FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

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

I. IDPH License ID Number: 0045682

Facility Name: LTC of Illinois-Friendship House of Centralia

Address: 100 Martin Luther King (Number) Centralia (City) 62801 (Zip Code)

County: Marion

Telephone Number: (618) 532-3642 **Fax #** (618) 533-3739

HFS ID Number:

Date of Initial License for Current Owners: 1/29/2002

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Matthew Larson **Telephone Number:** (404) 991-2430 ext 2036
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2011 to 12/31/2011 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Douglas Mittleider
(Title) President of Management Company

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Matthew Larson, Director of Reimbursement
(Firm Name & Address) Five Rivers Management LLC., 10945 State Bridge Rd. Ste 401-470, Alpharetta, GA 30022
(Telephone) (404) 991-2430 ext 2036 Fax # (404) 991-2431

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number LTC of Illinois-Friendship House of Centralia # 0045682 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	19	Skilled (SNF)	19	6,935	1
2		Skilled Pediatric (SNF/PED)			2
3	75	Intermediate (ICF)	75	27,375	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	94	TOTALS	94	34,310	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			1,984	1,984	8
9	SNF/PED					9
10	ICF	13,673	1,561	388	15,622	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,673	1,561	2,372	17,606	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 51.31%

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? _____

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 19 and days of care provided 1,984

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number LTC of Illinois-Friendship House of Centralia # 0045682 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	106,151	10,132	7,031	123,314		123,314		123,314			1
2	Food Purchase		113,058		113,058		113,058	(2,629)	110,429			2
3	Housekeeping	60,457	8,680	2,726	71,863		71,863		71,863			3
4	Laundry	49,162	6,588		55,750		55,750		55,750			4
5	Heat and Other Utilities			114,305	114,305		114,305		114,305			5
6	Maintenance	40,244	15,560	31,792	87,596		87,596		87,596			6
7	Other (specify):*			13,084	13,084	7,796	20,880		20,880			7
8	TOTAL General Services	256,014	154,018	168,938	578,970	7,796	586,766	(2,629)	584,137			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	887,215	48,794	7,796	943,805	7,741	951,546		951,546			10
10a	Therapy	90,749	263	19,957	110,969		110,969		110,969			10a
11	Activities	26,414	748	2,972	30,134		30,134		30,134			11
12	Social Services	27,810		970	28,780		28,780		28,780			12
13	CNA Training											13
14	Program Transportation			429	429		429	(429)				14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,032,188	49,805	44,124	1,126,117	7,741	1,133,858	(429)	1,133,429			16
	C. General Administration											
17	Administrative	67,947			67,947		67,947		67,947			17
18	Directors Fees											18
19	Professional Services			190,087	190,087		190,087	(183,996)	6,091			19
20	Dues, Fees, Subscriptions & Promotions			4,462	4,462		4,462	609	5,071			20
21	Clerical & General Office Expenses	105,708	6,801	137,289	249,798		249,798	37,530	287,328			21
22	Employee Benefits & Payroll Taxes			210,735	210,735		210,735	58,471	269,206			22
23	Inservice Training & Education			114	114		114	32	146			23
24	Travel and Seminar			2,533	2,533		2,533	709	3,242			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			58,939	58,939		58,939	16,491	75,430			26
27	Other (specify):*			11,590	11,590		11,590	3,123	14,713			27
28	TOTAL General Administration	173,655	6,801	615,749	796,205		796,205	(67,031)	729,174			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,461,857	210,624	828,811	2,501,292	15,537	2,516,829	(70,089)	2,446,740			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number LTC of Illinois-Friendship House of Centralia #0045682 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			36,664	36,664		36,664	2,104	38,768			30
31	Amortization of Pre-Op. & Org.			7,323	7,323		7,323	420	7,743			31
32	Interest			104,225	104,225		104,225	5,868	110,093			32
33	Real Estate Taxes			76,500	76,500		76,500	4,391	80,891			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			19,931	19,931	(15,537)	4,394	252	4,646			35
36	Other (specify):*											36
37	TOTAL Ownership			244,643	244,643	(15,537)	229,106	13,035	242,141			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		87,411	4,520	91,931		91,931	(2,804)	89,127			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			51,465	51,465		51,465		51,465			42
43	Other (specify):*			2,907	2,907		2,907		2,907			43
44	TOTAL Special Cost Centers		87,411	58,892	146,303		146,303	(2,804)	143,499			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,461,857	298,035	1,132,346	2,892,238		2,892,238	(59,858)	2,832,380			45

