	<u>Amount</u>
VA lab		289
VA physician		5,926
VA rehab		707
Total - Line 12	-	6,922

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

0017996

Report Period Beginning: **01/01/14**

Ending:

12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/14** (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	\$ (38,964)	\$ (38,964)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>-0-</u>)	1,131,837	1,131,837	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	14,438	14,438	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>A/R Employee</u>	5,925	5,925	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,113,236	\$ 1,113,236	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	167,913	100,000	13
14	Buildings, at Historical Cost	4,129,217	3,800,183	14
15	Leasehold Improvements, at Historical Cost	2,598,225	1,230,704	15
16	Equipment, at Historical Cost		1,276,875	16
17	Accumulated Depreciation (book methods)	(3,532,275)	(3,401,390)	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): _____			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,363,080	\$ 3,006,372	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,476,316	\$ 4,119,608	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 85,441	\$ 85,441	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	145,000	145,000	29
30	Accrued Salaries Payable	137,994	137,994	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,446	6,446	31
32	Accrued Real Estate Taxes(Sch.IX-B)	43,390	43,390	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Sch 17A</u>	152,821	152,821	36
37	_____			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 571,092	\$ 571,092	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	52,997	52,997	39
40	Mortgage Payable	632,984	632,984	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)	\$ 685,981	\$ 685,981	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,257,073	\$ 1,257,073	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,219,243	\$ 2,862,535	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,476,316	\$ 4,119,608	48

*(See instructions.)

Facility Name: Southgate Health Care Center
IDPH License ID Number: 0017996
Fiscal Year End: 12/31/14

Schedule 17A

XV. Balance Sheet

Line 36 Other Current Liabilities (specify):

Description	After	
	Operating	Consolidation
FIT W/H	-	-
Insurance - W/H Life Ins	(993)	(993)
Insurance - Health Ins	(1,336)	(1,336)
Credit Union Withheld	-	-
Other Accrued Expenses	(66,216)	(66,216)
Accrued Licensed Bed Tax	(84,276)	(84,276)
Due to DPA Audit	-	-
Due to DPA Coinsurance	-	-
Total - Line 36	(152,821)	(152,821)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,120,685	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,120,685	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	330,069	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	(231,511)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 98,558	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)	\$ 3,219,243	24 *

* This must agree with page 17, line 47.

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	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,289,062	1
2	Discounts and Allowances for all Levels	(465,312)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,823,750	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,071,543	6
7	Oxygen	5,066	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,076,609	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	201,776	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	26,380	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 228,156	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	7,616	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 7,616	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	<u>Other Income</u>	9,419	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 9,419	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,145,550	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,306,673	31
32	Health Care	2,623,454	32
33	General Administration	1,468,396	33
B. Capital Expense			
34	Ownership	395,298	34
C. Ancillary Expense			
35	Special Cost Centers	687,933	35
36	Provider Participation Fee	333,727	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,815,481	40
41	Income before Income Taxes (line 30 minus line 40)**	330,069	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 330,069	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,678,955	44
45	Private Pay - Net Inpatient Revenue	2,369,346	45
46	Medicare - Net Inpatient Revenue	389,771	46
47	Other-(specify) <u>Net VA Inpatient Revenue</u>	385,678	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,823,750	49

* 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.

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

^ - This entity is a cash basis taxpayer

Facility Name: Southgate Health Care Center
IDPH License ID Number: 0017996
Fiscal Year End: 12/31/14

Schedule 19A

XVII. Income Statement

Line 28 Other Revenue (specify):

<u>Description</u>	<u>Amount</u>
Other Income	9,403
Vending Income	16
Total - Line 28	<u><u>9,419</u></u>

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

0017996

Report Period Beginning: **01/01/14**

Ending:

12/31/14

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	2,112	\$ 63,742	\$ 30.18	1
2	Assistant Director of Nursing	2,090	45,270	21.66	2
3	Registered Nurses	13,032	354,843	27.23	3
4	Licensed Practical Nurses	32,903	532,243	16.18	4
5	CNAs & Orderlies	122,511	1,215,023	9.92	5
6	CNA Trainees				6
7	Licensed Therapist	8,724	327,178	37.50	7
8	Rehab/Therapy Aides				8
9	Activity Director	2,080	22,200	10.67	9
10	Activity Assistants	3,723	34,425	9.25	10
11	Social Service Workers	3,072	61,499	20.02	11
12	Dietician				12
13	Food Service Supervisor	4,226	39,539	9.36	13
14	Head Cook	7,437	64,474	8.67	14
15	Cook Helpers/Assistants	9,770	89,044	9.11	15
16	Dishwashers	5,965	64,792	10.86	16
17	Maintenance Workers	4,160	93,912	22.58	17
18	Housekeepers	24,428	201,533	8.25	18
19	Laundry	12,515	132,390	10.58	19
20	Administrator	2,080	64,338	30.93	20
21	Assistant Administrator				21
22	Other Administrative	2,080	242,200	116.44	22
23	Office Manager	2,080	40,040	19.25	23
24	Clerical	5,554	72,568	13.07	24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)				28
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)				30
31	Medical Records				31
32	Other Health Care				32
33	Other(specify) <u>Marketing Dir.</u>	2,027	16,720	8.25	33
34	TOTAL (lines 1 - 33)	272,569	\$ 3,777,973 *	\$ 13.86	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	\$ 8,303	1(7)	35
36	Medical Director	7,200	9(3)	36
37	Medical Records Consultant	1,842	10(3)	37
38	Nurse Consultant	53	10(3)	38
39	Pharmacist Consultant	1,357	10(3)	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47	<u>Physician Consultant</u>	Monthly 12,000	10(3)	47
48				48
49	TOTAL (lines 35 - 48)	\$ 30,755		49

C. CONTRACT NURSES

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

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	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	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Southgate Health Care Center

0017996

Report Period Beginning:

01/01/14

Ending:

12/31/14

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. IHCA - \$7,084
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 6 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 51,287 Line 10(2)
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 333,727
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. \$ 15,000 Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 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? N/A
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? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.