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.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

I. IDPH License ID Number: 0051755

Facility Name: Fireside House of Centralia

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

County: Marion

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

HFS ID Number:

Date of Initial License for Current Owners: 2/1/2012

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Matthew Larson **Telephone Number:** (678) 381-2820
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 1/16/12 to 12/31/2012 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) Daren Douston
(Title) Member/CFO

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) (678) 381-2820 Fax # (678) 381-2821

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

Facility Name & ID Number Fireside House of Centralia # 0051755 Report Period Beginning: 1/16/12 Ending: 12/31/2012

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	331		5,935	6,266	8
9	SNF/PED					9
10	ICF	15,825	2,604	73	18,502	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,156	2,604	6,008	24,768	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.24%

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)
None

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

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

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

I. On what date did you start providing long term care at this location?
Date started 01/16/2012

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 2/1/12 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 51 and days of care provided 5,643

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 2012 Fiscal Year: 2012

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

Facility Name & ID Number Fireside House of Centralia # 0051755 Report Period Beginning: 1/16/12 Ending: 12/31/2012

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

	Operating Expenses	Costs Per General Ledger: Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	132,989	22,930	10,028	165,947		165,947	(73)	165,874			1
2	Food Purchase		176,518		176,518		176,518	(34)	176,484			2
3	Housekeeping	107,112	14,469	(4,097)	117,484		117,484		117,484			3
4	Laundry	56,571	10,508	(1,191)	65,888		65,888		65,888			4
5	Heat and Other Utilities			104,580	104,580		104,580	(173)	104,407			5
6	Maintenance	36,316	13,531	50,586	100,433		100,433		100,433			6
7	Other (specify):*			7,675	7,675		7,675		7,675			7
8	**TOTAL General Services**	332,988	237,956	167,581	738,525		738,525	(280)	738,245			8
	B. Health Care and Programs											
9	Medical Director			11,527	11,527		11,527		11,527			9
10	Nursing and Medical Records	1,243,230	60,095	24,106	1,327,431		1,327,431		1,327,431			10
10a	Therapy	18,569	3	726,755	745,327		745,327		745,327			10a
11	Activities	34,755	3,265	2,083	40,103		40,103	(720)	39,383			11
12	Social Services	30,633		2,006	32,639		32,639		32,639			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,327,187	63,363	766,477	2,157,027		2,157,027	(720)	2,156,307			16
	C. General Administration											
17	Administrative	76,517			76,517	12,008	88,525		88,525			17
18	Directors Fees											18
19	Professional Services			378,991	378,991		378,991	(287,679)	91,312			19
20	Dues, Fees, Subscriptions & Promotions			11,307	11,307		11,307	(1,343)	9,964			20
21	Clerical & General Office Expenses	128,551	87,556	34,844	250,951	(12,008)	238,943	66,761	305,704			21
22	Employee Benefits & Payroll Taxes			336,932	336,932		336,932	200,201	537,133			22
23	Inservice Training & Education			1,485	1,485		1,485	882	2,367			23
24	Travel and Seminar			2,768	2,768		2,768	1,645	4,413			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			58,628	58,628		58,628	34,836	93,464			26
27	Other (specify):*			20,590	20,590		20,590	(20,589)	1			27
28	**TOTAL General Administration**	205,068	87,556	845,545	1,138,169		1,138,169	(5,286)	1,132,883			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,865,243	388,875	1,779,603	4,033,721		4,033,721	(6,286)	4,027,435			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 #0051755 Report Period Beginning: 1/16/12 Ending: 12/31/2012

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			11,559	11,559		11,559	591	12,150			30
31	Amortization of Pre-Op. & Org.			12,832	12,832		12,832	656	13,488			31
32	Interest			44,015	44,015		44,015	(11,864)	32,151			32
33	Real Estate Taxes			99,595	99,595		99,595	5,090	104,685			33
34	Rent-Facility & Grounds			419,461	419,461		419,461	21,437	440,898			34
35	Rent-Equipment & Vehicles			19,995	19,995		19,995	1,022	21,017			35
36	Other (specify):*											36
37	**TOTAL Ownership**			607,457	607,457		607,457	16,932	624,389			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation		2,448	1,390	3,838		3,838	(1,390)	2,448			38
39	Ancillary Service Centers		247,173	2,952	250,125		250,125	(656)	249,469			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			160,667	160,667		160,667		160,667			42
43	Other (specify):* **Radiology/Lab**			10,404	10,404		10,404		10,404			43
44	**TOTAL Special Cost Centers**		249,621	175,413	425,034		425,034	(2,046)	422,988			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,865,243	638,496	2,562,473	5,066,212		5,066,212	8,600	5,074,812			45

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

Facility Name & ID Number Fireside House of Centralia # 0051755 Report Period Beginning: 1/16/12 Ending: 12/31/2012

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	(34)	2		4
5	Telephone, TV & Radio in Resident Rooms	(173)	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	(14,113)	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)	(20)	27		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(9,448)	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	(20,197)	27		24
25	Fund Raising, Advertising and Promotional	(2,170)	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	(9,278)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (55,433)		$	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)	64,033		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 64,033		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 8,600		37

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

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

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

Fireside House of Centralia

ID# 0051755

Report Period Beginning: 1/16/12

Ending: 12/31/2012

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Chamber of Commerce Dues	$ (5,892)	20	1
2	Prior Year Expense-Other	(372)	27	2
3	Prior Year Expense Ancillary	(656)	39	3
4	Activities Revenue	(720)	11	4
5	Medical Tranportstion	(1,390)	38	5
6	Grease Trap Refund	(73)	1	6
7	Money Received for Copying	(175)	21	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**	(9,278)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Fireside House of Centralia # 0051755 **Report Period Beginning:** 1/16/12 **Ending:** 12/31/2012

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	(73)	0	0	0	0	0	0	0	0	0	0	(73)	1
2	Food Purchase	(34)	0	0	0	0	0	0	0	0	0	0	(34)	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	(173)	0	0	0	0	0	0	0	0	0	0	(173)	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**	(280)	0	0	0	0	0	0	0	0	0	0	(280)	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	(720)	0	0	0	0	0	0	0	0	0	0	(720)	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**	(720)	0	0	0	0	0	0	0	0	0	0	(720)	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	(287,679)	0	0	0	0	0	0	0	0	0	(287,679)	19
20	Fees, Subscriptions & Promotions	(8,062)	6,719	0	0	0	0	0	0	0	0	0	(1,343)	20
21	Clerical & General Office Expenses	(9,623)	76,384	0	0	0	0	0	0	0	0	0	66,761	21
22	Employee Benefits & Payroll Taxes	0	200,201	0	0	0	0	0	0	0	0	0	200,201	22
23	Inservice Training & Education	0	882	0	0	0	0	0	0	0	0	0	882	23
24	Travel and Seminar	0	1,645	0	0	0	0	0	0	0	0	0	1,645	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	34,836	0	0	0	0	0	0	0	0	0	34,836	26
27	Other (specify):*	(20,589)	0	0	0	0	0	0	0	0	0	0	(20,589)	27
28	**TOTAL General Administration**	(38,274)	32,988	0	0	0	0	0	0	0	0	0	(5,286)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(39,274)	32,988	0	0	0	0	0	0	0	0	0	(6,286)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Fireside House of Centralia # 0051755 **Report Period Beginning:** 1/16/12 **Ending:** 12/31/2012

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	591	0	0	0	0	0	0	0	0	0	591	30
31	Amortization of Pre-Op. & Org.	0	656	0	0	0	0	0	0	0	0	0	656	31
32	Interest	(14,113)	2,249	0	0	0	0	0	0	0	0	0	(11,864)	32
33	Real Estate Taxes	0	5,090	0	0	0	0	0	0	0	0	0	5,090	33
34	Rent-Facility & Grounds	0	0	21,437	0	0	0	0	0	0	0	0	21,437	34
35	Rent-Equipment & Vehicles	0	0	1,022	0	0	0	0	0	0	0	0	1,022	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(14,113)	8,586	22,459	0	0	0	0	0	0	0	0	16,932	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	(1,390)	0	0	0	0	0	0	0	0	0	0	(1,390)	38
39	Ancillary Service Centers	(656)	0	0	0	0	0	0	0	0	0	0	(656)	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	(2,046)	0	0	0	0	0	0	0	0	0	0	(2,046)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(55,433)	41,574	22,459	0	0	0	0	0	0	0	0	8,600	45

Facility Name & ID Number Fireside House of Centralia # 0051755 Report Period Beginning: 1/16/12 Ending: 12/31/2012

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
Daren Douston	50%	Frindship House of Centralia	Centralia	Five Rivers Manageme	Alpharetta	LTC Mgt/Accting
Kerry Gibson	50%	Great Bend Health & Rehab Center	Great Bend	Woodland-LTC, LLC	Shepherd	LTC Operator
				Rosewood-LTC, LLC	Converse	LTC Operator

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Accounting Fees	$ 33,000	Five Rivers Management, LLC.	100.00%	$	$ (33,000)	1
2	V	19	Management Fees	288,713	Five Rivers Management, LLC.	100.00%		(288,713)	2
3	V	19	Non-Related Professional Fees		Five Rivers Management, LLC.	100.00%	34,034	34,034	3
4	V	20	Dues, Fees, Subs and Promos		Five Rivers Management, LLC.	100.00%	6,719	6,719	4
5	V	21	Clerical and gen Office Exp		Five Rivers Management, LLC.	100.00%	76,384	76,384	5
6	V	22	Employee Benefits & Taxes		Five Rivers Management, LLC.	100.00%	200,201	200,201	6
7	V	23	In Svc Training & education		Five Rivers Management, LLC.	100.00%	882	882	7
8	V	24	Travel & Seminars		Five Rivers Management, LLC.	100.00%	1,645	1,645	8
9	V	26	Liabiluity Insurance		Five Rivers Management, LLC.	100.00%	34,836	34,836	9
10	V	30	Depreciation		Five Rivers Management, LLC.	100.00%	591	591	10
11	V	31	Amortization		Five Rivers Management, LLC.	100.00%	656	656	11
12	V	32	Non Related interest		Five Rivers Management, LLC.	100.00%	2,249	2,249	12
13	V	33	Ereal Estate Taxes		Five Rivers Management, LLC.	100.00%	5,090	5,090	13
14	Total			$ 321,713			$ 363,287	$ * 41,574	14

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

Facility Name & ID Number Fireside House of Centralia # 0051755 Report Period Beginning: 1/16/12 Ending: 12/31/2012

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	Building Lease	$	Five Rivers Management	100.00%	$ 21,437	$ 21,437	15
16	V	35	Rental Equip & Vehicles		Five Rivers Management	100.00%	1,022	1,022	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			$			$ 22,459	$ * 22,459	39

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

Facility Name & ID Number Fireside House of Centralia # 0051755 Report Period Beginning: 1/16/12 Ending: 12/31/2012

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	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
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 # 0051755 Report Period Beginning: 1/16/12 Ending: 2/31/2012

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: Five Rivers Management, LLC.
Street Address: 10945 State Bridge Road Suite 40`-470
City / State / Zip Code: Alpharetta, GA 30022
Phone Number: (404-991-2430
Fax Number: (404-991-2431

	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 Cost	23,512,170	9	$ 1,719,353	$ 226,417	4,850,525	$ 354,700	1
2	32	Capital	Total Cost	23,512,170	9	150,484		4,850,525	31,045	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					$ 1,869,837	$ 226,417		$ 385,745	25

Facility Name & ID Number Fireside House of Centralia # 0051755 Report Period Beginning: 1/16/12 Ending: 12/31/2012

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							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Zeigler Healthcare		X	AR Financing		8/19/2007	349,672	342,478		15.0000	12,509	6
7	1st Insurance Funding		X	Liability, WC Prop & Auto						variable	3,410	7
8	Gemino		X	AR Financing		2/1/2012	Variable				27,270	8
9	TOTAL Facility Related						$ 349,672	$ 342,478			$ 43,189	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 349,672	$ 342,478			$ 43,189	15

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

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

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

Facility Name & ID Number Fireside House of Centralia # 0051755 Report Period Beginning: 1/16/12 Ending: 12/31/2012

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	Independent Telecom		X	Phone System							115	6
7	Marlin Leasing		X	Phones							711	7
8												8
9	TOTAL Facility Related						$	$			$ 826	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 826	15

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

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

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

Facility Name & ID Number Fireside House of Centralia # 0051755 Report Period Beginning: 1/16/12 Ending: 12/31/2012

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 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 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 99,035	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.		$ 99,035	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007		8
	2008		9
	2009		10
	2010		11
	2011	99,035	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Fireside House of Centralia COUNTY Marion

FACILITY IDPH LICENSE NUMBER 0051755

CONTACT PERSON REGARDING THIS REPORT Matthew Larson

TELEPHONE (678) 381-2820 FAX #: (678) 381-2821

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

Enter the tax index number and real estate tax assessed for 2011 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 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-17-110-06	PT SW NE NW	$ 102,903.54	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 102,903.54	$

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

Facility Name & ID Number Fireside House of Centralia # 0051755 Report Period Beginning: 1/16/12 Ending: 12/31/2012

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (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. [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				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Fireside House of Centralia # 0051755 Report Period Beginning: 1/16/12 Ending: 12/31/2012

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					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Painting Upper half of West Wing Walls			2012	2,864	382	5	382	0	382	9
10	Drain Upgrade			2012	1,118	130	5	130	(0)	130	10
11	Drain Upgrade			2012	1,988	232	5	232	0	232	11
12	Kitchen Grease Trap replacement			2012	3,350	279	5	279	(0)	279	12
13	Comdial DX-120 Key Telephone System			2012	1,731	317	5	317	(0)	317	13
14	10-ton HVAC Unit 225,000 BTU			2012	8,139	678	10	678	(0)	678	14
15	Water Heater (State Brand; 80 Gallon)			2012	13,900	2,317	5	2,317	0	2,317	15
16	Thru-Wall Air Conditioner, Heat/Cool, UniFit 11,500/11,200 BTU			2012	2,027	237	5	237	0	237	16
17	Removal and Replacement of Rooftop Unit			2012	6,285	733	5	733	(0)	733	17
18	Gas Pack Unit 225k BUT 10 Ton Cooling Unit			2012	8,139	814	5	814	0	814	18
19	3 Ton AC Unit				1,891	189	5	189	(0)	189	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 # 0051755 Report Period Beginning: 1/16/12 Ending: 12/31/2012

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)		$ 51,434	$ 6,309		$ 6,308	$ (1)	$ 6,308	70

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

Facility Name & ID Number Fireside House of Centralia # 0051755 Report Period Beginning: 1/16/12 Ending: 12/31/2012

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	$	$	$	$		$	71
72	Current Year Purchases	8,455	1,452	5,251	3,799	3-10	7,362	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 8,455	$ 1,452	$ 5,251	$ 3,799		$ 7,362	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 59,889	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 7,761	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 11,559	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 3,798	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 13,670	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Fireside House of Centralia # 0051755 Report Period Beginning: 1/16/12 Ending: 12/31/2012

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: LTC of Illinois Fireside, Inc.
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. [X] 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:	1963	98	2/1/2012	$ 457,594	10	5	3
4	Additions							4
5								5
6								6
7	TOTAL		98		$ 457,594 **			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 [X] NO Terms: *

10. Effective dates of current rental agreement:
    Beginning 2/1/12
    Ending 1/31/2022

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

	Fiscal Year Ending	Annual Rent
12.	/2013	$ 465,601
13.	/2014	$ 473,750
14.	/2015	$ 482,040

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] 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 Fireside House of Centralia # 0051755 Report Period Beginning: 1/16/12 Ending: 12/31/2012

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Fireside House of Centralia # 0051755 Report Period Beginning: 1/16/12 Ending: 12/31/2012

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	250.65	hrs	$ 6,567		$	$	251	$ 6,567	1
2	Licensed Speech and Language Development Therapist	10A1	88.43	hrs	3,753				88	3,753	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10A1	290.46	hrs	8,249			3	290	8,252	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				$ 18,569		$	$ 3	630	$ 18,573	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 # 0051755 Report Period Beginning: 1/16/12 Ending: 12/31/2012

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2012 (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	$ 22,335	$	1
2	Cash-Patient Deposits	13,710		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,015,245		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	14,184		6
7	Other Prepaid Expenses	4,653		7
8	Accounts Receivable (owners or related parties)	229,992		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,300,119	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	9,320		15
16	Equipment, at Historical Cost	50,569		16
17	Accumulated Depreciation (book methods)	(7,761)		17
18	Deferred Charges	28,636		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 80,764	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,380,883	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 367,783	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,710		28
29	Short-Term Notes Payable	645,592		29
30	Accrued Salaries Payable	157,218		30
31	Accrued Taxes Payable (excluding real estate taxes)	29,309		31
32	Accrued Real Estate Taxes(Sch.IX-B)	93,500		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37	Other Accruals	94,393		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,401,505	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			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)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,401,505	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (20,622)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,380,883	$	48

***(See instructions.)**

Facility Name & ID Number Fireside House of Centralia # 0051755 Report Period Beginning: 1/16/12 Ending: 12/31/2012

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 7,068	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 7,068	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(35,815)	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) **Prior Year Equity Adjustment**	8,125	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (27,690)	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)**	$ (20,622)	24 *

