FOR BHF USE

LL1

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.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0045690

Facility Name: Fireside House of Centralia

Address: 1030 Martin Luther King (Number) Centralia (City) 62801 (Zip Code)

County: Marion

Telephone Number: (618) 532-1833 **Fax #** (618) 532-1308

HFS ID Number:

Date of Initial License for Current Owners: 01/29/2002

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Daren Douston **Telephone Number:** (770) 870-2859
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 01/01/2010 to 12/31/2010 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) Douglas Mittleider
(Title) President of Management Company

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Matthew Larson, Reimbursement Analyst
(Firm Name & Address) AltaCare Corporation, 5895 Windward Parkway, Alpharetta, GA 30005
(Telephone) (770) 870-2881 Fax # (770) 619-0262

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 Fireside House of Centralia # 0045690 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 _____

	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	51	Skilled (SNF)	51	18,615	1
2		Skilled Pediatric (SNF/PED)			2
3	47	Intermediate (ICF)	47	17,155	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	98	TOTALS	98	35,770	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	1,092	751	6,067	7,910	8
9	SNF/PED					9
10	ICF	17,331	1,453	3	18,787	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,423	2,204	6,070	26,697	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.64%

D. How many bed-hold days during this year were paid by the Department?
0 (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)

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1/29/2002

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 1/29/2002 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 51 and days of care provided _____

Medicare Intermediary Wisconsin Physicians Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number Fireside House of Centralia # 0045690 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	150,854	20,967	8,639	180,460		180,460		180,460			1
2	Food Purchase		163,867		163,867		163,867		163,867			2
3	Housekeeping	98,382	9,808		108,190		108,190		108,190			3
4	Laundry	68,131	10,249		78,380		78,380		78,380			4
5	Heat and Other Utilities			115,826	115,826		115,826	(235)	115,591			5
6	Maintenance	34,679	8,824	23,550	67,053		67,053		67,053			6
7	Other (specify):* Trash/Recylcing			9,871	9,871	14,982	24,853		24,853			7
8	TOTAL General Services	352,046	213,715	157,886	723,647	14,982	738,629	(235)	738,394			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,346,849	97,722	16,024	1,460,595	(14,982)	1,445,613		1,445,613			10
10a	Therapy	338,915	43	(66,685)	272,273		272,273		272,273			10a
11	Activities	35,320	3,153	3,474	41,947		41,947		41,947			11
12	Social Services	18,188		2,003	20,191		20,191		20,191			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,739,272	100,918	(33,184)	1,807,006	(14,982)	1,792,024		1,792,024			16
	C. General Administration											
17	Administrative	74,150			74,150	13,294	87,444		87,444			17
18	Directors Fees											18
19	Professional Services			318,652	318,652		318,652	(313,292)	5,360			19
20	Dues, Fees, Subscriptions & Promotions			12,330	12,330		12,330	(421)	11,909			20
21	Clerical & General Office Expenses	175,916	12,571	26,446	214,933	(13,294)	201,639	35,735	237,374			21
22	Employee Benefits & Payroll Taxes			382,476	382,476		382,476	135,752	518,228			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,285	2,285		2,285	820	3,105			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			61,563	61,563		61,563	22,083	83,646			26
27	Other (specify):*			55,459	55,459		55,459	(55,459)				27
28	TOTAL General Administration	250,066	12,571	859,211	1,121,848		1,121,848	(174,782)	947,066			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,341,384	327,204	983,913	3,652,501		3,652,501	(175,017)	3,477,484			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 Fireside House of Centralia #0045690 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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			91,073	91,073		91,073	3,519	94,592			30
31	Amortization of Pre-Op. & Org.			22,236	22,236		22,236	859	23,095			31
32	Interest			315,470	315,470		315,470	(63,417)	252,053			32
33	Real Estate Taxes			78,000	78,000		78,000	3,014	81,014			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			21,009	21,009		21,009	812	21,821			35
36	Other (specify):*											36
37	**TOTAL Ownership**			527,788	527,788		527,788	(55,213)	472,575			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			2,993	2,993		2,993	(2,993)				38
39	Ancillary Service Centers		291,263	11,778	303,041		303,041	(8,793)	294,248			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			53,655	53,655		53,655		53,655			42
43	Other (specify):*			21,906	21,906		21,906		21,906			43
44	**TOTAL Special Cost Centers**		291,263	90,332	381,595		381,595	(11,786)	369,809			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,341,384	618,467	1,602,033	4,561,884		4,561,884	(242,016)	4,319,868			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 Fireside House of Centralia # 0045690 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 Reference	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	(235)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(72,795)	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)	(46)	27		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(26,675)	21		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	(7,650)	27		24
25	Fund Raising, Advertising and Promotional	(1,635)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(50,310)	27		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(10,937)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (170,283)		$	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)	(71,733)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (71,733)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (242,016)		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.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Fireside House of Centralia

ID# 0045690

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Dues-Chamber of Commerce	$ (378)	20	1
2	Prior Year Expense-Workers Comp	(1,063)	22	2
3	Prior Year Expense	1,194	27	3
4	Prior Year Expense Ancillaries	(8,793)	39	4
5	Money Received for Copies	(257)	21	5
6	Medical Transportation	(2,993)	38	6
7	Prior Year Expense-Non Op	1,352	27	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
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25				25
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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**	(10,937)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Fireside House of Centralia # 0045690 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(235)	0	0	0	0	0	0	0	0	0	0	(235)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(235)	0	0	0	0	0	0	0	0	0	0	(235)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(313,292)	0	0	0	0	0	0	0	0	0	(313,292)	19
20	Fees, Subscriptions & Promotions	(2,013)	1,592	0	0	0	0	0	0	0	0	0	(421)	20
21	Clerical & General Office Expenses	(26,932)	62,668	0	0	0	0	0	0	0	0	0	35,736	21
22	Employee Benefits & Payroll Taxes	(1,063)	136,814	0	0	0	0	0	0	0	0	0	135,752	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	820	0	0	0	0	0	0	0	0	0	820	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	22,083	0	0	0	0	0	0	0	0	0	22,083	26
27	Other (specify):*	(55,460)	0	0	0	0	0	0	0	0	0	0	(55,460)	27
28	**TOTAL General Administration**	(85,467)	(89,315)	0	0	0	0	0	0	0	0	0	(174,782)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(85,702)	(89,315)	0	0	0	0	0	0	0	0	0	(175,017)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Fireside House of Centralia # 0045690 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	0	3,519	0	0	0	0	0	0	0	0	0	3,519	30
31	Amortization of Pre-Op. & Org.	0	859	0	0	0	0	0	0	0	0	0	859	31
32	Interest	(72,795)	9,378	0	0	0	0	0	0	0	0	0	(63,417)	32
33	Real Estate Taxes	0	3,014	0	0	0	0	0	0	0	0	0	3,014	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	812	0	0	0	0	0	0	0	0	0	812	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(72,795)	17,582	0	0	0	0	0	0	0	0	0	(55,213)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	(2,993)	0	0	0	0	0	0	0	0	0	0	(2,993)	38
39	Ancillary Service Centers	(8,793)	0	0	0	0	0	0	0	0	0	0	(8,793)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(11,786)	0	0	0	0	0	0	0	0	0	0	(11,786)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(170,283)	(71,733)	0	0	0	0	0	0	0	0	0	(242,016)	45

Facility Name & ID Number Fireside House of Centralia # 0045690 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
LTC of Illinois - Fireside, Inc.	100%	LTC of Illinois - Friendship house of Centralia	Centralia	AltaCare Corp	Alpharetta	LTC Mgt/Accting

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. [X] 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)	
1	V	19	Accounting Fees	$ 33,792	AltaCare Corporation	100.00%	$	$ (33,792)	1
2	V	19	Management Fees	280,915	AltaCare Corporation	100.00%		(280,915)	2
3	V	19	Non-related Professional Fees		AltaCare Corporation	100.00%	1,415	1,415	3
4	V	20	Dues, Fees, Subs and Promos		AltaCare Corporation	100.00%	1,592	1,592	4
5	V	21	Clerical and Gen Office Exp		AltaCare Corporation	100.00%	62,668	62,668	5
6	V	22	Employee Benefits & Taxes		AltaCare Corporation	100.00%	136,814	136,814	6
7	V	24	Travel & Seminars		AltaCare Corporation	100.00%	820	820	7
8	V	26	Liability Insurance		AltaCare Corporation	100.00%	22,083	22,083	8
9	V	30	Depreciation		AltaCare Corporation	100.00%	3,519	3,519	9
10	V	31	Amortization		AltaCare Corporation	100.00%	859	859	10
11	V	32	Non Related Interest		AltaCare Corporation	100.00%	9,378	9,378	11
12	V	33	Real Estate Taxes		AltaCare Corporation	100.00%	3,014	3,014	12
13	V	35	Rental Equip & Vehicles		AltaCare Corporation	100.00%	812	812	13
14	Total			$ 314,707			$ 242,974	$ * (71,733)	14

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

Facility Name & ID Number Fireside House of Centralia # 0045690 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		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 Fireside House of Centralia # 0045690 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

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 [X] NO [ ]

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

Name of Related Organization: AltaCare Corporation
Street Address: 5895 Windward Parkway Suite 200
City / State / Zip Code: Alpharetta, GA 30005
Phone Number: (770) 619-0866
Fax Number: (770) 619-0262

	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	19	Management fees	Total Costs	117,524,875	31	$ 5,806,613	$ 3,974,482	4,561,884	$ 225,391	1
2	32	Capital	Total Costs	117,524,875	31	452,972		4,561,884	17,583	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					$ 6,259,585	$ 3,974,482		$ 242,974	25

Facility Name & ID Number Fireside House of Centralia # 0045690 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	Zeigler HealthCare		X	Refinancing Loan	variable	8/31/2007	$ 3,787,104	$ 3,596,145	8/20/2012	5.6190	$ 261,718	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Zeigler HealthCare		X	AR Financing		8/19/2007	349,672	342,825	8/20/2012	15.0000	51,854	6
7	Insurance		X	Laibility, WC, Prop & Auto			variable			variable	1,898	7
8												8
9	TOTAL Facility Related						$ 4,136,776	$ 3,938,970			$ 315,470	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 4,136,776	$ 3,938,970			$ 315,470	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** 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 Fireside House of Centralia **#** 0045690 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	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.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 76,971	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.		$ 76,971	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005		8
2006		9
2007		10
2008		11
2009	76,971	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Fireside House of Centralia COUNTY Marion

FACILITY IDPH LICENSE NUMBER 0045690

CONTACT PERSON REGARDING THIS REPORT Daren Douston

TELEPHONE (770) 870-2859 FAX #: (770) 619-0262

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-17-100-006	PT SW NE NW	$ 76,971.22	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 76,971.22	$

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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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 Fireside House of Centralia # 0045690 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 29,800 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. [ ] (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).

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

1. Total Amount Incurred: 25,000
2. Number of Years Over Which it is Being Amortized: 30 years
3. Current Period Amortization:
4. Dates Incurred: 2002

Nature of Costs:
(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		162,206	2002	$ 32,463	1
2					2
3	TOTALS	162,206		$ 32,463	3

Facility Name & ID Number Fireside House of Centralia # 0045690 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	98		2002	1963	$ 2,921,637	$ 73,067	40	$ 73,067	$	$ 649,824	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Parking lot resurface - Howell Asphalt			2002	16,687	1,112	15	1,112		9,363	9
10	Reroof w/ dura-last roof system-Master Const Co			2008	71,832	1,796	40	1,796		5,088	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											25
26											26
27											27
28											28
29											29
30											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 Fireside House of Centralia # 0045690 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
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									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,010,156	$ 75,975		$ 75,975	$	$ 664,275	70

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

Facility Name & ID Number Fireside House of Centralia # 0045690 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 315,886	$ 14,609	$ 14,609	$	5,7&10	$ 255,072	71
72	Current Year Purchases	7,340	489	489		5	489	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 323,226	$ 15,098	$ 15,098	$		$ 255,561	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	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)	$ 3,365,845	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 91,073	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 91,073	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 919,836	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		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

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

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

Facility Name & ID Number Fireside House of Centralia # 0045690 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
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							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.	/2011	$
13.	/2012	$
14.	/2013	$

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

15. Is Movable equipment rental included in building rental? ☒ YES ☐ NO
16. Rental Amount for movable equipment: $ 21,009 Description: Copier $5133, Therapy Equip $15876
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

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

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

Facility Name & ID Number Fireside House of Centralia # 0045690 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

   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 Fireside House of Centralia

STATE OF ILLINOIS
0045690 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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-1,2&3	3533	hrs	$ 97,936		$	$ 11	3,533	$ 97,947	1
2	Licensed Speech and Language Development Therapist	10A-1,2&3	1790	hrs	72,108				1,790	72,108	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10A-1,2&3	6308	hrs	168,872			32	6,308	168,904	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy			# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify):										12
13	Other (specify):										13
14	TOTAL				$ 338,916		$	$ 43	11,631	$ 338,959	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 Fireside House of Centralia # 0045690 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2010 (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	$ 9,027	$	1
2	Cash-Patient Deposits	10,222		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	426,696		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	8,680		6
7	Other Prepaid Expenses	1,244		7
8	Accounts Receivable (owners or related parties)	2,677,569		8
9	Other(specify):	1,075,559		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,208,997	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	32,463		13
14	Buildings, at Historical Cost	2,993,199		14
15	Leasehold Improvements, at Historical Cost	16,687		15
16	Equipment, at Historical Cost	291,825		16
17	Accumulated Depreciation (book methods)	(919,836)		17
18	Deferred Charges	37,864		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs	561,188		20
21	Restricted Funds	78,615		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,092,005	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,301,002	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,179,344	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	10,222		28
29	Short-Term Notes Payable	71,212		29
30	Accrued Salaries Payable	200,953		30
31	Accrued Taxes Payable (excluding real estate taxes)	311,311		31
32	Accrued Real Estate Taxes(Sch.IX-B)	78,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Bed Taxes	13,524		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,864,566	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	342,825		40
41	Bonds Payable	3,596,145		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)**	$ 3,938,970	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,803,536	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,497,466	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,301,002	$	48

***(See instructions.)**

Facility Name & ID Number Fireside House of Centralia # 0045690 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,377,441	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,377,441	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	120,024	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	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **rounding**	1	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 120,025	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)**	$ 1,497,466	24 *

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

Facility Name & ID Number Fireside House of Centralia # 0045690 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	$ 3,671,601	1
2	Discounts and Allowances for all Levels	878,359	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,549,960	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	54,142	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 54,142	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	235	15
16	Rental of Facility Space		16
17	Sale of Drugs	3,372	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	1,147	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 4,754	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	72,795	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 72,795	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Money rcvd for Copying	257	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 257	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,681,908	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	723,647	31
32	Health Care	1,807,006	32
33	General Administration	1,121,848	33
	B. Capital Expense		
34	Ownership	527,788	34
	C. Ancillary Expense		
35	Special Cost Centers	327,940	35
36	Provider Participation Fee	53,655	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,561,884	40
41	**Income before Income Taxes (line 30 minus line 40)****	120,024	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 120,024	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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.**

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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	3,471	3,801	$ 124,026	$ 32.63	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,374	11,647	250,050	21.47	3
4	Licensed Practical Nurses	17,484	20,574	374,291	18.19	4
5	CNAs & Orderlies	39,344	58,962	584,059	9.91	5
6	CNA Trainees					6
7	Licensed Therapist	10,637	11,630	338,916	29.14	7
8	Rehab/Therapy Aides					8
9	Activity Director	3,023	3,471	35,320	10.18	9
10	Activity Assistants					10
11	Social Service Workers	1,388	1,614	18,188	11.27	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,101	16,378	150,854	9.21	15
16	Dishwashers					16
17	Maintenance Workers	1,885	2,071	34,679	16.75	17
18	Housekeepers	9,756	10,894	98,382	9.03	18
19	Laundry	7,109	7,754	68,131	8.79	19
20	Administrator	1,866	2,080	87,444	42.04	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,676	8,412	162,622	19.33	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	1,233	1,372	14,422	10.51	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	130,347	160,660	$ 2,341,384 *	$ 14.57	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	201	$ 8,639	1-3	35
36	Medical Director		12,000	9-3	36
37	Medical Records Consultant	29	1,457	10-3	37
38	Nurse Consultant	16	(415)	10-3	38
39	Pharmacist Consultant			39-3	39
40	Physical Therapy Consultant	1,913	(51,287)	10A-3	40
41	Occupational Therapy Consultant	432	(11,983)	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	85	(3,415)	10A-3	43
44	Activity Consultant	63	3,473	11.3	44
45	Social Service Consultant	36	2,002	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,775	$ (39,529)		49

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				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Dave Eifert	Administrator		$ 87,444
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 87,444

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Neimann & Parker	Legal	$ 160
AltaCare Corp	Accounting	33,792
AltaCare Corp	Management	280,915
PayDay USA	Payroll Processing	3,545
CT Corporation	Registered Agent	240
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 318,652

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 78,663
Unemployment Compensation Insurance	
FICA Taxes	216,586
Employee Health Insurance	81,397
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Dental Insurance	6
Life Insurance	2,255
Employee Appreciation/Parties	2,505
TOTAL (agree to Schedule V, line 22, col.8)	$ 381,412

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

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,204
Advertising: Employee Recruitment	243
Health Care Worker Background Check	2,914
(Indicate # of checks performed 204)	
Patient Background Checks	
Advertising	1,635
Health Dept Permit	75
Camber of Commerce	378
IHCA Dues	5,880
Less: Public Relations Expense	(1,635)
Non-allowable advertising	(378)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,316

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 2,079
In-State Travel	206
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,285

**See instructions.

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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													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

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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 - $5880

(3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report?

(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?

(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? 5-10 years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ Line

(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.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ 53,655
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. $ 0 Has any meal income been offset against related costs? No Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? Yes
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. $
c. What percent of all travel expense relates to transportation of nurses and patients?
d. Have vehicle usage logs been maintained? N/A
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?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name:

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes

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

Schedule V - Ancillary Expenses
Other: Line 43 Column 3

Radiology Consulting Fees

Consultant	Amount
BIOTECH X-RAY, INC.	3,652.30
GAMMA HEALTHCARE	416.66
ORTHOPAEDIC CENTER OF SO.IL	27.26
ST. MARY'S HOSPITAL	478.48
	4,575

Labratory Consulting Fees

Consultant	Amount
BIOTECH LABORATORY INC	15,962.52
CROSSROADS COMMUNITY HOSPITAL	26.29
GAMMA HEALTHCARE	1,187.00
GOOD SAMARITAN REGIONAL	55.32
ST. MARY'S HOSPITAL	100.38
	17,332

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Schedule XV - Balance Sheet
Other: Line 9 Column 1

Description	Amount
Note Rec - Sumter HCI	932,619.15
Interest Rec - HP/Hopewel	21,801.83
Interest Rec - HP/Operati	41,865.81
Interest Rec - Sumter HCI	79,272.67
	1,075,559