

		FOR BHF USE					

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2009
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2009)

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.

<p>I. IDPH License ID Number: <u>0045690</u></p> <p>Facility Name: <u>Fireside House of Centralia</u></p> <p>Address: <u>1030 Martin Luther King</u> <u>Centralia</u> <u>62801</u> Number City Zip Code</p> <p>County: <u>Marion</u></p> <p>Telephone Number: <u>(618) 532-1833</u> Fax # <u>(618) 532-1308</u></p> <p>HFS ID Number: <u>6001614</u></p> <p>Date of Initial License for Current Owners: <u>01/29/2002</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code <u> </u></td> <td><input checked="" type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other <u> </u></td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other <u> </u></td> <td></td> </tr> </table>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code <u> </u>	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other <u> </u>		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other <u> </u>		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2009</u> to <u>12/31/2009</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Douglas Mittleider</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>President of Management Company</u></td> <td></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>Matthew Larson</u> <u>Reimbursement Analyst</u></td> <td></td> </tr> <tr> <td>(Firm Name & Address) <u>AltaCare Corporation</u> <u>5895 Windward Pkwy, Suite 200, Alpharetta, GA, 30005</u></td> <td></td> </tr> <tr> <td>(Telephone) <u>(770) 870-2881</u> Fax # <u>(770) 619-0262</u></td> <td></td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>Douglas Mittleider</u>			(Title) <u>President of Management Company</u>		Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) <u>Matthew Larson</u> <u>Reimbursement Analyst</u>		(Firm Name & Address) <u>AltaCare Corporation</u> <u>5895 Windward Pkwy, Suite 200, Alpharetta, GA, 30005</u>		(Telephone) <u>(770) 870-2881</u> Fax # <u>(770) 619-0262</u>	
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<p>In the event there are further questions about this report, please contact: Name: <u>Daren Douston</u> Telephone Number: <u>(770) 870-2859</u> Email Address: _____</p>	<p>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</p>																																									

Facility Name & ID Number Fireside House of Centralia

0045690 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

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	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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	873	1,492	5,587	7,952	8
9	SNF/PED					9
10	ICF	18,112	2,075	11	20,198	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,985	3,567	5,598	28,150	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.70%

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

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 1/29/2002 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: 12/31/2009 Fiscal Year: 12/31/2009

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

Facility Name & ID Number Fireside House of Centralia # 0045690 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

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
	A. General Services										
1	Dietary	144,369	20,697	8,898	173,964		173,964		173,964		1
2	Food Purchase		158,053		158,053		158,053		158,053		2
3	Housekeeping	96,746	13,976		110,722		110,722		110,722		3
4	Laundry	68,421	10,083		78,504		78,504		78,504		4
5	Heat and Other Utilities			124,710	124,710		124,710	(505)	124,205		5
6	Maintenance	26,378	9,578	23,438	59,394		59,394		59,394		6
7	Other (specify):* Trash Removal			8,678	8,678	11,063	19,741		19,741		7
8	TOTAL General Services	335,914	212,387	165,724	714,025	11,063	725,088	(505)	724,583		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	1,366,103	104,828	642	1,471,573	(11,063)	1,460,510		1,460,510		10
10a	Therapy	309,119	409	(20,370)	289,158		289,158		289,158		10a
11	Activities	34,991	2,619	3,121	40,731		40,731		40,731		11
12	Social Services	16,601		1,933	18,534		18,534		18,534		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,726,814	107,856	(2,674)	1,831,996	(11,063)	1,820,933		1,820,933		16
	C. General Administration										
17	Administrative	75,386			75,386	9,689	85,075		85,075		17
18	Directors Fees										18
19	Professional Services			336,808	336,808		336,808	(310,723)	26,085		19
20	Dues, Fees, Subscriptions & Promotions			13,577	13,577		13,577	2,490	16,067		20
21	Clerical & General Office Expenses	179,512	12,702	49,769	241,983	(9,689)	232,294	27,966	260,260		21
22	Employee Benefits & Payroll Taxes			381,037	381,037		381,037	138,199	519,236		22
23	Inservice Training & Education			435	435		435	148	583		23
24	Travel and Seminar			1,902	1,902		1,902	646	2,548		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			61,990	61,990		61,990	21,062	83,052		26
27	Other (specify):*			104,015	104,015		104,015	(104,014)	1		27
28	TOTAL General Administration	254,898	12,702	949,533	1,217,133		1,217,133	(224,226)	992,907		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,317,626	332,945	1,112,583	3,763,154		3,763,154	(224,731)	3,538,423		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

