		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0017996

Facility Name: Southgate Health Care Center, Inc.

Address: 900 West 9th Street (Number) Metropolis (City) 62960 (Zip Code)

County: Massac

Telephone Number: (618) 524-2683 **Fax #** (618) 524-3048

HFS ID Number:

Date of Initial License for Current Owners: 01/01/1964

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Michael W. Martin **Telephone Number:** (217) 258-8888
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/11 to 12/31/11 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) SEE ACCOUNTANTS' PREPARATION REPORT (Date)
(Print Name and Title)
(Firm Name & Address) McGladrey & Pullen, LLP, 20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847) 517-7067

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Southgate Health Care Center, Inc. # 0017996 Report Period Beginning: 1/1/11 Ending: 12/31/11

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	75	Skilled (SNF)	75	27,375	1
2		Skilled Pediatric (SNF/PED)			2
3	65	Intermediate (ICF)	65	23,725	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: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	11,915	6,760	4,673	23,348	8
9	SNF/PED					9
10	ICF	11,132	3,598	1,844	16,574	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,047	10,358	6,517	39,922	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.13%

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 [X] 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 [X] 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 [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 75 and days of care provided 3,531

Medicare Intermediary Cigna Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/11 Fiscal Year: 12/31/11

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

Facility Name & ID Number Southgate Health Care Center, Inc. # 0017996 Report Period Beginning: 1/1/11 Ending: 12/31/11

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	209,088	21,902	8,669	239,659		239,659		239,659			1
2	Food Purchase		200,812		200,812		200,812		200,812			2
3	Housekeeping	153,585	25,649		179,234		179,234		179,234			3
4	Laundry	103,768	16,375	1,116	121,259		121,259		121,259			4
5	Heat and Other Utilities			146,539	146,539		146,539		146,539			5
6	Maintenance	80,076	26,317	36,515	142,908		142,908		142,908			6
7	Other (specify):*											7
8	**TOTAL General Services**	546,517	291,055	192,839	1,030,411		1,030,411		1,030,411			8
	B. Health Care and Programs											
9	Medical Director			7,363	7,363		7,363		7,363			9
10	Nursing and Medical Records	1,564,963	169,260	16,434	1,750,657		1,750,657		1,750,657			10
10a	Therapy	315,352			315,352		315,352		315,352			10a
11	Activities	54,394	2,784		57,178		57,178		57,178			11
12	Social Services	64,582			64,582		64,582		64,582			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,999,291	172,044	23,797	2,195,132		2,195,132		2,195,132			16
	C. General Administration											
17	Administrative	338,368			338,368		338,368		338,368			17
18	Directors Fees			5,784	5,784		5,784		5,784			18
19	Professional Services			17,001	17,001		17,001		17,001			19
20	Dues, Fees, Subscriptions & Promotions			55,867	55,867		55,867	(39,137)	16,730			20
21	Clerical & General Office Expenses	113,063	22,208	62,047	197,318		197,318	1,685	199,003			21
22	Employee Benefits & Payroll Taxes			546,239	546,239		546,239		546,239			22
23	Inservice Training & Education			4,614	4,614		4,614		4,614			23
24	Travel and Seminar			18,841	18,841		18,841	(13,302)	5,540			24
25	Other Admin. Staff Transportation			30,468	30,468		30,468		30,468			25
26	Insurance-Prop.Liab.Malpractice			109,671	109,671		109,671		109,671			26
27	Other (specify):*											27
28	**TOTAL General Administration**	451,431	22,208	850,532	1,324,171		1,324,171	(50,754)	1,273,418			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,997,239	485,307	1,067,168	4,549,714		4,549,714	(50,754)	4,498,961			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, Inc. #0017996 Report Period Beginning: 1/1/11 Ending: 12/31/11

