

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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

Address: 900 E. Ninth St., P.O. Box 843 Metropolis 62960
Number City 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
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☒ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Amanda Springborn Telephone Number: (314) 925-3838
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 1/1/12 to 12/31/12 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) _____ (Date) _____
(Print Name and Title) _____
(Firm Name & Address) McGladrey 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# 0017996 Report Period Beginning: 1/1/12 Ending: 12/31/12

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 bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>75</u>	Skilled (SNF)	<u>106</u>	<u>35,727</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>65</u>	Intermediate (ICF)	<u>34</u>	<u>15,513</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>140</u>	TOTALS	<u>140</u>	<u>51,240</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>13,293</u>	<u>10,420</u>	<u>6,915</u>	<u>30,628</u>	8
9	SNF/PED					9
10	ICF	<u>9,807</u>	<u>3,098</u>	<u>860</u>	<u>13,765</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>23,100</u>	<u>13,518</u>	<u>7,775</u>	<u>44,393</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 86.64%

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?

YesG. 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/ANO ☒

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

YES ☒NO ☐If YES, enter number
of beds certified 75 and days of care provided 4,051Medicare Intermediary Cigna Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/12Fiscal Year: 12/31/12

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

	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	221,412	27,286	9,390	258,088		258,088		258,088			1
2	Food Purchase		221,946		221,946		221,946		221,946			2
3	Housekeeping	180,641	38,703		219,344		219,344		219,344			3
4	Laundry	111,273	16,178		127,451		127,451		127,451			4
5	Heat and Other Utilities			156,535	156,535		156,535		156,535			5
6	Maintenance	80,199	34,093	46,890	161,182		161,182		161,182			6
7	Other (specify):*											7
8	TOTAL General Services	593,525	338,206	212,815	1,144,546		1,144,546		1,144,546			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	1,838,398	199,180	14,924	2,052,502		2,052,502		2,052,502			10
10a	Therapy											10a
11	Activities	48,329	4,142		52,471		52,471		52,471			11
12	Social Services	67,858			67,858		67,858		67,858			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,954,585	203,322	22,124	2,180,031		2,180,031		2,180,031			16
	C. General Administration											
17	Administrative	318,684			318,684		318,684		318,684			17
18	Directors Fees			7,223	7,223		7,223		7,223			18
19	Professional Services			20,591	20,591		20,591		20,591			19
20	Dues, Fees, Subscriptions & Promotions			52,511	52,511		52,511	(38,976)	13,535			20
21	Clerical & General Office Expenses	114,792	23,252	58,808	196,852		196,852	1,516	198,368			21
22	Employee Benefits & Payroll Taxes			511,610	511,610		511,610		511,610			22
23	Inservice Training & Education			153	153		153		153			23
24	Travel and Seminar			16,480	16,480		16,480	(10,078)	6,402			24
25	Other Admin. Staff Transportation			25,351	25,351		25,351		25,351			25
26	Insurance-Prop.Liab.Malpractice			121,661	121,661		121,661		121,661			26
27	Other (specify):*											27
28	TOTAL General Administration	433,476	23,252	814,388	1,271,116		1,271,116	(47,538)	1,223,578			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,981,586	564,780	1,049,327	4,595,693		4,595,693	(47,538)	4,548,155			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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			202,444	202,444		202,444	(41,255)	161,189			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			46,523	46,523		46,523	(4,208)	42,315			32
33	Real Estate Taxes			42,485	42,485		42,485		42,485			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			14,305	14,305		14,305		14,305			35
36	Other (specify):*											36
37	TOTAL Ownership			305,757	305,757		305,757	(45,463)	260,294			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	327,308	167,705	5,446	500,459		500,459		500,459			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			370,229	370,229		370,229		370,229			42
43	Other (specify):* Non-Allowable Co	28,662		100,461	129,123		129,123	(129,123)				43
44	TOTAL Special Cost Centers	355,970	167,705	476,136	999,811		999,811	(129,123)	870,688			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,337,556	732,485	1,831,220	5,901,261		5,901,261	(222,124)	5,679,137			45