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

Facility Name & ID Number LTC of Illinois-Friendship House of Centralia # 0045682 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,629)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(108)	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)	(148)	27		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(25,288)	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	(2,350)	27		24
25	Fund Raising, Advertising and Promotional	(31)	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	1,211			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (29,343)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(30,929)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (30,929)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (60,272)		37

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

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

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

LTC of Illinois-Friendship House of Centralia

ID# 0045682

Report Period Beginning: 1/1/2011

Ending: 12/31/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non Medical Transportation	$ (429)	14	1
2	Chamber of Commerce Dues	(378)	20	2
3	Prior Year Expense-Workers Comp	(385)	22	3
4	Prior Year Expense	5,621	27	4
5	Prior Year Expense - Ancillary	(2,804)	39	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				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**	1,625		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number LTC of Illinois-Friendship House of Centralia **#** 0045682 **Report Period Beginning:** 1/1/2011 **Ending:** 12/31/2011

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,629)	0	0	0	0	0	0	0	0	0	0	(2,629)	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	0	0	0	0	0	0	0	0	0	0	0	0	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**	(2,629)	0	0	0	0	0	0	0	0	0	0	(2,629)	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	(429)	0	0	0	0	0	0	0	0	0	0	(429)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(429)	0	0	0	0	0	0	0	0	0	0	(429)	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	(183,996)	0	0	0	0	0	0	0	0	0	(183,996)	19
20	Fees, Subscriptions & Promotions	(409)	1,018	0	0	0	0	0	0	0	0	0	609	20
21	Clerical & General Office Expenses	(25,288)	62,818	0	0	0	0	0	0	0	0	0	37,530	21
22	Employee Benefits & Payroll Taxes	(385)	58,856	0	0	0	0	0	0	0	0	0	58,471	22
23	Inservice Training & Education	0	32	0	0	0	0	0	0	0	0	0	32	23
24	Travel and Seminar	0	709	0	0	0	0	0	0	0	0	0	709	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	16,491	0	0	0	0	0	0	0	0	0	16,491	26
27	Other (specify):*	3,123	0	0	0	0	0	0	0	0	0	0	3,123	27
28	**TOTAL General Administration**	(22,959)	(44,072)	0	0	0	0	0	0	0	0	0	(67,031)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(26,017)	(44,072)	0	0	0	0	0	0	0	0	0	(70,089)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number LTC of Illinois-Friendship House of Centralia # 0045682 **Report Period Beginning:** 1/1/2011 **Ending:** 12/31/2011

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

	Capital Expense / D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	0	2,104	0	0	0	0	0	0	0	0	0	2,104	30
31	Amortization of Pre-Op. & Org.	0	420	0	0	0	0	0	0	0	0	0	420	31
32	Interest	(108)	5,976	0	0	0	0	0	0	0	0	0	5,868	32
33	Real Estate Taxes	0	4,391	0	0	0	0	0	0	0	0	0	4,391	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	252	0	0	0	0	0	0	0	0	252	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(108)	12,891	252	0	0	0	0	0	0	0	0	13,035	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(2,804)	0	0	0	0	0	0	0	0	0	0	(2,804)	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**	(2,804)	0	0	0	0	0	0	0	0	0	0	(2,804)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(28,929)	(31,181)	252	0	0	0	0	0	0	0	0	(59,858)	45