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

Facility Name & ID Number Fireside House of Centralia # 0051755 Report Period Beginning: 1/16/12 Ending: 12/31/2012

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,580,608	1
2	Discounts and Allowances for all Levels	1,091,003	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,671,611	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	343,379	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 343,379	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	34	14
15	Telephone, Television and Radio	173	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	840	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,047	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	14,113	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 14,113	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Refund for Grease Trap & Copies	248	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 248	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,030,399	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	738,526	31
32	Health Care	2,157,028	32
33	General Administration	1,138,169	33
	B. Capital Expense		
34	Ownership	607,456	34
	C. Ancillary Expense		
35	Special Cost Centers	264,368	35
36	Provider Participation Fee	160,667	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,066,214	40
41	**Income before Income Taxes (line 30 minus line 40)****	(35,815)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (35,815)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$	49

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

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

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

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

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	3,519	3,957	$ 122,534	$ 30.97	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,428	10,216	226,486	22.17	3
4	Licensed Practical Nurses	16,987	18,825	365,149	19.40	4
5	CNAs & Orderlies	48,274	52,916	528,046	9.98	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,963	3,202	34,755	10.85	10
11	Social Service Workers	1,809	1,959	30,633	15.64	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,132	14,256	132,989	9.33	15
16	Dishwashers					16
17	Maintenance Workers	2,147	2,317	36,316	15.67	17
18	Housekeepers	10,961	11,836	107,112	9.05	18
19	Laundry	5,733	6,329	56,571	8.94	19
20	Administrator	1,855	2,153	88,525	41.12	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,194	5,747	116,543	20.28	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	768	888	11,016	12.41	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	122,770	134,601	$ 1,856,675 *	$ 13.79	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	220	$ 10,028	1-3	35
36	Medical Director		11,527	9-3	36
37	Medical Records Consultant	30	1,485	23-3	37
38	Nurse Consultant		(2,808)	10-3	38
39	Pharmacist Consultant		2,296	39-3	39
40	Physical Therapy Consultant		334,308	10A-3	40
41	Occupational Therapy Consultant		340,266	10A-3	41
42	Respiratory Therapy Consultant			10A-3	42
43	Speech Therapy Consultant		51,182	10A-3	43
44	Activity Consultant	38	2,083	11-3	44
45	Social Service Consultant	36	2,006	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	324	$ 752,373		49

C. CONTRACT NURSES

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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kathy Berck	Administrator	0	$ 46,335
Eric Clark	Administrator	0	22,863
David Eifert	Administrator	0	7,319
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 76,517

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
AltaCare Corporation	Accounting Fee	$ 1,580
AltaCare Corporation	Management Fees	12,454
PayDay USA	Payroll	187
CT Corporation	Registered Agent Fees	1,114
Five Riversmanagement	Accounting Fees	33,000
Proliant	Payroll Processing	10,287
Regions Bank	Service Fees	2,770
Saylor Law	Legal Fees	692
McNair, Mclemore, Middlebrook	Auditing Fees	3,141
Five Rivers Management	Management Fees	288,713
Gemino	3rd Party Mgt Fees	16,872
Gemino	Auditing Fees	8,179
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 378,991

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 79,089
Unemployment Compensation Insurance	
FICA Taxes	199,724
Employee Health Insurance	47,540
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Appreciation	2,541
Dental Insurance	(43)
Life Insurance	6,690
Vision Ianurance	(108)
Moving Expense	1,500
TOTAL (agree to Schedule V, line 22, col.8)	$ 336,933

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 237
Advertising: Employee Recruitment	800
Health Care Worker Background Check	2,711
(Indicate # of checks performed 46)	
Patient Background Checks	
	5,892
	60
	75
	1,532
Less Subscriptions and Permits	(132)
Less: Public Relations Expense	(5,892)
Non-allowable advertising	(2,035)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,249

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Milage	2,727
meals	20
Seminar Expense	
	21
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,768

**See instructions.

Facility Name & ID Number Fireside House of Centralia # 0051755 Report Period Beginning: 1/16/12 Ending: 12/31/2012

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 Fireside House of Centralia # 0051755 Report Period Beginning: 1/16/12 Ending: 12/31/2012

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. **IL Healthcare Association $5491.52**

(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? **3-10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,633** Line **10-2**

(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. $ **51,602**
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. $ **34**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
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? **0**
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.