



Facility Name & ID Number Fireside House of Centralia# 0045690 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

## 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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>51</u>	Skilled (SNF)	<u>51</u>	<u>18,615</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>47</u>	Intermediate (ICF)	<u>47</u>	<u>17,155</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>98</u>	TOTALS	<u>98</u>	<u>35,770</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>1,009</u>	<u>11</u>	<u>6,497</u>	<u>7,517</u>	8
9	SNF/PED					9
10	ICF	<u>18,286</u>	<u>4,169</u>	<u>144</u>	<u>22,599</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>19,295</u>	<u>4,180</u>	<u>6,641</u>	<u>30,116</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.19%

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)

Meals with a MissionF. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 &amp; 4 include expenses for services or investments not directly related to patient care?

YES  NO 

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES  NO 

I. On what date did you start providing long term care at this location?

Date started 01/29/2002

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

YES  Date 01/29/2002 NO 

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

YES  NO  If YES, enter number of beds certified 51 and days of care provided \_\_\_\_\_Medicare Intermediary Wisconsin Physicians Services

## IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\* Is your fiscal year identical to your tax year? YES  NO Tax Year: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number      Fireside House of Centralia      #      0045690      Report Period Beginning:      01/01/2008      Ending:      12/31/2008

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	151,996	17,234	8,384	177,614		177,614		177,614		1
2	Food Purchase		173,222		173,222		173,222		173,222		2
3	Housekeeping	102,061	15,567		117,628		117,628		117,628		3
4	Laundry	72,991	13,659		86,650		86,650		86,650		4
5	Heat and Other Utilities			157,827	157,827		157,827	(865)	156,962		5
6	Maintenance	28,634	18,190	26,563	73,387		73,387		73,387		6
7	Other (specify):* <b>Trash Removal</b>			8,387	8,387		8,387		8,387		7
8	<b>TOTAL General Services</b>	<b>355,682</b>	<b>237,872</b>	<b>201,161</b>	<b>794,715</b>		<b>794,715</b>	<b>(865)</b>	<b>793,850</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	1,361,047	114,845	(20,493)	1,455,399		1,455,399		1,455,399		10
10a	Therapy	356,289	2,484	(30,724)	328,049		328,049		328,049		10a
11	Activities	30,442	2,845	1,923	35,210		35,210		35,210		11
12	Social Services	21,584		1,523	23,107		23,107		23,107		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>1,769,362</b>	<b>120,174</b>	<b>(35,771)</b>	<b>1,853,765</b>		<b>1,853,765</b>		<b>1,853,765</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	70,573			70,573	11,642	82,215		82,215		17
18	Directors Fees										18
19	Professional Services			352,240	352,240		352,240	(347,132)	5,108		19
20	Dues, Fees, Subscriptions & Promotions			10,486	10,486	3,973	14,459	454	14,913		20
21	Clerical & General Office Expenses	173,489	12,028	55,953	241,470	(15,615)	225,855	62,061	287,916		21
22	Employee Benefits & Payroll Taxes			397,965	397,965		397,965	149,569	547,534		22
23	Inservice Training & Education			567	567		567	220	787		23
24	Travel and Seminar			3,775	3,775		3,775	1,464	5,239		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			61,680	61,680		61,680	23,916	85,596		26
27	Other (specify):* <b>Franchise-Tax</b>			55,971	55,971		55,971	(55,471)	500		27
28	<b>TOTAL General Administration</b>	<b>244,062</b>	<b>12,028</b>	<b>938,637</b>	<b>1,194,727</b>		<b>1,194,727</b>	<b>(164,919)</b>	<b>1,029,808</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,369,106</b>	<b>370,074</b>	<b>1,104,027</b>	<b>3,843,207</b>		<b>3,843,207</b>	<b>(165,784)</b>	<b>3,677,423</b>		<b>29</b>

\*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: 01/01/2008 Ending: 12/31/2008

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>D. Ownership</b>										
30	Depreciation			114,590	114,590	114,590	13,232	127,822			30
31	Amortization of Pre-Op. & Org.			22,236	22,236	22,236	2,568	24,804			31
32	Interest			327,571	327,571	327,571	(314,659)	12,912			32
33	Real Estate Taxes			78,000	78,000	78,000	7,536	85,536			33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			17,068	17,068	17,068	1,949	19,017			35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			559,465	559,465	559,465	(289,374)	270,091			37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation			756	756	756	(756)				38
39	Ancillary Service Centers		329,518	8,842	338,360	338,360	(5,465)	332,895			39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			53,802	53,802	53,802		53,802			42
43	Other (specify):* <a href="#">See Page 24</a>			27,019	27,019	27,019		27,019			43
44	<b>TOTAL Special Cost Centers</b>		329,518	90,419	419,937	419,937	(6,221)	413,716			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,369,106	699,592	1,753,911	4,822,609	4,822,609	(461,379)	4,361,230			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: 01/01/2008