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			85,938	85,938		85,938	29,356	115,294			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			7,311	7,311		7,311	(7,311)				32
33	Real Estate Taxes			39,552	39,552		39,552		39,552			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			28,583	28,583		28,583		28,583			35
36	Other (specify):*											36
37	**TOTAL Ownership**			161,384	161,384		161,384	22,045	183,429			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		123,552	6,379	129,931		129,931		129,931			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			193,928	193,928		193,928		193,928			42
43	Other (specify):* **Non-Allow Costs**	19,946		91,446	111,392		111,392	(111,392)				43
44	**TOTAL Special Cost Centers**	19,946	123,552	291,753	435,251		435,251	(111,392)	323,859			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,017,185	608,859	1,520,305	5,146,349		5,146,349	(140,101)	5,006,249			45

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

Facility Name & ID Number Southgate Health Care Center, Inc. # 0017996 Report Period Beginning: 1/1/11 Ending: 12/31/11

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 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	29,356	30		9
10	Interest and Other Investment Income	(7,311)	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				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	(36,828)	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	(125,318)	Vari		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (140,101)		$	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 Amount	2 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
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (140,101)		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 Yes	2 No	3 Amount	4 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, Inc.

ID# 0017996

Report Period Beginning: 1/1/11

Ending: 12/31/11

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Offset Other Income revenue	$ (368)	21	1
2	Reclass assets to repairs/supplies per regs.		1	2
3	Reclass assets to repairs/supplies per regs.	2,053	21	3
4	Reclass assets to repairs/supplies per regs.		6	4
5	Out of state travel, meals & entertainment		24	5
6	Out of state travel, meals & entertainment	(11,534)	24	6
7	Out of state travel, meals & entertainment	(1,768)	24	7
8	Marketing salaries	(19,946)	43	8
9	Nonallowable marketing evenets	(18,952)	43	9
10	Contributions	(7,498)	43	10
11	Tax expense	(32,971)	43	11
12	Nonallowable auto expense	(9,463)	43	12
13	Medicare Lab	(7,848)	43	13
14	Medicare X-Ray	(2,435)	43	14
15	Directors' health, disability & life insurance	(4,122)	43	15
16	PAC contributions	(2,309)	20	16
17	IHCA PAC Expenses	(679)	43	17
18	Gain/(Loss) on Sale of Assets	500	43	18
19	Medicare Support Services	(213)	43	19
20	Bad Debt	(7,765)	43	20
21	Nonallowable legal fees		19	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**	(125,318)		49

Facility Name & ID Number Southgate Health Care Center, Inc. # 0017996 Report Period Beginning: 1/1/11 Ending: 12/31/11

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 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 [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
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	$ * 0	14

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

Facility Name & ID Number Southgate Health Care Center, Inc. # 0017996 Report Period Beginning: 1/1/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ * 0	39

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

Facility Name & ID Number Southgate Health Care Center, Inc. # 0017996 Report Period Beginning: 1/1/11 Ending: 12/31/11

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Sam Thompson	Operations	Administrative	6.25	None	40+	100.00	Salary	$ 236,200	17(1)	1
2	Jeff Thompson	Maintenance	Maintenance	6.25	None	40+	100.00	Salary	31,642	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)	1,446	18(3)	5
6	Jeff Thompson	Director	Administrative	6.25	None	40+	100.00	Dir. Fees (A)	1,446	18(3)	6
7	Shelly MacCauley	Director	Administrative	6.25	None	<1	<2%	Dir. Fees (A)	1,446	18(3)	7
8	William Parker	Director	Administrative	0.00	None	<1	<2%	Dir. Fees (A)	1,446	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 $.										12
13								TOTAL	$ 325,666		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

Facility Name & ID Number Southgate Health Care Center, Inc. # 0017996 Report Period Beginning: 1/1/11 Ending: 12/31/11

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 [X]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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

Facility Name & ID Number Southgate Health Care Center, Inc. # 0017996 Report Period Beginning: 1/1/11 Ending: 12/31/11

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	City National Bank		X	Construction Loan	none	9/18/10	$ 40,000	$ 1,041,581	demand	0.0525	$ 7,083	1
2												2
3												3
4												4
5												5
	Working Capital											
6	City National Bank		x	Working Capital	demand	3/12/11	50,000	50,000	3/19/12	0.0525		6
7												7
8												8
9	TOTAL Facility Related						$ 90,000	$ 1,091,581			$ 7,083	9
	B. Non-Facility Related*											
10	BMW Credit	X		Vehicle Purchase	$971.96	8/1/08	57,004	18,304	7/1/13	0.0090	228	10
11								Interest income offset			(7,083)	11
12												12
13								Disallow non-care related interest			(228)	13
14	TOTAL Non-Facility Related				$971.96		$ 57,004	$ 18,304			$ (7,083)	14
15	TOTALS (line 9+line14)						$ 147,004	$ 1,109,885			$	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.)