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

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	(41,255)	30		9
10	Interest and Other Investment Income	(4,208)	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		20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(33,460)			26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(143,201)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (222,124)		\$	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))	\$ (222,124)		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

ID# 0017996

Report Period Beginning: 1/1/12

Ending: 12/31/12

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Offset Other Income revenue	\$ (315)	21	1
2	Reclass assets to repairs/supplies per regs.	(320)	1	2
3	Reclass assets to repairs/supplies per regs.	1,831	21	3
4	Out of state travel, meals & entertainment	(9,730)	24	4
5	Out of state travel, meals & entertainment	(348)	24	5
6	Marketing salaries	(28,662)	43	6
7	Nonallowable marketing evenets	(22,844)	43	7
8	Contributions	(1,500)	43	8
9	Tax expense	(34,912)	43	9
10	Nonallowable auto expense	(7,258)	43	10
11	Medicare Lab	(14,674)	43	11
12	Medicare X-Ray	(2,359)	43	12
13	Directors' health, disability & life insurance	(1,892)	43	13
14	PAC contributions	(5,196)	20	14
15	IHCA PAC Expenses	(672)	43	15
16	Bad Debt	(14,350)	43	16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(143,201)		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 MacCauley	6.25					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

YES

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	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		\$			\$	\$ *		14

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

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

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	\$ 252,681	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)	1,806	18(3)	5
6	Jeff Thompson	Director	Administrative	6.25	None	40+	100.00	Dir. Fees (A)	1,806	18(3)	6
7	Shelly MacCauley	Director	Administrative	6.25	None	<1	<2%	Dir. Fees (A)	1,806	18(3)	7
8	William Parker	Director	Administrative	0.00	None	<1	<2%	Dir. Fees (A)	1,805	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	\$ 345,224		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 # 0017996 Report Period Beginning: 1/1/12 Ending: 12/31/12

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				N/A		\$	\$			1
2										2
3										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	Construction Loan	None	9/18/10	\$ 40,000	\$	Demand	0.0525	\$ 21,695	1	
2	City National Bank		X	Mortgage Note Payable	\$7,683.40	6/15/12	1,000,000	976,551	6/15/27	0.0450	18,784	2	
3	Wells Fargo Dealer Services		X	Auto Loan	\$548.80	10/24/12	39,416	38,416	10/24/17			3	
4												4	
5												5	
	Working Capital												
6	Sam Thompson	X		Working Capital	Demand	3/20/12	50,000	50,000	3/19/13	0.0450	2,250	6	
7	City National Bank		X	Working Capital	Monthly	3/20/12	337,000	337,000	3/19/13	0.0450	3,670	7	
8												8	
9	TOTAL Facility Related				\$8,232.20		\$ 1,466,416	\$ 1,401,967			\$ 46,399	9	
	B. Non-Facility Related*												
10	TD Auto Finance		X	Vehicle Purchase	\$622.19	12/18/12	40,189	40,189	12/18/17	0.0364	124	10	
11								Interest income offset			(4,084)	11	
12												12	
13								Disallow non-care related interest			(124)	13	
14	TOTAL Non-Facility Related				\$622.19		\$ 40,189	\$ 40,189			\$ (4,084)	14	
15	TOTALS (line 9+line14)						\$ 1,506,605	\$ 1,442,156			\$ 42,315	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

1. Real Estate Tax accrual used on 2011 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	38,776	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.)		2011		\$	40,631	2																			
3. Under or (over) accrual (line 2 minus line 1).				\$	1,855	3																			
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	40,630	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.				\$	42,485	7																			
Real Estate Tax History:																									
Real Estate Tax Bill for Calendar Year:	2007	48,255	8	<table border="1"> <tr> <td colspan="3">FOR BHF USE ONLY</td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2011</td> <td>\$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td>\$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6</td> <td>\$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td>\$</td> <td>16</td> </tr> </table>			FOR BHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2011	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
FOR BHF USE ONLY																									
13	FROM R. E. TAX STATEMENT FOR 2011	\$	13																						
14	PLUS APPEAL COST FROM LINE 5	\$	14																						
15	LESS REFUND FROM LINE 6	\$	15																						
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																						
	2008	45,848	9																						
	2009	37,073	10																						
	2010	38,776	11																						
	2011	40,631	12																						
Accrual based on prior year real estate tax bill.																									