Fireside House of Centralia

#0045690

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

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	
	D. Ownership											
30	Depreciation			98,983	98,983		98,983	5,075	104,058			30
31	Amortization of Pre-Op. & Org.			22,236	22,236		22,236	1,140	23,376			31
32	Interest			317,907	317,907		317,907	(59,835)	258,072			32
33	Real Estate Taxes			78,000	78,000		78,000	3,999	81,999			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			19,565	19,565		19,565	1,003	20,568			35
36	Other (specify):*											36
37	TOTAL Ownership			536,691	536,691		536,691	(48,618)	488,073			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			3,129	3,129		3,129	(3,129)				38
39	Ancillary Service Centers		328,247	15,029	343,276		343,276	(11,501)	331,775			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):* See pg 24			30,852	30,852		30,852		30,852			43
44	TOTAL Special Cost Centers		328,247	102,812	431,059		431,059	(14,630)	416,429			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,317,626	661,192	1,752,086	4,730,904		4,730,904	(287,979)	4,442,925			45

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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(81)	22		4
5	Telephone, TV & Radio in Resident Rooms	(505)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(72,421)	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)	(3,129)	38		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(34,349)	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	(21,951)	27		24
25	Fund Raising, Advertising and Promotional	(1,207)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(74,906)	27		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(16,144)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (224,693)		\$	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)	(63,286)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (63,286)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (287,979)		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	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY							
48		49		50		51	52

Fireside House of Centralia

ID# 0045690

Report Period Beginning: 1/1/2009

Ending: 12/31/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Dues-Chamber of Commerce	\$ (378)	20	1
2	Misc Revenue-Non Operating	(3,688)	21	2
3	Prior Year Expense-Workers Comp	6,580	22	3
4	Prior Year Expense	(7,125)	27	4
5	Resident Expenses	(32)	27	5
6	Prior Year Expenses-Ancillaries	(11,501)	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	Total	(16,144)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Fireside House of Centralia# 0045690 Report Period Beginning:

1/1/2009

Ending: 12/31/2009

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)	
	A. General Services													
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	(505)	0	0	0	0	0	0	0	0	0	0	(505)	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	(505)	0	0	0	0	0	0	0	0	0	0	(505)	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	(310,723)	0	0	0	0	0	0	0	0	0	(310,723)	19
20	Fees, Subscriptions & Promotions	(1,585)	4,075	0	0	0	0	0	0	0	0	0	2,490	20
21	Clerical & General Office Expenses	(38,037)	66,003	0	0	0	0	0	0	0	0	0	27,966	21
22	Employee Benefits & Payroll Taxes	6,499	131,700	0	0	0	0	0	0	0	0	0	138,199	22
23	Inservice Training & Education	0	148	0	0	0	0	0	0	0	0	0	148	23
24	Travel and Seminar	0	646	0	0	0	0	0	0	0	0	0	646	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	21,062	0	0	0	0	0	0	0	0	0	21,062	26
27	Other (specify):*	(104,014)	0	0	0	0	0	0	0	0	0	0	(104,014)	27
28	TOTAL General Administration	(137,137)	(87,089)	0	(224,226)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(137,642)	(87,089)	0	(224,731)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Fireside House of Centralia# 0045690

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	0	5,075	0	0	0	0	0	0	0	0	0	5,075	30
31	Amortization of Pre-Op. & Org.	0	1,140	0	0	0	0	0	0	0	0	0	1,140	31
32	Interest	(72,421)	12,586	0	0	0	0	0	0	0	0	0	(59,835)	32
33	Real Estate Taxes	0	3,999	0	0	0	0	0	0	0	0	0	3,999	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	1,003	0	0	0	0	0	0	0	0	1,003	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(72,421)	22,800	1,003	0	(48,618)	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	(3,129)	0	0	0	0	0	0	0	0	0	0	(3,129)	38
39	Ancillary Service Centers	(11,501)	0	0	0	0	0	0	0	0	0	0	(11,501)	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	(14,630)	0	0	0	0	0	0	0	0	0	0	(14,630)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(224,693)	(64,289)	1,003	0	(287,979)	45							