Facility Name & ID Number Southgate Health Care Center, Inc. # 0017996 Report Period Beginning: 1/1/11 Ending: 12/31/11

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$ 38,000	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.)	2010	$ 38,776	2
3. Under or (over) accrual (line 2 minus line 1).		$ 776	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 38,776	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.		$ 39,552	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	46,830	8
	2007	48,255	9
	2008	45,848	10
	2009	37,073	11
	2010	38,776	12

Accrual based on prior year real estate tax bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Southgate Health Care Center, Inc. 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 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-01-449-001	Nursing Facility	$ 1,694.48	$ 1,694.48
2.	08-01-451-001	Nursing Facility	$ 702.88	$ 702.88
3.	08-01-448-004	Nursing Facility	$ 267.35	$ 267.35
4.	08-01-450-001	Nursing Facility	$ 34,430.00	$ 34,430.00
5.	08-01-448-005	Nursing Facility	$ 258.00	$ 258.00
6.	08-01-448-002	Nursing Facility	$ 301.08	$ 301.08
7.	08-01-448-008	Nursing Facility	$ 1,123.06	$ 1,123.06
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 38,776.85	$ 38,776.85

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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

Facility Name & ID Number Southgate Health Care Center, Inc. # 0017996 Report Period Beginning: 1/1/11 Ending: 12/31/11

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 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: N/A
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	185,500	1972	$ 5,000	1
2	Resident Care	193,500	2002	95,000	2
3	TOTALS	379,000		$ 100,000	3

Facility Name & ID Number Southgate Health Care Center, Inc. # 0017996 Report Period Beginning: 1/1/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 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	437,055	6
7	5			1993	598,429	15,344	30	19,948	4,604	369,038	7
8				1994	13,658	350	30	455	105	8,170	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	25,462	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	11,267	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, Inc. # 0017996 Report Period Beginning: 1/1/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
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	1,407	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	1,204	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	11,098	46
47									47
48	Roof - Section B	2000	31,346	436	20	1,567	1,131	17,662	48
49									49
50	New laundry building	2001	179,249	4,596	20	8,962	4,366	94,562	50
51	Laundry building flooring	2001	1,219	80	10	68	(12)	1,219	51
52	Roof replacement	2001	84,500	2,167	20	4,225	2,058	44,393	52
53									53
54	Design & remodel dining room	2002	97,732	2,506	40	2,443	(63)	23,209	54
55	Flooring	2002	39,834		10	3,683	3,683	35,138	55
56	Blinds	2002	2,473		10	247	247	2,347	56
57	Awning	2002	996		10	100	100	950	57
58	Walk in cooler repair	2002	3,361	105	10	336	231	3,192	58
59	Lighting	2002	2,563		10	256	256	2,432	59
60									60
61	Flooring	2003	871	27	10	87	60	740	61
62	Entryway Carpeting	2003	2,367	74	10	237	163	2,014	62
63									63
64									64
65									65
66									66
67	Flooring	2004	18,000		10	1,800	1,800	13,500	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,499,386	$ 46,401		$ 66,571	$ 20,170	$ 1,874,989	70

