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.

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

I. IDPH License ID Number: 0045690

Facility Name: LTC of Illinois-Fireside dba Fireside House of Centralia

Address: 1030 Martin Luther King Drive (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: Matthew Larson **Telephone Number:** (404) 991-2430 ext 2036
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 01/01/2011 to 12/31/2011 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, Director of Reimbursement
(Firm Name & Address) Five Rivers Management, LLC. 10945 State Bridge Rd Ste401-470 Alpharetta, GA 30022
(Telephone) (404) 991-2430 ext 2036 Fax # (404) 991-2431

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 LTC of Illinois-Fireside dba Fireside House of Centralia # 0045690 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	528	907	6,050	7,485	8
9	SNF/PED					9
10	ICF	16,823	899	64	17,786	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,351	1,806	6,114	25,271	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.65%

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)
N/A

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 01/29/2002

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 01/29/2002 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 5,982

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2011 Fiscal Year: 12/31/2011

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

Facility Name & ID Number LTC of Illinois-Fireside dba Fireside House o # 0045690 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	150,025	20,872	7,515	178,412		178,412		178,412			1
2	Food Purchase		166,779		166,779		166,779	(274)	166,505			2
3	Housekeeping	108,611	13,385	(2,726)	119,270		119,270		119,270			3
4	Laundry	72,883	11,953		84,836		84,836		84,836			4
5	Heat and Other Utilities			118,429	118,429		118,429	(180)	118,249			5
6	Maintenance	45,022	19,055	34,473	98,550		98,550		98,550			6
7	Other (specify):* Trash/Recycling			10,223	10,223	21,021	31,244		31,244			7
8	TOTAL General Services	376,541	232,044	167,914	776,499	21,021	797,520	(454)	797,066			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,238,932	91,647	22,501	1,353,080	(21,021)	1,332,059		1,332,059			10
10a	Therapy	394,453		(19,957)	374,496		374,496		374,496			10a
11	Activities	27,605	3,142	2,267	33,014		33,014		33,014			11
12	Social Services	28,195		2,284	30,479		30,479		30,479			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,689,185	94,789	19,095	1,803,069	(21,021)	1,782,048		1,782,048			16
	C. General Administration											
17	Administrative	75,505			75,505	9,695	85,200		85,200			17
18	Directors Fees											18
19	Professional Services			338,469	338,469		338,469	(329,088)	9,381			19
20	Dues, Fees, Subscriptions & Promotions			15,187	15,187		15,187	(1,655)	13,532			20
21	Clerical & General Office Expenses	182,936	11,930	116,954	311,820	(9,695)	302,125	28,042	330,167			21
22	Employee Benefits & Payroll Taxes			373,303	373,303		373,303	133,625	506,928			22
23	Inservice Training & Education			424	424		424	152	576			23
24	Travel and Seminar			2,567	2,567		2,567	919	3,486			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			59,772	59,772		59,772	21,396	81,168			26
27	Other (specify):*			34,982	34,982		34,982	(34,982)	0			27
28	TOTAL General Administration	258,441	11,930	941,658	1,212,029		1,212,029	(181,591)	1,030,438			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,324,167	338,763	1,128,667	3,791,597		3,791,597	(182,045)	3,609,552			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 LTC of Illinois-Fireside dba Fireside House of Centralia #0045690 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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			92,612	92,612		92,612	3,615	96,227			30
31	Amortization of Pre-Op. & Org.			22,236	22,236		22,236	868	23,104			31
32	Interest			309,527	309,527		309,527	(63,701)	245,826			32
33	Real Estate Taxes			102,000	102,000		102,000	3,982	105,982			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			20,566	20,566		20,566	803	21,369			35
36	Other (specify):*											36
37	TOTAL Ownership			546,941	546,941		546,941	(54,433)	492,508			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			8,762	8,762		8,762	(8,762)				38
39	Ancillary Service Centers		279,444	7,789	287,233		287,233	(4,855)	282,378			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):*			10,511	10,511		10,511		10,511			43
44	TOTAL Special Cost Centers		279,444	80,717	360,161		360,161	(13,617)	346,544			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,324,167	618,207	1,756,325	4,698,699		4,698,699	(250,095)	4,448,604			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 LTC of Illinois-Fireside dba Fireside House of Centralia # 0045690 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(274)	2		4
5	Telephone, TV & Radio in Resident Rooms	(180)	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	(75,784)	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)	(199)	27		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(6,893)	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	(14,928)	27		24
25	Fund Raising, Advertising and Promotional	(1,211)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,955)	27		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(66,944)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (169,368)		$	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)	(80,728)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (80,728)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (250,096)		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