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	19 Accounting Fees	\$ 32,784	AltaCare Corporation	100.00%	\$	\$ (32,784)	1
2	V	19 Management Fees	284,554	AltaCare Corporation	100.00%		(284,554)	2
3	V	19 Non-Related Professional Fees		AltaCare Corporation	100.00%	6,615	6,615	3
4	V	20 Dues, Fees, Subs and Promos		AltaCare Corporation	100.00%	4,075	4,075	4
5	V	21 Clerical & Gen Office Exp		AltaCare Corporation	100.00%	66,003	66,003	5
6	V	22 Employee Benefits & Taxes		AltaCare Corporation	100.00%	131,700	131,700	6
7	V	23 Training & Education		AltaCare Corporation	100.00%	148	148	7
8	V	24 Travel & Seminars		AltaCare Corporation	100.00%	646	646	8
9	V	26 Liability Insurance		AltaCare Corporation	100.00%	21,062	21,062	9
10	V	30 Depreciation		AltaCare Corporation	100.00%	5,075	5,075	10
11	V	31 Amortization		AltaCare Corporation	100.00%	1,140	1,140	11
12	V	32 Non Related Interest		AltaCare Corporation	100.00%	12,586	12,586	12
13	V	33 Real Estate Taxes		AltaCare Corporation	100.00%	3,999	3,999	13
14	Total		\$ 317,338			\$ 253,049	\$ * (64,289)	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	35 Rent Equipment and Vehicles	\$	AltaCare Corporation	100.00%	\$ 1,003	\$	1,003	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		\$			\$ 1,003	\$ *	1,003	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:

1/1/2009

Ending:

12/31/2009

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: 1/1/2009 Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization AltaCare Corporation
 Street Address 5895 Windward Pkwy, Suite 200
 City / State / Zip Code Alpharetta, GA 30005-8805
 Phone Number (770) 619-0866
 Fax Number (770) 619-0262

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	Management Fees	Total Costs	32	\$ 5,810,195	\$ 4,206,343	4,730,902	\$ 230,250	1
2	32	Capital	Total Costs	32	600,657		4,730,902	23,803	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 6,410,852	\$ 4,206,343		\$ 254,053	25

Facility Name & ID Number

Fireside House of Centralia

0045690

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

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		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	Zeigler Healthcare		X	Refinancing	variable	8/31/2007	\$ 3,787,104	\$ 3,650,638	8/20/2012	5.6190	\$ 264,460	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6	Zeigler Healthcare		X	AR Financing		8/19/2007	349,672	345,076	8/20/2012	15.0000	52,123	6						
7	Insurance		X	Liability, WC, Prop & Crime			variable			variable	1,324	7						
8												8						
9	TOTAL Facility Related						\$ 4,136,776	\$ 3,995,714			\$ 317,907	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 4,136,776	\$ 3,995,714			\$ 317,907	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

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill

1. Real Estate Tax accrual used on 2008 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 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	77,676 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.		\$	77,676 7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2004	8	
	2005	9	
	2006	10	
	2007	11	
	2008	77,676 12	
			FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2008 \$	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.

Facility Name & ID Number Fireside House of Centralia

0045690 Report Period Beginning:

1/1/2009 Ending:

12/31/2009

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).

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: 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		<u>162,206</u>	<u>2002</u>	<u>\$ 32,463</u>	1
2					2
3	TOTALS	162,206		\$ 32,463	3

Facility Name & ID Number Fireside House of Centralia

0045690

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	98	2002	1963	\$ 2,921,637	\$ 73,067	40	\$ 73,067	\$	\$ 576,757	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Parking Lot Resurfacing-Howell Asphalt		2002	16,687	1,112	15	1,112		8,251	9
10	reroof w/ dural last roof sys-Master Const. Co		2008	71,832	1,796	40	1,796	0	3,292	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number **Fireside House of Centralia**

0045690

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

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)	\$	\$		\$	\$	\$	70	
			3,010,156		75,975		75,975	0	588,300

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

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	\$ 304,588	\$ 21,509	\$ 21,509	\$	5,7,&10	\$ 247,861	71
72	Current Year Purchases	11,298	1,499	1,499		5	1,499	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 315,886	\$ 23,008	\$ 23,008	\$		\$ 249,360	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)	\$ 3,358,505	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 98,983	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 98,983	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 0	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 837,660	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	TOTAL				\$ _____			7

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

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

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ 19,565 Description: Copier-\$3589, Therapy Equip-\$15976

(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

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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* 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			
		1	2	3	4
		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.

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	3694 hrs	\$ 101,130		\$	14	3,694	\$ 101,144	1
2	Licensed Speech and Language Development Therapist	10A-1,2&3	1162 hrs	53,194			372	1,162	53,566	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-1,2&3	5840 hrs	154,794			23	5,840	154,817	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							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			\$ 309,118		\$	409	10,696	\$ 309,527	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: 1/1/2009

Ending:

12/31/2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2009

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (47,047)	\$	1
2	Cash-Patient Deposits	16,278		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	594,156		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	5,139		6
7	Other Prepaid Expenses	249		7
8	Accounts Receivable (owners or related parties)	2,329,145		8
9	Other(specify):	1,004,089		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,902,009	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	32,463		13
14	Buildings, at Historical Cost	2,993,199		14
15	Leasehold Improvements, at Historical Cost	16,687		15
16	Equipment, at Historical Cost	315,886		16
17	Accumulated Depreciation (book methods)	(837,660)		17
18	Deferred Charges	60,100		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	455,434		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,036,109	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,938,118	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 861,378	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	16,278		28
29	Short-Term Notes Payable	66,045		29
30	Accrued Salaries Payable	193,450		30
31	Accrued Taxes Payable (excluding real estate taxes)	181,758		31
32	Accrued Real Estate Taxes(Sch.IX-B)	232,529		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Bed Taxes	13,524		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,564,962	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	345,076		39
40	Mortgage Payable	3,650,638		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)	\$ 3,995,714	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,560,676	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,377,442	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,938,118	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,365,784	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,365,784	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	11,657	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) rounding	1	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 11,658	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)	\$ 1,377,442	24 *

* This must agree with page 17, line 47.

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	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,539,580	1
2	Discounts and Allowances for all Levels	996,852	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,536,432	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	126,738	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 126,738	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	81	14
15	Telephone, Television and Radio	505	15
16	Rental of Facility Space		16
17	Sale of Drugs	1,189	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	111	19
20	Radiology and X-Ray		20
21	Other Medical Services	1,394	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 3,280	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	72,421	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 72,421	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Misc Revenue-Non Operating</u>	3,688	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,688	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,742,559	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	714,025	31
32	Health Care	1,831,996	32
33	General Administration	1,217,133	33
	B. Capital Expense		
34	Ownership	536,690	34
	C. Ancillary Expense		
35	Special Cost Centers	377,257	35
36	Provider Participation Fee	53,802	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,730,903	40
41	Income before Income Taxes (line 30 minus line 40)**	11,656	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 11,656	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:

1/1/2009

Ending:

12/31/2009

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,229	2,779	\$ 97,706	\$ 35.16	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,036	12,538	271,306	21.64	3
4	Licensed Practical Nurses	17,854	23,080	408,541	17.70	4
5	CNAs & Orderlies	51,891	60,430	576,417	9.54	5
6	CNA Trainees					6
7	Licensed Therapist	9,883	10,696	309,118	28.90	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,293	3,516	34,991	9.95	10
11	Social Service Workers	1,320	1,529	16,601	10.86	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,002	16,249	144,369	8.88	15
16	Dishwashers					16
17	Maintenance Workers	1,703	1,872	26,378	14.09	17
18	Housekeepers	10,033	11,401	96,746	8.49	18
19	Laundry	7,507	8,308	68,421	8.24	19
20	Administrator	1,820	2,080	85,075	40.90	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,555	9,404	169,823	18.06	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,032	1,187	12,133	10.22	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	142,158	165,069	\$ 2,317,625 *	\$ 14.04	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	207	\$ 8,898	1-3	35
36	Medical Director		12,000	9-3	36
37	Medical Records Consultant	40	2,021	10-3	37
38	Nurse Consultant	473	(12,464)	10-3	38
39	Pharmacist Consultant		3,528	39-3	39
40	Physical Therapy Consultant	520	(13,773)	10A-3	40
41	Occupational Therapy Consultant	369	10,105	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	365	(16,702)	10A-3	43
44	Activity Consultant	57	3,121	11-3	44
45	Social Service Consultant	35	1,933	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,066	\$ (1,333)		49

C. CONTRACT NURSES

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

Facility Name & ID Number Fireside House of Centralia# 0045690

Report Period Beginning:

1/1/2009

Ending:

12/31/2009**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. \$ 81
- (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: _____
- (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

Fireside House of Centralia

0045690

Report Period Beginning: 1/1/2009

Ending: 12/31/2009

Schedule V - Ancillary Expense**Other: Line 43 Column 3****Radiology Consulting Fees**

Consultant	Amount
BIOTECH X-RAY, INC.	8616.69
NEUROMUSCULAR ORTHOPAEI	230.43
ORTHOPAEDIC CENTER OF SO.	110.22
ST. MARY'S HOSPITAL	4807.09
Grand Total	\$ 13,764.43

Laboratory Consultant Fees

Laboratory	Amount
BIOTECH LABORATORY INC	17019.03
CROSSROADS COMMUNITY HO	68.87
Grand Total	\$ 17,087.90

Schedule XV - Balance Sheet
Other: Line 9 Column 1

Description	Amount
Note Receivable - Sumter HCI	932619.15
Interest Rec - HP/Hopewel	10900.91
Interest Rec - HP/Operati	20932.89
Interest Rec - Sumter HCI	39636.31
Grand Total	\$ 1,004,089