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

Facility Name & ID Number Southgate Health Care Center, Inc. # 0017996 Report Period Beginning: 1/1/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,499,386	$ 46,401		$ 66,571	$ 20,170	$ 1,874,989	1
2	Flooring	2005	22,140		10	2,214	2,214	12,177	2
3	Drywall Hallways in A&D Wings & Various Resident Rooms	2005	19,233		10	1,923	1,923	12,500	3
4									4
5	Shelving unit for kitchen	2006	2,377		7	340	340	1,870	5
6	Drywall	2006	3,325	230	15	222	(8)	1,221	6
7	Air condtioning unit	2006	5,091	636	7	727	91	3,999	7
8	Flooring	2006	2,572	321	7	367	46	2,018	8
9									9
10	Air Conditioners Unit	2007	8,325		7	1,190	1,190	5,355	10
11	New Flooring/Shelving Units	2007	4,616		7	659	659	2,965	11
12	Instalation of new lighting fixtures	2007	2,966		7	424	424	1,908	12
13	Repair to Laundry and Dishwasher Equip	2007	3,784		7	540	540	2,430	13
14	Additions to wandreguard & alarm system	2007	5,618		7	804	804	3,258	14
15									15
16	New flooring	2008	4,318	377	7	617	240	1,586	16
17									17
18	Flooring	2009	6,993	1,713	7	999	(714)	2,604	18
19	Replacement Roof	2009	40,000	2,667	15	2,667		6,667	19
20	HVAC Units	2009	2,591	634	7	370	(264)	925	20
21									21
22	Installation Exp for Electric & Gas Line for Generator	2010	8,165	1,693	7	1,166	(526)	1,223	22
23	Flooring	2010	4,191	599	7	599	0	899	23
24	Replacement Roof	2010	25,392	1,166	15	1,693	526	3,065	24
25									25
26	Water Heater	2011	12,126	726	5	1,213	487	1,213	26
27	Mechanical Lifts	2011	7,623	181	7	544	363	544	27
28	Flooring	2011	2,700	32	7	193	161	193	28
29									29
30	Adjustment to Agree to Current Depreciation			(8,144)			8,144		30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,693,532	$ 49,232		$ 86,042	$ 36,810	$ 1,943,609	34

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

Facility Name & ID Number Southgate Health Care Center, Inc. # 0017996 Report Period Beginning: 1/1/11 Ending: 12/31/11

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	$ 302,962	$ 33,884	$ 24,869	$ (9,015)	5-10	$ 213,544	71
72	Current Year Purchases	37,514	2,822	3,285	463	7	2,822	72
73	Fully Depreciated Assets	592,745					592,745	73
74								74
75	TOTALS	$ 933,221	$ 36,706	$ 28,154	$ (8,552)		$ 809,111	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	1989 Chevrolet Van	1989	$ 18,500	$	$	$	5	$ 18,500	76
77	Resident Care	Dodge Dakota	2000	14,504				5	14,504	77
78	Resident Care	Chevy Truck	2011	10,977		1,098	1,098	5	1,098	78
79										79
80	TOTALS			$ 43,981	$	$ 1,098	$ 1,098		$ 34,102	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,770,734	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 85,938	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 115,294	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 29,355	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,786,822	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	10,019		88
89	Jeep Cherokee	40,164			89
90	Land	67,912			90
91	TOTALS	$ 241,684	$ 10,019	$	91

G. Construction-in-Progress

	Description	Cost	
92	New facility design &	$	92
93	construction. Not yet in	2,026,029	93
94	service.		94
95		$ 2,026,029	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 & ID Number Southgate Health Care Center, Inc. # 0017996 Report Period Beginning: 1/1/11 Ending: 12/31/11

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: *

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.	/2012	$
13.	/2013	$
14.	/2014	$

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: $ 28,583 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			$ N/A	$	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.

Southgate Health Care
Facility ID: 0017996
12/31/2011

Supplementary Information
Schedule 14A

Equipment Rental Lease

Rent a/c 01-456	Amount
Phone System	6,000.00
Postage Machine	159.00
Ice Machines	2,300.00
Propane Gas Tanks	108.00
Total per General Ledger	8,567.00
Dietary Equip Rental a/c 03-552	
Dish Machine	2,906.09
Nursing Equip Rental a/c 06-712	
KCI mattress rental	2,034.90
Nursing Oxygen and Rental a/c 06-722	
Oxygen Rental	10,074.20
Oxygen Supplies	2,181.37
Concentrators	2,819.83
Total	15,075.40
TOTAL Schedule XII B 16	28,583.39

Facility Name & ID Number Southgate Health Care Center, Inc. # 0017996 Report Period Beginning: 1/1/11 Ending: 12/31/11

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.