Facility Name & ID Number LTC of Illinois-Friendship House of Centralia # 0045682 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
LTC of Illinois-Friendship, Inc.	100%	Fireside House of Centralia	Centralia	AltaCare Corporation	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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Management Fees	$ 150,468	AltaCare Corporation	100.00%	$	$ (150,468)	1
2	V	19	Accounting Fees	34,860	AltaCare Corporation	100.00%		(34,860)	2
3	V	19	Non-Related Professional Svc		AltaCare Corporation	100.00%	1,332	1,332	3
4	V	20	Dues, Fees, Subs and Promos		AltaCare Corporation	100.00%	1,018	1,018	4
5	V	21	Clerical & General Office Exp		AltaCare Corporation	100.00%	62,818	62,818	5
6	V	22	Employee Benefits & Taxes		AltaCare Corporation	100.00%	58,856	58,856	6
7	V	23	Training & Education		AltaCare Corporation	100.00%	32	32	7
8	V	24	Travel & Seminars		AltaCare Corporation	100.00%	709	709	8
9	V	26	Liability Insurance		AltaCare Corporation	100.00%	16,491	16,491	9
10	V	30	Depreciation		AltaCare Corporation	100.00%	2,104	2,104	10
11	V	31	Amortization		AltaCare Corporation	100.00%	420	420	11
12	V	32	Non Related Interest		AltaCare Corporation	100.00%	5,976	5,976	12
13	V	33	Real Estate Taxes		AltaCare Corporation	100.00%	4,391	4,391	13
14	Total			$ 185,328			$ 154,147	$ * (31,181)	14

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

Facility Name & ID Number LTC of Illinois-Friendship House of Centralia # 0045682 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	35	Rental Equipment and Vehicles	$	AltaCare Corporation	100.00%	$ 252	$ 252	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			$			$ 252	$ * 252	39

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

Facility Name & ID Number LTC of Illinois-Friendship House of Centralia # 0045682 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
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								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

Facility Name & ID Number LTC of Illinois-Friendship House of Centrali # 0045682 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number LTC of Illinois-Friendship House of Centralia # 0045682 Report Period Beginning: 1/1/2011 Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: AltaCare Corporation
Street Address: 5895 Windward Parkway, Suite 200
City / State / Zip Code: Alpharetta, GA 30019
Phone Number: ((770) 619-0866
Fax Number: ((770) 619-0262

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Management Fees	Total Expense	104,295,095	28	$ 5,093,729	$ 3,432,451	2,892,237	$ 141,256	1
2	32	Capital	Total Expense	104,295,095	28	473,930		2,892,237	13,143	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,567,659	$ 3,432,451		$ 154,399	25

Facility Name & ID Number LTC of Illinois-Friendship House of Centralia # 0045682 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Zeigler Healthcare		X	Refinancing Mortgage	variable	8/31/07	$ 1,195,927	$ 1,132,815	08/20/2012	variable	$ 76,245	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Zeigler Healthcare		X	AR Financing			149,860	146,776	08/20/2012	15.0000	14,701	6
7	Insurance		X	Prop, Auto, Liab, WC Ins			Variable			variable	1,864	7
8	Omni Care		X	Pharmacy Debt	$4,300.00	12/1/2010	225,005	141,931	12/1/2015	6.0000	11,173	8
9	TOTAL Facility Related				$4,300.00		$ 1,570,792	$ 1,421,522			$ 103,982	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,570,792	$ 1,421,522			$ 103,982	15

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

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number LTC of Illinois-Friendship House of Centralia # 0045682 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		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							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Indepentant Telecom Assoc.		X	Telephone System	$181.00	6/1/2011	3,836	2,812	5/1/2013	12.2500	243	6
7												7
8												8
9	TOTAL Facility Related				$181.00		$ 3,836	$ 2,812			$ 243	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 3,836	$ 2,812			$ 243	15

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

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number LTC of Illinois-Friendship House of Centralia **#** 0045682 **Report Period Beginning:** 1/1/2011 **Ending:** 12/31/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 76,500	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 76,500	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2006		8
2007		9
2008		10
2009		11
2010	76,500	12

FOR BHF USE ONLY

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

NOTES:

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

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME LTC of Illinois-Friendship House of Centralia COUNTY Marion

FACILITY IDPH LICENSE NUMBER 0045682

CONTACT PERSON REGARDING THIS REPORT Daren Douston

TELEPHONE (404) 991-2430 ext 2002 FAX #: (404) 991-2431

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

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

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-17-000-059	W1/2W6 ASW NE NW Tract 1&2	$ 75,914.34	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 75,914.34	$

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 _____ NO

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

C. **Tax Bills**

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

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

Facility Name & ID Number LTC of Illinois-Friendship House of Centralia # 0045682 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 23,100 B. General Construction Type: Exterior Brick & Block Frame Masonry Number of Stories 1

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

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

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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 [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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	LTC	174,240	2002	$ 22,915	1
2					2
3	TOTALS	174,240		$ 22,915	3

Facility Name & ID Number LTC of Illinois-Friendship House of Centralia # 0045682 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	98		2002	1965	$ 965,160	$ 24,129	40	$ 24,129	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Parking Lot Resurfacing-Howell Asphalt			2002	31,694	2,113	15	2,113		19,897	9
10	250ft Sidewalk-JR Construction			2005	4,300	287	15	287		1,744	10
11	75ft Fenceon Eastside-Consolidate Fence			2007	2,175	145	15	145		640	11
12	Replace Shingles-Roy Pack			2008	17,360	434	15	434		1,555	12
13	Replace Sidewalk-Joe Parker Construction			2008	3,600	240	15	240		940	13
14	Repair N & S Roof - Master Construction Co			2010	11,800	295	40	295		418	14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number LTC of Illinois-Friendship House of Centralia # 0045682 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,036,089	$ 27,643		$ 27,643	$	$ 25,194	70

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

Facility Name & ID Number LTC of Illinois-Friendship House of Centralia # 0045682 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 136,910	$ 7,337	$ 7,337	$	5&10	$ 105,255	71
72	Current Year Purchases	43,117	1,685	1,685		5&10	1,685	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 180,027	$ 9,021	$ 9,021	$		$ 106,940	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Trips	Intl Thomas Bus 1995	2005	$ 5,750	$	$	$	5	$ 5,750	76
77										77
78										78
79										79
80	TOTALS			$ 5,750	$	$	$		$ 5,750	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)	$ 1,244,781	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 36,664	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 36,664	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)	$ 137,884	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number LTC of Illinois-Friendship House of Centralia # 0045682 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2012	$
13.	/2013	$
14.	/2014	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number LTC of Illinois-Friendship House of Centralia # 0045682 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number LTC of Illinois-Friendship House of Centralia # 0045682 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A1	1919 hrs	$ 53,630	7	$ 191	$ 263	1,926	$ 54,084	1
2	Licensed Speech and Language Development Therapist	10A1	hrs		1	62		1	62	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A1	1572 hrs	37,119	725	19,704		2,297	56,823	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$ 90,749	734	$ 19,957	$ 263	4,225	$ 110,969	14

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

STATE OF ILLINOIS

Facility Name & ID Number LTC of Illinois-Friendship House of Centralia # 0045682 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2011 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (213,177)	$	1
2	Cash-Patient Deposits	23,170		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	648,666		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	8,897		6
7	Other Prepaid Expenses	1,685		7
8	Accounts Receivable (owners or related parties)	(2,503,887)		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ (2,034,646)	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	22,914		13
14	Buildings, at Historical Cost	994,320		14
15	Leasehold Improvements, at Historical Cost	65,201		15
16	Equipment, at Historical Cost	162,346		16
17	Accumulated Depreciation (book methods)	(377,163)		17
18	Deferred Charges	11,527		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	204,666		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,083,811	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ (950,835)	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 629,612	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	23,170		28
29	Short-Term Notes Payable	193,028		29
30	Accrued Salaries Payable	105,699		30
31	Accrued Taxes Payable (excluding real estate taxes)	261,677		31
32	Accrued Real Estate Taxes(Sch.IX-B)	76,500		32
33	Accrued Interest Payable	83,665		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Bed Taxes	16,762		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,390,113	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	147,654		39
40	Mortgage Payable	1,132,816		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,280,470	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,670,583	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (3,621,418)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ (950,835)	$	48

*(See instructions.)