STATE OF ILLINOIS

LTC of Illinois-Fireside dba Fireside House of Centralia

ID# 0045690

Report Period Beginning: 01/01/2011

Ending: 12/31/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Chamber of Commerce Dues	$ (5,880)	20	1
2	Money Rcvd for Copying	(194)	21	2
3	Overdraft Fees	(30,353)	21	3
4	Prior Year Expense-Non Op	(23,758)	27	4
5	Prior Year Expense -Other	6,858	27	5
6	Medical Transportation	(8,762)	38	6
7	Prior Year Expense - Ancillaries	(4,855)	39	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				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**	(66,944)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number LTC of Illinois-Fireside dba Fireside House of Centralia # 0045690 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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	(274)	0	0	0	0	0	0	0	0	0	0	(274)	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	(180)	0	0	0	0	0	0	0	0	0	0	(180)	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**	(454)	0	0	0	0	0	0	0	0	0	0	(454)	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	(329,088)	0	0	0	0	0	0	0	0	0	(329,088)	19
20	Fees, Subscriptions & Promotions	(7,091)	5,436	0	0	0	0	0	0	0	0	0	(1,655)	20
21	Clerical & General Office Expenses	(37,440)	65,482	0	0	0	0	0	0	0	0	0	28,042	21
22	Employee Benefits & Payroll Taxes	0	133,625	0	0	0	0	0	0	0	0	0	133,625	22
23	Inservice Training & Education	0	152	0	0	0	0	0	0	0	0	0	152	23
24	Travel and Seminar	0	919	0	0	0	0	0	0	0	0	0	919	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	21,396	0	0	0	0	0	0	0	0	0	21,396	26
27	Other (specify):*	(34,982)	0	0	0	0	0	0	0	0	0	0	(34,982)	27
28	**TOTAL General Administration**	(79,513)	(102,078)	0	0	0	0	0	0	0	0	0	(181,591)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(79,967)	(102,078)	0	0	0	0	0	0	0	0	0	(182,045)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number LTC of Illinois-Fireside dba Fireside House of Centralia # 0045690 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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	3,615	0	0	0	0	0	0	0	0	0	3,615	30
31	Amortization of Pre-Op. & Org.	0	868	0	0	0	0	0	0	0	0	0	868	31
32	Interest	(75,784)	12,083	0	0	0	0	0	0	0	0	0	(63,701)	32
33	Real Estate Taxes	0	3,982	0	0	0	0	0	0	0	0	0	3,982	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	803	0	0	0	0	0	0	0	0	803	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(75,784)	20,548	803	0	0	0	0	0	0	0	0	(54,433)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	(8,762)	0	0	0	0	0	0	0	0	0	0	(8,762)	38
39	Ancillary Service Centers	(4,855)	0	0	0	0	0	0	0	0	0	0	(4,855)	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**	(13,617)	0	0	0	0	0	0	0	0	0	0	(13,617)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(169,368)	(81,530)	803	0	0	0	0	0	0	0	0	(250,095)	45

Facility Name & ID Number LTC of Illinois-Fireside dba Fireside House of Centralia # 0045690 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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
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	$ 34,860	AltaCare Corporation	100.00%	$	$ (34,860)	1
2	V	19	Management Fees	296,701	AltaCare Corporation	100.00%		(296,701)	2
3	V	19	Non-related Professional Fees		AltaCare Corporation	100.00%	2,473	2,473	3
4	V	20	Dues, Fees, Subs and Promos		AltaCare Corporation	100.00%	5,436	5,436	4
5	V	21	Clerical and Gen Office Exp		AltaCare Corporation	100.00%	65,482	65,482	5
6	V	22	Employee Benefits & Taxes		AltaCare Corporation	100.00%	133,625	133,625	6
7	V	23	In Svc Training & Education		AltaCare Corporation	100.00%	152	152	7
8	V	24	Travel & Seminars		AltaCare Corporation	100.00%	919	919	8
9	V	26	Liability Insurance		AltaCare Corporation	100.00%	21,396	21,396	9
10	V	30	Depreciation		AltaCare Corporation	100.00%	3,615	3,615	10
11	V	31	Amortization		AltaCare Corporation	100.00%	868	868	11
12	V	32	Non Related Interest		AltaCare Corporation	100.00%	12,083	12,083	12
13	V	33	Real Estate Taxes		AltaCare Corporation	100.00%	3,982	3,982	13
14	Total			$ 331,561			$ 250,031	$ * (81,530)	14

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

Facility Name & ID Number LTC of Illinois-Fireside dba Fireside House of Centralia # 0045690 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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)	
15	V	35	Rental Equip & Vehicles	$	AltaCare Corporation	100.00%	$ 803	$ 803	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 803	$ * 803	39

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

Facility Name & ID Number LTC of Illinois-Fireside dba Fireside House (# 0045690 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 LTC of Illinois-Fireside dba Fireside House of Centralia # 0045690 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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 ☐

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Management Fees	Total Costs	104,295,095	28	$ 5,093,729	$ 3,023,229	4,698,694	$ 229,482	1
2	32	Capital	Total Costs	104,295,095	28	473,930		4,698,694	21,351	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					$ 5,567,659	$ 3,023,229		$ 250,833	25

Facility Name & ID Number LTC of Illinois-Fireside dba Fireside House of # 0045690 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	$ 3,766,292	8/20/2012	5.6190	$ 259,407	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Zeigler HealthCare		X	AR Financing		8/19/2007	349,672	342,478	8/20/2012	15.0000	19,977	6
7	Insurance Financing		X	Liability, WC, Prop & Auto			variable			variable	2,599	7
8	Omni Care		X	Pharmacy Debt		12/1/2010	554,664	430,320	11/30/2015		27,543	8
9	TOTAL Facility Related						$ 4,691,440	$ 4,539,090			$ 309,526	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 4,691,440	$ 4,539,090			$ 309,526	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 LTC of Illinois-Fireside dba Fireside House of Centralia **#** 0045690 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	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 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 101,758	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.		$ 101,758	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2006		8
2007		9
2008		10
2009		11
2010	101,758	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2010	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME LTC of Illinois-Fireside dba Fireside House of Centralia COUNTY Marion

FACILITY IDPH LICENSE NUMBER 0045690

CONTACT PERSON REGARDING THIS REPORT Matthew Larson

TELEPHONE (404) 991-2430 ext. 2036 FAX #: (404) 991-2431

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

Enter the tax index number and real estate tax assessed for 2010 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-17-110-006	PT SW NE NW	$ 101,757.98	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 101,757.98	$

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number LTC of Illinois-Fireside dba Fireside House of Centralia # 0045690 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 LTC of Illinois-Fireside dba Fireside House of Centralia # 0045690 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	98		2002	1963	$ 2,896,517	$ 72,413	40	$ 72,413	$	$ 718,095	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Parking Lot Resurfacing			2002	16,687	1,112	15	1,112		10,476	9
10											10
11	Reroof w/ dura last roof system			2008	71,832	1,796	40	1,796		6,884	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 LTC of Illinois-Fireside dba Fireside House of Centralia # 0045690 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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			$	$		$	$	$	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)		$ 2,985,036	$ 75,321		$ 75,321	$	$ 735,455	70

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

Facility Name & ID Number LTC of Illinois-Fireside dba Fireside House of Centr # 0045690 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	$ 316,675	$ 13,826	$ 13,826	$	5,7$10	$ 273,529	71
72	Current Year Purchases	58,171	3,465	3,465		5,7&10	3,465	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 374,846	$ 17,291	$ 17,291	$		$ 276,994	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				$	$	$	$		$	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)	$ 3,392,345	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 92,612	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 92,612	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)	$ 1,012,449	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 LTC of Illinois-Fireside dba Fireside House of Centralia # 0045690 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ Description:
(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 LTC of Illinois-Fireside dba Fireside House of Centralia # 0045690 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 LTC of Illinois-Fireside dba Fireside House of Centralia # 0045690 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	5158	hrs	$ 136,691		$	$	5,158	$ 136,691	1
2	Licensed Speech and Language Development Therapist	10A 1,2&3	1630	hrs	67,738				1,630	67,738	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10A 1,2&3	7005	hrs	190,024				7,005	190,024	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				$ 394,453		$	$	13,793	$ 394,453	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 LTC of Illinois-Fireside dba Fireside House of Centralia # 0045690 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2011 (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	$ (178,983)	$	1
2	Cash-Patient Deposits	14,232		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,076,436		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	10,108		6
7	Other Prepaid Expenses	498		7
8	Accounts Receivable (owners or related parties)	3,429,766		8
9	Other(specify):	1,147,030		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,499,087	$	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	50,131		15
16	Equipment, at Historical Cost	316,552		16
17	Accumulated Depreciation (book methods)	(1,012,448)		17
18	Deferred Charges	15,628		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	580,416		21
22	Other Long-Term Assets (specify):	78,615		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,054,556	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 8,553,643	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,298,149	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	14,232		28
29	Short-Term Notes Payable	488,780		29
30	Accrued Salaries Payable	187,538		30
31	Accrued Taxes Payable (excluding real estate taxes)	310,400		31
32	Accrued Real Estate Taxes(Sch.IX-B)	102,000		32
33	Accrued Interest Payable	259,407		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Bed Taxes	40,425		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,700,931	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	342,630		39
40	Mortgage Payable	3,766,292		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)**	$ 4,108,922	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,809,853	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,743,789	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 8,553,642	$	48

*(See instructions.)

Facility Name & ID Number LTC of Illinois-Fireside dba Fireside House of Centralia # 0045690 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,497,466	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,497,466	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	246,323	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)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 246,323	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)**	$ 1,743,789	24 *

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

Facility Name & ID Number LTC of Illinois-Fireside dba Fireside House of Cent # 0045690 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	$ 3,575,866	1
2	Discounts and Allowances for all Levels	1,176,201	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,752,067	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	110,419	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 110,419	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	274	14
15	Telephone, Television and Radio	180	15
16	Rental of Facility Space		16
17	Sale of Drugs	2,642	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	7	19
20	Radiology and X-Ray	87	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 3,190	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	75,784	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 75,784	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28		3,557	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,557	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,945,017	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	776,498	31
32	Health Care	1,803,066	32
33	General Administration	1,212,028	33
	B. Capital Expense		
34	Ownership	546,941	34
	C. Ancillary Expense		
35	Special Cost Centers	306,506	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)***	$ 4,698,694	40
41	**Income before Income Taxes (line 30 minus line 40)****	246,323	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 246,323	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.**