Facility Name & ID Number Southgate Health Care Center, Inc. # 0017996 Report Period Beginning: 1/1/11 Ending: 12/31/11

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A(1)	3467 hrs	$ 130,029		$	$	3,467	$ 130,029	1
2	Licensed Speech and Language Development Therapist	10A(1)	1661 hrs	48,895				1,661	48,895	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(1)	3710 hrs	136,428				3,710	136,428	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				123,552		123,552	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): VA Lab	39(3)				2,364			2,364	12
13	Other (specify): VA Physician	39(3)				4,015			4,015	13
14	TOTAL			$ 315,352		$ 6,379	$ 123,552	8,838	$ 445,283	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.

STATE OF ILLINOIS

Facility Name & ID Number Southgate Health Care Center, Inc. # 0017996 Report Period Beginning: 1/1/11 Ending: 12/31/11

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/11 (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	$ 3,000	$ 3,000	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 25,376)	1,599,178	1,599,178	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	29,483	29,483	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,631,661	$ 1,631,661	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	3,667,187	2,538,706	14
15	Leasehold Improvements, at Historical Cost	129,634	154,826	15
16	Equipment, at Historical Cost		977,202	16
17	Accumulated Depreciation (book methods)	(2,782,023)	(2,786,822)	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): See Sch 17A	2,028,329	2,028,329	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,211,039	$ 3,012,241	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,842,700	$ 4,643,902	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 212,764	$ 212,764	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	50,000	50,000	29
30	Accrued Salaries Payable	82,855	82,855	30
31	Accrued Taxes Payable (excluding real estate taxes)	22,215	22,215	31
32	Accrued Real Estate Taxes(Sch.IX-B)	38,776	38,776	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	346,753	346,753	36
37	Deferred Income-Resident Liability	199,228	199,228	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 952,591	$ 952,591	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,059,885	1,059,885	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)**	$ 1,059,885	$ 1,059,885	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,012,476	$ 2,012,476	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,830,224	$ 2,631,426	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,842,700	$ 4,643,902	48

*(See instructions.)

Southgate Health Care Center, Inc.
Provider ID # 0017996
12/31/2011 **Schedule 17A**

XV. Balance Sheet

	Operating	After Consolidation
Line 23 (Other)		
Employee Advances	2,300	2,300
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	2,026,029	2,026,029
	2,028,329	2,028,329

Line 36 (Other Current Liabilities)		
Payroll withholdings	17,550	17,550
Due to DHFS - Coinsurance	43,373	43,373
Other Accrued Expenses	117,278	117,278
Accrued Licensed Bed Tax	168,552	168,552
	346,753	346,753

Facility Name & ID Number Southgate Health Care Center, Inc. # 0017996 Report Period Beginning: 1/1/11 Ending: 12/31/11

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,749,396	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,749,396	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	392,440	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	(311,612)	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)**	$ 80,828	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)**	$ 2,830,224	24 *

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

Facility Name & ID Number Southgate Health Care Center, Inc. # 0017996 Report Period Beginning: 1/1/11 Ending: 12/31/11

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,237,321	1
2	Discounts and Allowances for all Levels	795,392	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,032,713	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	1,091	5
6	Therapy	321,564	6
7	Oxygen	425	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 323,080	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	160,704	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	10,540	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 171,244	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	10,956	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 10,956	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Income	368	28
28a	Vending Income	428	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 796	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,538,789	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,030,411	31
32	Health Care	2,195,132	32
33	General Administration	1,324,171	33
	B. Capital Expense		
34	Ownership	161,384	34
	C. Ancillary Expense		
35	Special Cost Centers	241,323	35
36	Provider Participation Fee	193,928	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,146,349	40
41	**Income before Income Taxes (line 30 minus line 40)****	392,440	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 392,440	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.**