Facility Name & ID Number LTC of Illinois-Friendship House of Centralia # 0045682 **Report Period Beginning:** 1/1/2011 **Ending:** 12/31/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (3,236,986)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (3,236,986)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(384,433)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe) **Rounding**	1	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (384,432)	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)**	$ (3,621,418)	24 *

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

Facility Name & ID Number LTC of Illinois-Friendship House of Centralia # 0045682 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,204,416	1
2	Discounts and Allowances for all Levels	248,675	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,453,091	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	46,796	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 46,796	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	87	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,629	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	2,568	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	2,526	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 7,810	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	108	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 108	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,507,805	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	578,970	31
32	Health Care	1,126,116	32
33	General Administration	796,205	33
	B. Capital Expense		
34	Ownership	244,644	34
	C. Ancillary Expense		
35	Special Cost Centers	94,838	35
36	Provider Participation Fee	51,465	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,892,238	40
41	**Income before Income Taxes (line 30 minus line 40)****	(384,433)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (384,433)	43

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

**** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

***** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number LTC of Illinois-Friendship House of Centralia # 0045682 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	4,010	4,452	$ 127,814	$ 28.71	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,599	5,930	124,322	20.96	3
4	Licensed Practical Nurses	11,522	12,696	238,896	18.82	4
5	CNAs & Orderlies	35,810	38,532	395,022	10.25	5
6	CNA Trainees					6
7	Licensed Therapist	3,303	3,491	90,749	26.00	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,139	2,422	26,414	10.91	9
10	Activity Assistants					10
11	Social Service Workers	1,842	1,970	27,810	14.12	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	10,198	11,082	106,151	9.58	15
16	Dishwashers					16
17	Maintenance Workers	2,591	2,887	40,244	13.94	17
18	Housekeepers	6,062	6,730	60,457	8.98	18
19	Laundry	4,776	5,403	49,162	9.10	19
20	Administrator	1,990	2,080	71,117	34.19	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,818	5,399	102,538	18.99	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	57	57	791	13.88	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	94,717	103,131	$ 1,461,487 *	$ 14.17	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	156	$ 7,031	1-3	35
36	Medical Director		12,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		1,716	39-3	39
40	Physical Therapy Consultant	725	19,704	10A-3	40
41	Occupational Therapy Consultant	7	191	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1	62	10A-3	43
44	Activity Consultant	54	2,972	11-3	44
45	Social Service Consultant	18	970	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	962	$ 44,646		49

C. CONTRACT NURSES

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

Facility Name & ID Number LTC of Illinois-Friendship House of Centralia # 0045682 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Terri Rumler	Administrator	0	$ 68,656
Mary Scharlemann	Administrator	0	7,692
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 76,348

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Ziemer, Stayman, Weitzel	Legal	$ 1,257
Howard Kahn	Legal	545
AltaCare Corporation	Accounting	34,860
AltaCare Corporation	Management	150,468
PayDay, Inc	Payroll	2,437
Hodges-Mace Benefits Group	Employee Benefits Mgt	519
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 190,087

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 54,926
Unemployment Compensation Insurance	
FICA Taxes	124,801
Employee Health Insurance	25,906
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Appreciation/Parties	3,110
Dental Insurance	135
Life Insurance	1,504
Uniforms	(32)
TOTAL (agree to Schedule V, line 22, col.8)	$ 210,350

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,251
Advertising: Employee Recruitment	218
Health Care Worker Background Check	
(Indicate # of checks performed 67)	1,010
Patient Background Checks	
Dues	792
Subscriptions	60
Permits	100
Community Awareness	31
Less: Public Relations Expense	(378)
Non-allowable advertising	(31)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,052

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 1,955
In-State Travel	505
Seminar Expense	72
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,533

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number LTC of Illinois-Friendship House of Centralia # 0045682 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number LTC of Illinois-Friendship House of Centralia **#** 0045682 **Report Period Beginning:** 1/1/2011 **Ending:** 12/31/2011

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA - $413.00**

(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**

(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. $ **51,465**
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. $ ____ Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **2,629**

(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? **N/A**
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? **Yes**
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.

Special Cost Centers Other
Line 43 Column 3

Radiology Consulting Fees

BioTech X-Ray, Inc	821.72
St. Mary's Hospital	78.03
	899.75

Laboratory Consulting Fees

BioTech Laboratory Inc.	13.06
Gamma HealthCare	1994
	2007.06