Ending: 12/31/2008

**VI. ADJUSTMENT DETAIL**

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(225)	22		4
5	Telephone, TV & Radio in Resident Rooms	(865)	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	(315,996)	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)	(296)	27		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(21,637)	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	(13,355)	27		24
25	Fund Raising, Advertising and Promotional	(1,692)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(49,759)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (403,825)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(57,554)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (57,554)		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (461,379)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY						
48		49		50		51
						52

Fireside House of Centralia

ID# 0045690

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Dues-Chamber of Commerce	\$ (378)	20	1
2	Prior Year Expenses	(41,820)	27	2
3	Reduce Property Tax to Accual	(1,471)	33	3
4	Money Received for Copying	(20)	35	4
5	Medical Transportation	(756)	38	5
6	Prior Year Ancillary Expense	(5,314)	39	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				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	<b>Total</b>	(49,759)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Fireside House of Centralia

# 0045690

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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

	Operating Expenses	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)	
	<b>A. General Services</b>													
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	(865)	0	0	0	0	0	0	0	0	0	0	(865)	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	<b>TOTAL General Services</b>	<b>(865)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(865)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
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	(347,132)	0	0	0	0	0	0	0	0	0	(347,132)	19
20	Fees, Subscriptions & Promotions	(2,070)	2,524	0	0	0	0	0	0	0	0	0	454	20
21	Clerical & General Office Expenses	(21,637)	83,698	0	0	0	0	0	0	0	0	0	62,061	21
22	Employee Benefits & Payroll Taxes	(225)	149,794	0	0	0	0	0	0	0	0	0	149,569	22
23	Inservice Training & Education	0	220	0	0	0	0	0	0	0	0	0	220	23
24	Travel and Seminar	0	1,464	0	0	0	0	0	0	0	0	0	1,464	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	23,916	0	0	0	0	0	0	0	0	0	23,916	26
27	Other (specify):*	(55,471)	0	0	0	0	0	0	0	0	0	0	(55,471)	27
28	<b>TOTAL General Administration</b>	<b>(79,403)</b>	<b>(85,516)</b>	<b>0</b>	<b>(164,919)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(80,268)</b>	<b>(85,516)</b>	<b>0</b>	<b>(165,784)</b>	<b>29</b>								

STATE OF ILLINOIS

Facility Name & ID Number Fireside House of Centralia

# 0045690

Report Period Beginning:

01/01/2008 Ending:

Summary B

12/31/2008

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	13,232	0	0	0	0	0	0	0	0	0	13,232	30
31	Amortization of Pre-Op. & Org.	0	2,568	0	0	0	0	0	0	0	0	0	2,568	31
32	Interest	(315,996)	1,337	0	0	0	0	0	0	0	0	0	(314,659)	32
33	Real Estate Taxes	(1,471)	0	9,007	0	0	0	0	0	0	0	0	7,536	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	(20)	0	1,969	0	0	0	0	0	0	0	0	1,949	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(317,487)</b>	<b>17,137</b>	<b>10,976</b>	<b>0</b>	<b>(289,374)</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	(756)	0	0	0	0	0	0	0	0	0	0	(756)	38
39	Ancillary Service Centers	(5,314)	(151)	0	0	0	0	0	0	0	0	0	(5,465)	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	<b>TOTAL Special Cost Centers</b>	<b>(6,070)</b>	<b>(151)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(6,221)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(403,825)</b>	<b>(68,530)</b>	<b>10,976</b>	<b>0</b>	<b>(461,379)</b>	<b>45</b>							

Facility Name & ID Number Fireside House of Centralia# 0045690Report Period Beginning: 01/01/2008 Ending: 12/31/2008

## 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
				HP/Ancillaries	Alpharetta	Med/Dietary Supplie

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	39 Medical Supplies	\$ 1,246	HP/Ancillaries	100.00%	\$ 1,095	\$ (151)	1
2	V	19 Accounting Fees	31,561	AltaCare Corporation	100.00%		(31,561)	2
3	V	19 Management Fees	316,998	AltaCare Corporation	100.00%		(316,998)	3
4	V	19 Non-Related Professional Fees		AltaCare Corporation	100.00%	1,427	1,427	4
5	V	20 Dues, Fees, Subs and Promos		AltaCare Corporation	100.00%	2,524	2,524	5
6	V	21 Clerical & Gen Office Exp		AltaCare Corporation	100.00%	83,698	83,698	6
7	V	22 Employee Benefits & Taxes		AltaCare Corporation	100.00%	149,794	149,794	7
8	V	23 Training & Education		AltaCare Corporation	100.00%	220	220	8
9	V	24 Travel & Seminars		AltaCare Corporation	100.00%	1,464	1,464	9
10	V	26 Liability Insurance		AltaCare Corporation	100.00%	23,916	23,916	10
11	V	30 Depreciation		AltaCare Corporation	100.00%	13,232	13,232	11
12	V	31 Amortization		AltaCare Corporation	100.00%	2,568	2,568	12
13	V	32 Non Related Interest		AltaCare Corporation	100.00%	1,337	1,337	13
14	Total		\$ 349,805			\$ 281,275	\$ * (68,530)	14

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

**VII. RELATED PARTIES (continued)**

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	33	Real Estate Taxes	\$	Alta Care Corporation	100.00%	\$ 9,007	\$ 9,007	15
16	V	35	Rent Equipment and Vehicles		Alta Care Corporation	100.00%	1,969	1,969	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			\$			\$ 10,976	\$ * 10,976	39

\* 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: 01/01/2008 Ending: 12/31/2008

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		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: 01/01/2008

Ending: 2/31/2008

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 AltaCare Corporation  
 Street Address 5895 Windward Pkwy, Suite 200  
 City / State / Zip Code Alpharetta, GA 30005  
 Phone Number ( 770) 619-0866  
 Fax Number ( 770) 619-0262

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	19	Management Fees	Total Costs	117,817,699	35	\$ 6,426,199	\$ 4,277,275	4,822,607	\$ 263,042	1
2	32	Capital	Total Costs	117,817,699	35	686,764		4,822,607	28,111	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					\$ 7,112,963	\$ 4,277,275		\$ 291,153	25

Facility Name &amp; ID Number

Fireside House of Centralia

# 0045690

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

## 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 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense		
		YES	NO				Original	Balance					
		<b>A. Directly Facility Related</b>											
<b>Long-Term</b>													
1	Zeigler Healthcare		X	Refinancing	variable	8/31/2007	\$ 3,787,104	\$ 3,700,246	8/20/2012	5.6190	\$ 272,989	1	
2												2	
3												3	
4												4	
5												5	
<b>Working Capital</b>													
6	Zeigler Healthcare		X	AR Financing		8/19/2007	349,672	347,016	8/20/2012	15.0000	52,354	6	
7	Insurance		X	Liability, WC, Prop & Crime			variable			variable	2,228	7	
8												8	
9	<b>TOTAL Facility Related</b>							\$ 4,136,776	\$ 4,047,262			\$ 327,571	9
<b>B. Non-Facility Related*</b>													
10												10	
11												11	
12												12	
13												13	
14	<b>TOTAL Non-Facility Related</b>							\$	\$			\$	14
15	<b>TOTALS (line 9+line14)</b>							\$ 4,136,776	\$ 4,047,262			\$ 327,571	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.)

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

B. Real Estate Taxes

<p><b>Important</b>, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																																				
1. Real Estate Tax accrual used on 2007 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 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ <b>76,529</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6																																	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ <b>76,529</b>	7																																	
Real Estate Tax History:																																				
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2003</td><td>_____</td><td>8</td></tr> <tr><td>2004</td><td>_____</td><td>9</td></tr> <tr><td>2005</td><td>_____</td><td>10</td></tr> <tr><td>2006</td><td>_____</td><td>11</td></tr> <tr><td>2007</td><td><b>76,529</b></td><td>12</td></tr> </table>	2003	_____	8	2004	_____	9	2005	_____	10	2006	_____	11	2007	<b>76,529</b>	12	<table border="1"> <tr><td colspan="2"><b>FOR BHF USE ONLY</b></td><td></td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2007</td><td>\$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5</td><td>\$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6</td><td>\$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION</td><td>\$</td><td>16</td></tr> </table>	<b>FOR BHF USE ONLY</b>			13	FROM R. E. TAX STATEMENT FOR 2007	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
2003	_____	8																																		
2004	_____	9																																		
2005	_____	10																																		
2006	_____	11																																		
2007	<b>76,529</b>	12																																		
<b>FOR BHF USE ONLY</b>																																				
13	FROM R. E. TAX STATEMENT FOR 2007	\$	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.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2008 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2007 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 \_\_\_\_\_

TELEPHONE ( ) \_\_\_\_\_ FAX #: ( ) \_\_\_\_\_

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

Enter the tax index number and real estate tax assessed for 2007 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 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>14-17-100-006</u>	<u>PT SW NE NW</u>	\$ <u>76,528.72</u>	\$ <u>76,528.72</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>76,528.72</u>	\$ <u>76,528.72</u>

**B. Real Estate Tax Cost Allocations**

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

If YES, attach an explanation & 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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

**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:

01/01/2008 Ending:

12/31/2008

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 29,800 B. General Construction Type: Exterior Brick Frame Concrete/Stucco Number of Stories 1

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

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

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

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

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

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

1. Total Amount Incurred: 25,000 2. Number of Years Over Which it is Being Amortized: 25000 for 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1		<u>162,206</u>	<u>2002</u>	<u>\$ 32,463</u>	1
2					2
3	<b>TOTALS</b>	<b>162,206</b>		<b>\$ 32,463</b>	<b>3</b>

Facility Name & ID Number Fireside House of Centralia

# 0045690

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

**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	\$ 2,921,367	\$ 73,067	40	\$ 73,067	\$	\$ 503,690	4
5											5
6											6
7											7
8											8
<b>Improvement Type**</b>											
9		Parking Lot Resurfacing-Howell Asphalt		2002	16,687	1,112	15	1,112		7,138	9
10		reroof w/ dural last roof sys-Master Const. Co		2008	71,832	1,496	40	1,496		1,496	10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
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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:

01/01/2008

Ending:

12/31/2008

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	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)	\$ 3,009,886	\$ 75,676		\$ 75,676	\$	\$ 512,325	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: 01/01/2008 Ending: 12/31/2008

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	\$ 244,527	\$ 35,127	\$ 35,127	\$	5,7 & 10	\$ 222,565	71
72	Current Year Purchases	48,062	3,787	3,787		5	3,787	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 292,589	\$ 38,914	\$ 38,914	\$		\$ 226,352	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)	\$	3,334,938	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	114,590	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	114,590	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)	\$	738,677	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.

**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	<b>TOTAL</b>				\$ _____			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending                      Annual Rent

12.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized \_\_\_\_\_  
by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental?  YES  NO

16. Rental Amount for movable equipment: \$ 17,068 Description: Copier\$3767, Postage Machine\$568, other small equip\$12733

(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	<b>TOTAL</b>		\$ _____	\$ _____	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.

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A-1,2&3	2697 hrs	\$ 76,574		\$	\$ 1,112	2,697	\$ 77,686	1
2	Licensed Speech and Language Development Therapist	10A-1,2&3	2269 hrs	101,821			114	2,269	101,935	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-1,2&3	6356 hrs	177,893			1,257	6,356	179,150	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	<b>TOTAL</b>			\$ 356,288		\$	\$ 2,484	11,322	\$ 358,772	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Fireside House of Centralia # 0045690 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2008 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (69,973)	\$	1
2	Cash-Patient Deposits	13,005		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	964,987		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	16,159		6
7	Other Prepaid Expenses	1,244		7
8	Accounts Receivable (owners or related parties)	1,811,091		8
9	Other(specify): <u>Note Rec-Sumter HCI</u>	932,619		9
	<b>TOTAL Current Assets</b>			
10	(sum of lines 1 thru 9)	\$ 3,669,132	\$	10
	<b>B. Long-Term Assets</b>			
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	304,588		16
17	Accumulated Depreciation (book methods)	(738,678)		17
18	Deferred Charges	95,328		18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	466,581		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
	<b>TOTAL Long-Term Assets</b>			
24	(sum of lines 11 thru 23)	\$ 3,170,168	\$	24
	<b>TOTAL ASSETS</b>			
25	(sum of lines 10 and 24)	\$ 6,839,300	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 788,183	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,005		28
29	Short-Term Notes Payable	154,916		29
30	Accrued Salaries Payable	186,480		30
	Accrued Taxes Payable (excluding real estate taxes)	89,186		31
32	Accrued Real Estate Taxes(Sch.IX-B)	154,529		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Accrued Bed Taxes</u>	39,955		36
37				37
	<b>TOTAL Current Liabilities</b>			
38	(sum of lines 26 thru 37)	\$ 1,426,254	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	347,016		39
40	Mortgage Payable	3,700,246		40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
	<b>TOTAL Long-Term Liabilities</b>			
45	(sum of lines 39 thru 44)	\$ 4,047,262	\$	45
	<b>TOTAL LIABILITIES</b>			
46	(sum of lines 38 and 45)	\$ 5,473,516	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 1,365,784	\$	47
	<b>TOTAL LIABILITIES AND EQUITY</b>			
48	(sum of lines 46 and 47)	\$ 6,839,300	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>905,091</b>	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>905,091</b>	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	460,694	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) <b>Rounding</b>	(1)	15
16	Other (describe)		16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>460,693</b>	17
	<b>B. Transfers (Itemize):</b>		
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,365,784</b>	24 *

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

Facility Name & ID Number Fireside House of Centralia

# 0045690

Report Period Beginning: 01/01/2008

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**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,769,982	1
2	Discounts and Allowances for all Levels	1,098,244	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 4,868,226</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	92,559	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 92,559</b>	8
<b>C. Other Operating Revenue</b>			
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	225	14
15	Telephone, Television and Radio	865	15
16	Rental of Facility Space		16
17	Sale of Drugs	4,104	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	258	19
20	Radiology and X-Ray	1,048	20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 6,500</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	315,996	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 315,996</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Money Received for copying</u>	20	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 20</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 5,283,301</b>	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	794,714	31
32	Health Care	1,853,764	32
33	General Administration	1,194,726	33
<b>B. Capital Expense</b>			
34	Ownership	559,465	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	366,135	35
36	Provider Participation Fee	53,802	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 4,822,606</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>460,695</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 460,695</b>	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 Fireside House of Centralia

# 0045690

Report Period Beginning: 01/01/2008

Ending:

12/31/2008

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,693	2,203	\$ 86,920	\$ 39.46	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,459	12,559	285,716	22.75	3
4	Licensed Practical Nurses	18,824	22,649	397,576	17.55	4
5	CNAs & Orderlies	53,849	64,792	587,657	9.07	5
6	CNA Trainees					6
7	Licensed Therapist	10,042	11,322	356,288	31.47	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,826	3,166	30,442	9.62	10
11	Social Service Workers	1,817	2,034	21,584	10.61	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,891	17,447	151,996	8.71	15
16	Dishwashers					16
17	Maintenance Workers	1,936	2,106	28,634	13.60	17
18	Housekeepers	10,195	12,147	102,061	8.40	18
19	Laundry	7,894	9,221	72,991	7.92	19
20	Administrator	1,766	2,058	82,527	40.10	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,275	8,486	161,535	19.04	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	292	306	3,178	10.39	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	142,759	170,496	\$ 2,369,105 *	\$ 13.90	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	195	\$ 8,384	1-3	35
36	Medical Director				36
37	Medical Records Consultant	19	942	10-3	37
38	Nurse Consultant	6	(57)	10-3	38
39	Pharmacist Consultant		3,528	39-3	39
40	Physical Therapy Consultant	29	(814)	10A-3	40
41	Occupational Therapy Consultant	497	14,104	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	981	(44,013)	10A-3	43
44	Activity Consultant	35	1,923	11-3	44
45	Social Service Consultant	28	1,523	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,789	\$ (14,482)		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	0	\$ 0		50
51	Licensed Practical Nurses	0	0		51
52	Certified Nurse Assistants/Aides	0	0		52
53	TOTAL (lines 50 - 52)		\$		53





Facility Name &amp; ID Number Fireside House of Centralia

**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. \$ 53,802  
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. \$ 225
- (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? N/A  
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: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (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 &amp; ID Number

Fireside House of Centralia

# 0045690

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

**Schedule V - Ancillary Expense**

Other: Line 43 Column 3

**Radiology Consulting Fees**

<b>Consultant</b>	<b>Amount</b>
BIOTECH X-RAY, INC.	3309.92
JOEL K BARRIENTOS MD	494.11
NEUROMUSCULAR ORTHOPAEDIC INST	103
ORTHOPAEDIC CENTER OF SO.IL	27.53
ST. MARY'S HOSPITAL	4102.13
<b>Grand Total</b>	<b>\$ 8,036.69</b>

**Laboratory Consultant Fees**

<b>Laboratory</b>	<b>Amount</b>
BIOTECH LABORATORY INC	16816.19
CLIA LABORATORY PROGRAM	150
CROSSROADS COMMUNITY HOSPITAL	174.97
ST. MARY'S HOSPITAL	1841.22
<b>Grand Total</b>	<b>\$ 18,982.38</b>