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

Facility Name & ID Number Southgate Health Care Center, Inc. # 0017996 Report Period Beginning: 1/1/11 Ending: 12/31/11

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,080	$ 60,926	$ 29.29	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,597	8,597	183,603	21.36	3
4	Licensed Practical Nurses	28,187	28,187	472,332	16.76	4
5	CNAs & Orderlies	92,427	92,427	848,102	9.18	5
6	CNA Trainees					6
7	Licensed Therapist	8,339	8,339	315,352	37.82	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,789	1,789	19,038	10.64	9
10	Activity Assistants	3,994	3,994	35,356	8.85	10
11	Social Service Workers	4,041	4,041	64,582	15.98	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	35,580	17.11	13
14	Head Cook	6,448	6,448	55,478	8.60	14
15	Cook Helpers/Assistants	7,110	7,110	60,025	8.44	15
16	Dishwashers	6,854	6,854	58,005	8.46	16
17	Maintenance Workers	4,160	4,160	80,076	19.25	17
18	Housekeepers	17,337	17,337	153,585	8.86	18
19	Laundry	11,173	11,173	103,768	9.29	19
20	Administrator	2,080	2,080	102,168	49.12	20
21	Assistant Administrator					21
22	Other Administrative	2,080	2,080	236,200	113.56	22
23	Office Manager	2,080	2,080	40,040	19.25	23
24	Clerical	5,475	5,475	73,023	13.34	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) Marketing Dir.	1,476	1,476	19,946	13.51	33
34	TOTAL (lines 1 - 33)	217,807	217,807	$ 3,017,185 *	$ 13.85	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 8,669	1(3)	35
36	Medical Director	Monthly	7,363	9(3)	36
37	Medical Records Consultant	Quarterly	1,424	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,482	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) Medicare Consult.		592	10(3)	46
47	Physician Consultant	Monthly	12,000	10(3)	47
48					48
49	TOTAL (lines 35 - 48)		$ 31,530		49

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C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	28	936	10(3)	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	28	$ 936		53

Facility Name & ID Number Southgate Health Care Center, Inc. # 0017996 Report Period Beginning: 1/1/11 Ending: 12/31/11

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Michelle Cavitt	Administrator	0	$ 89,589
Sam Thompson	Administrative	6.25	248,779
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 338,368

B. Administrative - Other

Description	Amount
N/A	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
RSM McGladrey, Inc.	Accounting	$ 10,550
Williams, Williams, Lentz	Accounting	4,125
Kemper CPA	Accounting	2,326
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 17,001

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 132,546
Unemployment Compensation Insurance	
FICA Taxes	244,229
Employee Health Insurance	126,198
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations & Morale	33,355
Pension Contributions	9,911
TOTAL (agree to Schedule V, line 22, col.8)	$ 546,239

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 4,695
Advertising: Employee Recruitment	1,851
Health Care Worker Background Check	
(Indicate # of checks performed 83)	997
Patient Background Checks 83	996
Miscellaneous Licenses & Fees	1,381
Misc. Dues & Subscriptions	3,155
IHCA	5,964
Nonallowable Advertising	36,828
Less: PAC Dues	(2,109)
Less: Public Relations Expense	( )
Non-allowable advertising	(37,028)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,730

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 6,160
In-State Travel	6,202
Seminar Expense	6,480
Less: Nonallowable out of state travel, meals & entertainment	(13,302)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,540

**See instructions.

Facility Name & ID Number Southgate Health Care Center, Inc. # 0017996 Report Period Beginning: 1/1/11 Ending: 12/31/11

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		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Southgate Health Care Center, Inc. # 0017996 Report Period Beginning: 1/1/11 Ending: 12/31/11

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 - $5,964**

(3) Did the nursing home make political contributions or payments to a politica
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? **7 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **40,268** 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 fo
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 Departmen
during this cost report period. $ **193,928**
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 tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
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. $ **0** 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 fo
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 othe
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
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services
performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees