

Facility Name & ID Number Fireside House of Centralia

0051755 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	82		6,074	6,156	8
9	SNF/PED					9
10	ICF	18,136	3,663	93	21,892	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,218	3,663	6,167	28,048	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.41%

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

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

YES NO

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

Date started 01/16/2012

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

YES Date 02/01/2012 NO

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

YES NO If YES, enter number of beds certified 51 and days of care provided _____

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 2013 Fiscal Year: 2013

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

Facility Name & ID Number

Fireside House of Centralia

0051755

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	146,466	20,974	8,697	176,137		176,137		176,137		1
2	Food Purchase		194,050		194,050		194,050	(2,221)	191,829		2
3	Housekeeping	104,906	12,039	(4,760)	112,185		112,185		112,185		3
4	Laundry	57,785	10,121		67,906		67,906		67,906		4
5	Heat and Other Utilities			115,880	115,880		115,880	(155)	115,725		5
6	Maintenance	33,257	6,382	40,011	79,650		79,650		79,650		6
7	Other (specify):* Trash/Recycling			10,234	10,234		10,234		10,234		7
8	TOTAL General Services	342,414	243,566	170,062	756,042		756,042	(2,376)	753,666		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	1,368,583	72,085	14,912	1,455,580		1,455,580		1,455,580		10
10a	Therapy		347	785,080	785,427		785,427		785,427		10a
11	Activities	41,096	4,016	2,192	47,304		47,304	(260)	47,044		11
12	Social Services	33,800	59	1,700	35,559		35,559		35,559		12
13	CNA Training										13
14	Program Transportation							(115)	(115)		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,443,479	76,507	815,884	2,335,870		2,335,870	(375)	2,335,495		16
	C. General Administration										
17	Administrative	90,978			90,978		90,978		90,978		17
18	Directors Fees										18
19	Professional Services			424,526	424,526		424,526	(257,861)	166,665		19
20	Dues, Fees, Subscriptions & Promotions			18,078	18,078		18,078	(10,684)	7,394		20
21	Clerical & General Office Expenses	138,783	90,764	27,068	256,615		256,615	57,240	313,855		21
22	Employee Benefits & Payroll Taxes			345,208	345,208		345,208	83,440	428,648		22
23	Inservice Training & Education			2,162	2,162		2,162	537	2,699		23
24	Travel and Seminar			3,220	3,220		3,220	34,322	37,542		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			61,053	61,053		61,053	15,168	76,221		26
27	Other (specify):*			11,638	11,638		11,638	(11,638)			27
28	TOTAL General Administration	229,761	90,764	892,953	1,213,478		1,213,478	(89,476)	1,124,002		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,015,654	410,837	1,878,899	4,305,390		4,305,390	(92,227)	4,213,163		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:

1/1/2013

Ending:

12/31/2013

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			14,916	14,916		14,916	2,072	16,988			30
31	Amortization of Pre-Op. & Org.			14,769	14,769		14,769	2,052	16,821			31
32	Interest			44,018	44,018		44,018	(22,864)	21,154			32
33	Real Estate Taxes			102,238	102,238		102,238	14,202	116,440			33
34	Rent-Facility & Grounds			464,934	464,934		464,934		464,934			34
35	Rent-Equipment & Vehicles			14,412	14,412		14,412	2,002	16,414			35
36	Other (specify):*			(2,070)	(2,070)		(2,070)		(2,070)			36
37	TOTAL Ownership			653,217	653,217		653,217	(2,536)	650,681			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation		4,809	1,656	6,465		6,465	(1,541)	4,924			38
39	Ancillary Service Centers		271,518	5,058	276,576		276,576	(2,430)	274,146			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			177,902	177,902		177,902		177,902			42
43	Other (specify):* See Pg 24			14,458	14,458		14,458		14,458			43
44	TOTAL Special Cost Centers		276,327	199,074	475,401		475,401	(3,971)	471,430			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,015,654	687,164	2,731,190	5,434,008		5,434,008	(98,734)	5,335,274			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: 1/1/2013

Ending: 12/31/2013

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-	BHF USE	
			ence	ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(452)	2		4
5	Telephone, TV & Radio in Resident Rooms	(155)	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	(25,444)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,769)	2		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)	(314)	27		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(358)	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	(43,516)	27		24
25	Fund Raising, Advertising and Promotional	(5,398)	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	15,078			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (62,328)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(36,406)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (36,406)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (98,734)		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