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.**

2011 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 2011 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 2011.

(A)		(B)	(C)	(D)
Tax Index Number		Property Description	Total Tax	Tax Applicable to Nursing Home
1.	08-01-448-004	Nursing Facility	\$ 280.00	\$ 280.00
2.	08-01-448-005	Nursing Facility	\$ 270.00	\$ 270.00
3.	08-01-448-008	Nursing Facility	\$ 1,177.00	\$ 1,177.00
4.	08-01-450-999	Nursing Facility	\$ 38,903.00	\$ 38,903.00
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
TOTALS			\$ 40,630.00	\$ 40,630.00

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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.**

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: N/A
(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	Resident Care	185,500	1972	\$ 5,000	1
2	Resident Care	193,500	2002	95,000	2
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	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	456,493	6
7	5			1993	598,429	15,344	30	19,948	4,604	388,986	7
8				1994	13,658	350	30	455	105	8,625	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	26,546	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	11,860	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

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		10			674	38
39	Kitchen plumbing	1997	1,947	50	20	97	47	1,504	39
40	Tile floor	1997	784		10			784	40
41	Water softener	1997	667		10			667	41
42	Interior design	1997	1,245	32	15	41	9	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	11,960	46
47									47
48	Roof - Section B	2000	31,346	436	20	1,567	1,131	19,229	48
49									49
50	New laundry building	2001	179,249	4,596	20	8,962	4,366	103,524	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	48,618	52
53									53
54	Design & remodel dining room	2002	97,732	2,506	40	2,443	(63)	25,652	54
55	Flooring	2002	39,834		10	3,683	3,683	38,821	55
56	Blinds	2002	2,473		10	126	126	2,473	56
57	Awning	2002	996		10	46	46	996	57
58	Walk in cooler repair	2002	3,361	105	10	169	64	3,361	58
59	Lighting	2002	2,563		10	131	131	2,563	59
60									60
61	Flooring	2003	871	27	10	87	60	827	61
62	Entryway Carpeting	2003	2,367	74	10	237	163	2,251	62
63									63
64									64
65									65
66									66
67	Flooring	2004	18,000		10	1,800	1,800	15,300	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,499,386	\$ 46,238		\$ 65,994	\$ 19,756	\$ 1,940,983	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:

1/1/12

Ending:

12/31/12

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	\$ 46,238		\$ 65,994	\$ 19,756	\$ 1,940,983	1
2	Flooring	2005	22,140		10	2,214	2,214	14,391	2
3	Drywall Hallways in A&D Wings & Various Resident Rooms	2005	19,233		10	1,923	1,923	14,423	3
4									4
5	Shelving unit for kitchen	2006	2,377		7	340	340	2,210	5
6	Drywall	2006	3,325	230	15	222	(8)	1,443	6
7	Air conditioning unit	2006	5,091	636	7	727	91	4,726	7
8	Flooring	2006	2,572	321	7	367	46	2,385	8
9									9
10	Air Conditioners Unit	2007	8,325		7	1,190	1,190	6,545	10
11	New Flooring/Shelving Units	2007	4,616		7	659	659	3,624	11
12	Instalation of new lighting fixtures	2007	2,966		7	424	424	2,332	12
13	Repair to Laundry and Dishwasher Equip	2007	3,784		7	540	540	2,970	13
14	Additions to wandreguard & alarm system	2007	5,618		7	804	804	4,062	14
15									15
16	New flooring	2008	4,318	377	7	617	240	2,203	16
17									17
18	Flooring	2009	6,993	1,713	7	999	(714)	3,603	18
19	Replacement Roof	2009	40,000	2,667	15	2,667		9,334	19
20	HVAC Units	2009	2,591	634	7	370	(264)	1,295	20
21									21
22	Installation Exp for Electric & Gas Line for Generator	2010	8,165	1,693	7	1,166	(527)	2,389	22
23	Flooring	2010	4,191	599	7	599		1,498	23
24	Replacement Roof	2010	25,392	1,166	15	1,693	527	4,758	24
25									25
26	Water Heater	2011	12,126	726	5	2,426	1,700	3,639	26
27	Mechanical Lifts	2011	7,623	181	7	1,088	907	1,632	27
28	Flooring	2011	2,700	32	7	286	254	479	28
29									29
30	32 Bed Addition - 18,000 sq ft	2012	2,000,442	81,428	39	25,647	(55,781)	25,647	30
31	Architect Fees for 32 Bed Addition - 18,000 sq ft	2012	361,088	14,698	39	4,629	(10,069)	4,629	31
32									32
33	Adjustment to Agree to Current Depreciation			21,688			(21,688)		33
34	TOTAL (lines 1 thru 33)		\$ 5,055,062	\$ 175,027		\$ 117,591	\$ (57,436)	\$ 2,061,200	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	\$ 200,821	\$ 10,983	\$ 25,932	\$ 14,949	5-7	\$ 102,642	71
72	Current Year Purchases	156,874	16,434	11,520	(4,914)	5-7	11,520	72
73	Fully Depreciated Assets	732,400					732,400	73
74								74
75	TOTALS	\$ 1,090,095	\$ 27,417	\$ 37,452	\$ 10,035		\$ 846,562	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	3,293	78
79	Resident Care	Buick Enclave	2012	39,513		3,951	3,951	5	3,951	79
80	TOTALS			\$ 83,494	\$	\$ 6,146	\$ 6,146		\$ 40,248	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)	\$ 6,328,651	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 202,444	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 161,189	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (41,255)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,948,010	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	4,019	4,019	89
90	Land	67,912			90
91	TOTALS	\$ 281,873	\$ 4,019	\$ 177,791	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.

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:				\$ N/A			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-

9. Option to Buy:
- ☐ YES☐ NO
- Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$ 14,305
- 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

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.	/2013	\$
13.	/2014	\$
14.	/2015	\$

* 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
12/31/2012

Supplementary Information
Schedule 14A

Equipment Rental Lease

Rent a/c 01-456	Amount
Phone System	6,000.00
Postage Machine	0.00
Ice Machines	212.00
Propane Gas Tanks	108.00
Total per General Ledger	<u>6,320.00</u>
Dietary Equip Rental a/c 03-552	
Dish Machine	<u>3,237.00</u>
Nursing Equip Rental a/c 06-712	
KCI mattress rental	<u>0.00</u>
Nursing Oxygen and Rental a/c 06-722	
Oxygen Rental	2,335.00
Oxygen Supplies	2,413.00
Concentrators	0.00
Total	<u>4,748.00</u>
TOTAL Schedule XII B 16	<u>14,305.00</u>

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

☒ 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

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

In the box below record the amount of income your facility received training CNAs from other facilities.

		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)	\$			

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.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(1)	4186 hrs	\$ 152,133		\$	\$	4,186	\$ 152,133	1
2	Licensed Speech and Language Development Therapist	39(1)	1558 hrs	56,586				1,558	56,586	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(1)	3063 hrs	118,589				3,063	118,589	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				167,705		167,705	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>VA Lab</u>	39(3)				275			275	12
13	Other (specify): <u>VA Physician/Podiatrist</u>	39(3)				5,171			5,171	13
14	TOTAL			\$ 327,308		\$ 5,446	\$ 167,705	8,807	\$ 500,459	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.

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	\$ 3,000	\$ 3,000	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance zero)	1,955,120	1,955,120	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	28,821	28,821	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,986,941	\$ 1,986,941	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	3,802,547	2,538,706	14
15	Leasehold Improvements, at Historical Cost	2,585,503	2,516,356	15
16	Equipment, at Historical Cost		1,173,589	16
17	Accumulated Depreciation (book methods)	(2,984,467)	(2,948,010)	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			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,571,495	\$ 3,380,641	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,558,436	\$ 5,367,582	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 352,669	\$ 352,669	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	387,000	387,000	29
30	Accrued Salaries Payable	116,360	116,360	30
31	Accrued Taxes Payable (excluding real estate taxes)	25,476	25,476	31
32	Accrued Real Estate Taxes(Sch.IX-B)	40,630	40,630	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	374,926	374,926	36
37	Deferred Income-Resident Liability	226,506	226,506	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,523,567	\$ 1,523,567	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	78,605	78,605	39
40	Mortgage Payable	976,551	976,551	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)	\$ 1,055,156	\$ 1,055,156	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,578,723	\$ 2,578,723	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,979,713	\$ 2,788,859	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,558,436	\$ 5,367,582	48

*(See instructions.)

XV. Balance Sheet

Line 23 (Other)

Employee Advances

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	-	-
	<u>-</u>	<u>-</u>
	<u><u>-</u></u>	<u><u>-</u></u>

Line 36 (Other Current Liabilities)

Payroll withholdings	18,841	18,841
Due to DHFS - Coinsurance	168,522	168,522
Other Accrued Expenses	-	-
Accrued Licensed Bed Tax	<u>187,563</u>	<u>187,563</u>
	<u><u>374,926</u></u>	<u><u>374,926</u></u>

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,830,224	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,830,224	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	410,260	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	260,771	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)	\$ 149,489	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)	\$ 2,979,713	24 *

* This must agree with page 17, line 47.

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

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		2
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,093,733	1
2	Discounts and Allowances for all Levels	615,361	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,709,094	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	844	5
6	Therapy	331,288	6
7	Oxygen	907	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 333,039	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	237,830	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	26,684	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 264,514	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,084	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,084	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Income	790	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 790	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,311,521	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,144,546	31
32	Health Care	2,180,031	32
33	General Administration	1,271,116	33
	B. Capital Expense		
34	Ownership	305,757	34
	C. Ancillary Expense		
35	Special Cost Centers	629,582	35
36	Provider Participation Fee	370,229	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,901,261	40
41	Income before Income Taxes (line 30 minus line 40)**	410,260	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 410,260	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,486,150	44
45	Private Pay - Net Inpatient Revenue	1,763,458	45
46	Medicare - Net Inpatient Revenue	1,136,502	46
47	Other-(specify) <u>VA</u>	322,984	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,709,094	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.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,080	2,080	\$ 62,981	\$ 30.28	1
2	Assistant Director of Nursing	2,080	2,080	32,752	15.75	2
3	Registered Nurses	11,131	11,131	244,682	21.98	3
4	Licensed Practical Nurses	29,278	29,278	501,987	17.15	4
5	CNAs & Orderlies	107,978	107,978	995,996	9.22	5
6	CNA Trainees					6
7	Licensed Therapist	8,807	8,807	327,308	37.16	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,484	1,484	16,468	11.10	9
10	Activity Assistants	3,725	3,725	31,861	8.55	10
11	Social Service Workers	3,868	3,868	67,858	17.54	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	36,624	17.61	13
14	Head Cook	9,493	9,493	81,821	8.62	14
15	Cook Helpers/Assistants	6,741	6,741	58,184	8.63	15
16	Dishwashers	5,242	5,242	44,783	8.54	16
17	Maintenance Workers	4,160	4,160	80,199	19.28	17
18	Housekeepers	20,136	20,136	180,641	8.97	18
19	Laundry	11,798	11,798	111,273	9.43	19
20	Administrator	2,168	2,168	66,003	30.44	20
21	Assistant Administrator					21
22	Other Administrative	2,080	2,080	252,681	121.48	22
23	Office Manager	2,080	2,080	40,040	19.25	23
24	Clerical	5,784	5,784	74,752	12.92	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Marketing Dir.</u>	2,080	2,080	28,662	13.78	33
34	TOTAL (lines 1 - 33)	244,273	244,273	\$ 3,337,556 *	\$ 13.66	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 9,390	1(3)	35
36	Medical Director	Monthly	7,200	9(3)	36
37	Medical Records Consultant	Quarterly	1,430	10(3)	37
38	Nurse Consultant		56	10(3)	38
39	Pharmacist Consultant	Monthly	1,438	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	Physician Consultant	Monthly	12,000	10(3)	47
48					48
49	TOTAL (lines 35 - 48)		\$ 31,514		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

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

** See instructions.

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

- (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 - \$8,400, AHCA \$110
- (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?

7 yrs
- (6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$

48,923

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.

\$

370,229

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.

\$

14,600

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 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.