Facility Name & ID Number LTC of Illinois-Fireside dba Fireside House of Centralia # 0045690 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	3,718	4,360	$ 118,597	$ 27.20	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,010	9,686	205,656	21.23	3
4	Licensed Practical Nurses	19,532	20,990	385,669	18.37	4
5	CNAs & Orderlies	49,427	53,374	517,985	9.70	5
6	CNA Trainees					6
7	Licensed Therapist	12,548	13,793	394,453	28.60	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,467	2,672	27,605	10.33	9
10	Activity Assistants					10
11	Social Service Workers	1,881	2,041	28,195	13.81	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,702	16,037	150,025	9.35	15
16	Dishwashers					16
17	Maintenance Workers	2,870	3,025	45,022	14.88	17
18	Housekeepers	10,863	12,123	108,611	8.96	18
19	Laundry	7,353	8,206	72,883	8.88	19
20	Administrator	1,863	2,080	85,200	40.96	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,728	8,743	173,241	19.81	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	976	1,083	11,024	10.18	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	144,938	158,213	$ 2,324,166 *	$ 14.69	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	167	$ 7,515	1-3	35
36	Medical Director		12,000	9-3	36
37	Medical Records Consultant	29	1,426	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,442	39-3	39
40	Physical Therapy Consultant	(725)	(19,704)	10A-3	40
41	Occupational Therapy Consultant	(7)	(191)	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	(1)	(62)	10A-3	43
44	Activity Consultant	41	2,267	11-3	44
45	Social Service Consultant	42	2,284	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	(456)	$ 7,975		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

Facility Name & ID Number LTC of Illinois-Fireside dba Fireside House of Centr # 0045690 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
David Eifert	Administrator	0	$ 85,200
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 85,200

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
AltaCare Corp	Management	$ 296,701
AltaCare Corp	Accounting	34,860
PayDayUSA	Payroll	3,438
Neimann & Parker	Legal	2,746
	Benefits Program Mgt	724
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 338,469

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 81,496
Unemployment Compensation Insurance	
FICA Taxes	217,558
Employee Health Insurance	68,928
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Dental Insurance	(318)
Life insurance	3,301
Employee Appreciation	2,337
TOTAL (agree to Schedule V, line 22, col.8)	$ 373,302

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	$ 3,585
Advertising: Employee Recruitment	1,051
Health Care Worker Background Check	3,460
(Indicate # of checks performed 105)	
Patient Background Checks	
Dues	5,880
Advertising Promotions	1,211
Less: Public Relations Expense	(5,880)
Non-allowable advertising	(1,211)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,096

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 891
In-State Travel	1,550
Seminar Expense	125
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,566

**See instructions.

Facility Name & ID Number LTC of Illinois-Fireside dba Fireside House of Centralia # 0045690 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number LTC of Illinois-Fireside dba Fireside House of Centralia **#** 0045690 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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? **Yes** Indicate the amount. $ **274**

(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?
e. Are all vehicles stored at the nursing home during the night and all other times when not in use?
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.

Facility Name & ID Number LTC of Illinois-Fireside dba Fireside House of Centralia 0045690 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

Schedule V - Ancillary Expenses
Other: Line 43 column 3

Radiology Consulting Fees

Consultant		
ACCUPATH DIAG DBA US LABS	$	183.95
BARNES JEWISH HOSPITAL	$	19.30
BIOMEDICAL IMAGING	$	500.93
CARDIOVASCULAR ASSOC OF S.A.	$	22.08
CARDIOVASCULAR SPECIALISTS	$	22.08
GAMMA HEALTHCARE	$	930.22
ORTHOPAEDIC CENTER OF SO.IL	$	450.90
PATHOLOGY SERVICES INC	$	55.24
SAJJAN K NEMANI M.C.,F.A.A.N	$	147.84
ST. MARY'S HOSPITAL	$	1,321.70
	$	3,654.24

Laboratory Consulting Fees

Consultant		
ANDERSON HOSPITAL	$	32.36
CROSSROADS COMMUNITY HOSPITAL	$	5.81
GAMMA HEALTHCARE	$	6,104.12
ST. MARY'S HOSPITAL	$	714.27
	$	6,856.56

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Schedule VX - Balance Sheet
Other: Line 9 Column 1

Description	Amount	
Note Rec - Sumter HCI	$	932,619.15
Interest Rec - HP/Hopewel	$	32,702.75
Interest Rec - HP/Operati	$	62,798.73
Interest Rec - Sumter HCI	$	118,909.03
	$	**1,147,029.66**

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