Fireside House of Centralia

ID# 0051755

Report Period Beginning: 1/1/2013

Ending: 12/31/2013

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Activities Revenue	\$ (260)	11	1
2	Non-Medical Transportation	(115)	14	2
3	Chamber of Commerce Dues	(6,241)	20	3
4	Subscriptions	(442)	20	4
5	Permits	(75)	20	5
6	Money Received for Copying	(13)	21	6
7	Donations	(215)	21	7
8	Vendor Late Fees	(5,782)	21	8
9	Prior Year Expense-Operating	32,192	27	9
10	Medical Transportation	(1,541)	38	10
11	Prior Year Expense-Ancillaries	(2,430)	39	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		15,078	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Fireside House of Centralia# 0051755

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

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	(2,221)	0	0	0	0	0	0	0	0	0	0	(2,221)	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	(155)	0	0	0	0	0	0	0	0	0	0	(155)	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	(2,376)	0	0	0	0	0	0	0	0	0	0	(2,376)	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	(260)	0	0	0	0	0	0	0	0	0	0	(260)	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	(115)	0	0	0	0	0	0	0	0	0	0	(115)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(375)	0	0	0	0	0	0	0	0	0	0	(375)	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	(257,861)	0	0	0	0	0	0	0	0	0	(257,861)	19
20	Fees, Subscriptions & Promotions	(12,156)	1,472	0	0	0	0	0	0	0	0	0	(10,684)	20
21	Clerical & General Office Expenses	(6,368)	63,608	0	0	0	0	0	0	0	0	0	57,240	21
22	Employee Benefits & Payroll Taxes	0	83,440	0	0	0	0	0	0	0	0	0	83,440	22
23	Inservice Training & Education	0	537	0	0	0	0	0	0	0	0	0	537	23
24	Travel and Seminar	0	34,322	0	0	0	0	0	0	0	0	0	34,322	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	15,168	0	0	0	0	0	0	0	0	0	15,168	26
27	Other (specify):*	(11,638)	0	0	0	0	0	0	0	0	0	0	(11,638)	27
28	TOTAL General Administration	(30,162)	(59,314)	0	(89,476)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(32,913)	(59,314)	0	(92,227)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Fireside House of Centralia# 0051755

Report Period Beginning:

1/1/2013 Ending:

12/31/2013

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	2,072	0	0	0	0	0	0	0	0	0	2,072	30
31	Amortization of Pre-Op. & Org.	0	2,052	0	0	0	0	0	0	0	0	0	2,052	31
32	Interest	(25,444)	2,580	0	0	0	0	0	0	0	0	0	(22,864)	32
33	Real Estate Taxes	0	14,202	0	0	0	0	0	0	0	0	0	14,202	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	2,002	0	0	0	0	0	0	0	0	2,002	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(25,444)	20,906	2,002	0	(2,536)	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	(1,541)	0	0	0	0	0	0	0	0	0	0	(1,541)	38
39	Ancillary Service Centers	(2,430)	0	0	0	0	0	0	0	0	0	0	(2,430)	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	(3,971)	0	0	0	0	0	0	0	0	0	0	(3,971)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(62,328)	(38,408)	2,002	0	(98,734)	45							

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%	Friendship House of Centralia	Centralia	Five Rivers Management	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. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	19 Accounting Fees	\$ 37,650	Five Rivers Management, LLC	100.00%	\$	\$ (37,650)	1
2	V	19 Manangement Fees	325,680	Five Rivers Management, LLC	100.00%		(325,680)	2
3	V	19 Non-Related Professional Fees		Five Rivers Management, LLC	100.00%	105,469	105,469	3
4	V	20 Dues, Fees, Subs and Promos		Five Rivers Management, LLC	100.00%	1,472	1,472	4
5	V	21 Clerical and Gen Office Exp		Five Rivers Management, LLC	100.00%	63,608	63,608	5
6	V	22 Employee Benefits & Taxes		Five Rivers Management, LLC	100.00%	83,440	83,440	6
7	V	23 In Svc Traning & Educ		Five Rivers Management, LLC	100.00%	537	537	7
8	V	24 Travel & Seminars		Five Rivers Management, LLC	100.00%	34,322	34,322	8
9	V	26 Liability Insurance		Five Rivers Management, LLC	100.00%	15,168	15,168	9
10	V	30 Depreciation		Five Rivers Management, LLC	100.00%	2,072	2,072	10
11	V	31 Amortization		Five Rivers Management, LLC	100.00%	2,052	2,052	11
12	V	32 Non-Related Interest		Five Rivers Management, LLC	100.00%	2,580	2,580	12
13	V	33 Real Estate Taxes		Five Rivers Management, LLC	100.00%	14,202	14,202	13
14	Total		\$ 363,330			\$ 324,922	\$ * (38,408)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	35 Rental Equipment & Vehicles	\$	Five Rivers Management, LLC	100.00%	\$ 2,002	\$	2,002	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		\$			\$ 2,002	\$ *	2,002	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: 1/1/2013 Ending: 12/31/2013

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Fireside House of Centralia

0051755 Report Period Beginning: 1/1/2013

Ending: 2/31/2013

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	Management Fees	Total Cost	17	\$ 1,378,604	\$ 213,899	5,432,240	\$ 304,016	1
2	32	Capital	Total Cost	17	103,880		5,432,240	22,908	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				\$ 1,482,484	\$ 213,899		\$ 326,924	25

Facility Name & ID Number

Fireside House of Centralia

0051755

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10	11						
		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	Marlin Leasing		X	Time Clock	\$165.34	1/31/2012	\$ 2,964	\$	12/31/2013	29.2200	\$ 292	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6	1st Insurance Funding		X	Liability, WC, Prop & Auto			Variable				2,290	6						
7	Gemino Financial		X	AR Financing		2/1/2012	Variable				41,435	7						
8												8						
9	TOTAL Facility Related				\$165.34		\$ 2,964	\$			\$ 44,017	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 2,964	\$			\$ 44,017	15						

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2012 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 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	195,500		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.		\$	195,500		7	
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2008	_____	8	FOR BHF USE ONLY		
	2009	_____	9			
	2010	_____	10			
	2011	99,035	11			
	2012	101,793	12			
				13	FROM R. E. TAX STATEMENT FOR 2012 \$	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.

2012 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 2012 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 2012.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>14-17-100-006</u>	<u>PT SW NE NW</u>	\$ <u>101,793.34</u>	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>101,793.34</u></u>	\$ <u><u> </u></u>

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation 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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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:

1/1/2013 Ending:

12/31/2013

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

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

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

1. Total Amount Incurred: _____ 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Grade and Compact Service Drive		2013	2,796	320	8	320		320	9
10	Fire Suppression		2013	28,181	658	25	658		658	10
11	Fire Sprinkler renovation		2013	34,700	694	25	694		694	11
12	Water Heater		2013	12,460	1,246	10	1,246		1,246	12
13	Thru-Wall Air Conditioner		2013	2,694	225	5	225		225	13
14	Nurse Call System		2013	1,500	50	5	50		50	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Fireside House of Centralia

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 82,332	\$ 3,193		\$ 3,193	\$	\$ 3,193	70

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

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	\$ 59,889	\$ 8,219	\$ 8,219	\$	3-25	\$ 13,282	71
72	Current Year Purchases	21,097	3,407	3,407		3-10	3,407	72
73	Fully Depreciated Assets							73
74	Removal of Asset	(6,285)						74
75	TOTALS	\$ 74,701	\$ 11,625	\$ 11,625	\$		\$ 16,689	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	Transport Residents	Van, Dodge, 1999	2013	\$ 500	\$ 97	\$ 97	\$	3	\$ 97	76
77										77
78										78
79										79
80	TOTALS			\$ 500	\$ 97	\$ 97	\$		\$ 97	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)	\$ 157,533	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 14,915	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 14,915	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)	\$ 19,978	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: 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. 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:	<u>1963</u>	<u>98</u>	<u>2/1/2012</u>	\$	<u>10</u>	<u>5</u>	3
4	Additions							4
5								5
6								6
7	TOTAL		<u>98</u>		\$			7

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. /2014 \$ 473,750

13. /2015 \$ 482,040

14. /2016 \$ 490,476

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ _____ 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: 1/1/2013 Ending: 12/31/2013
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist		hrs	\$			\$ 344,537	\$		\$	344,537	1
2	Licensed Speech and Language Development Therapist		hrs				62,409				62,409	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist		hrs				378,134				378,134	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy		# of prescripts									9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify):											12
13	Other (specify):											13
14	TOTAL			\$			\$ 785,080	\$		\$	785,080	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# 0051755Report Period Beginning: 1/1/2013

Ending:

12/31/2013

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2013

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 9,629	\$	1
2	Cash-Patient Deposits	23,649		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,201,440		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	11,496		6
7	Other Prepaid Expenses	9,142		7
8	Accounts Receivable (owners or related parties)	435,782		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,691,138	\$	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	74,998		15
16	Equipment, at Historical Cost	84,766		16
17	Accumulated Depreciation (book methods)	(20,967)		17
18	Deferred Charges	16,123		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)	\$ 154,920	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,846,058	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 790,244	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	23,649		28
29	Short-Term Notes Payable	638,551		29
30	Accrued Salaries Payable	149,872		30
31	Accrued Taxes Payable (excluding real estate taxes)	31,885		31
32	Accrued Real Estate Taxes(Sch.IX-B)	195,500		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Audit fees and Occupancy Tax	26,437		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,856,138	\$	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)	\$ 1,856,138	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (10,081)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,846,057	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (20,620)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (20,620)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	10,539	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 10,539	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)	\$ (10,081)	24 *

* This must agree with page 17, line 47.

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

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,997,348	1
2	Discounts and Allowances for all Levels	1,072,082	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,069,430	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	332,601	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 332,601	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	452	14
15	Telephone, Television and Radio	155	15
16	Rental of Facility Space		16
17	Sale of Drugs	5,556	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	453	19
20	Radiology and X-Ray		20
21	Other Medical Services	8,460	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 15,076	23
D. Non-Operating Revenue			
24	Contributions	215	24
25	Interest and Other Investment Income***	25,444	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 25,659	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Raw Food Rebate</u>	1,769	28
28a	<u>Money Rcvd for copying</u>	13	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,782	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,444,548	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	621,112	31
32	Health Care	2,335,870	32
33	General Administration	1,348,410	33
B. Capital Expense			
34	Ownership	653,216	34
C. Ancillary Expense			
35	Special Cost Centers	297,499	35
36	Provider Participation Fee	177,902	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,434,009	40
41	Income before Income Taxes (line 30 minus line 40)**	10,539	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 10,539	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.

Facility Name & ID Number Fireside House of Centralia

0051755

Report Period Beginning: 1/1/2013

Ending: 12/31/2013

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	3,716	4,021	\$ 120,294	\$ 29.92	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,205	9,876	220,693	22.35	3
4	Licensed Practical Nurses	17,181	18,849	368,454	19.55	4
5	CNAs & Orderlies	53,903	58,609	592,724	10.11	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,533	3,969	41,094	10.35	10
11	Social Service Workers	1,978	2,145	33,800	15.76	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,202	15,438	146,466	9.49	15
16	Dishwashers					16
17	Maintenance Workers	2,054	2,204	33,257	15.09	17
18	Housekeepers	10,506	11,594	104,906	9.05	18
19	Laundry	5,923	6,401	57,779	9.03	19
20	Administrator	1,887	2,080	100,333	48.24	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,530	6,130	129,264	21.09	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,622	1,767	22,433	12.70	31
32	Other Health C: <u>MDS</u>	1,799	2,007	43,872	21.86	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	133,039	145,090	\$ 2,015,369 *	\$ 13.89	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	193	\$ 8,697	1-3	35
36	Medical Director		12,000	9-3	36
37	Medical Records Consultant	39	1,962	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,627	39-3	39
40	Physical Therapy Consultant		378,134	10A-3	40
41	Occupational Therapy Consultant		344,537	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant		62,409	10A-3	43
44	Activity Consultant	40	2,192	11-3	44
45	Social Service Consultant	31	1,700	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	303	\$ 814,257		49

C. CONTRACT NURSES

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

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	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	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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. _____
- (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. \$ _____ 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. \$ _____
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. \$ _____
- (16) Travel and Transportation
 - a. Are there costs included for out-of-state travel? _____
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? _____
 - 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.

Fireside House of Centralia
Provider # 0051755
FYE 12/31/2013
LINE 43 Column 3

<i>Description</i>	<i>Amount</i>
Radiology Services	
St. Marys Hospital	93.69
BioTech	6,444.00
Neuromuscular Orthopaedic Inst	55.03
The Retina Institute	15.92
	<hr/>
	6,608.64
	<hr/> <hr/>
 Lab Services	
St. Marys Hospital	50.51
MedLab	7,798.89
	<hr/>
	7,849.40
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