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.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

I. IDPH License ID Number: 0051755

Facility Name: FIRESIDE HOUSE OF CENTRALIA

Address: 1030 MLK DRIVE (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	
	Charitable Corp.	
	Trust	
	IRS Exemption Code	
	PROPRIETARY	
	Individual	
	Partnership	
	Corporation	
	"Sub-S" Corp.	
x	Limited Liability Co.	
	Trust	
	Other	
	GOVERNMENTAL	
	State	
	County	
	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 1/1/2014 to 12/31/2014 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 ROAD, STE 401-470
(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: 1/1/2014 Ending: 12/31/2014

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			5,978	5,978	8
9	SNF/PED					9
10	ICF	22,526	4,410	69	27,005	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,526	4,410	6,047	32,983	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.21%

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 1/16/2012

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 2/01/2012 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 _____

Medicare Intermediary WISCONSIN PHYSICIANS SERVICES

IV. ACCOUNTING BASIS

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

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

Tax Year: 2014 Fiscal Year: 2014

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

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA # 0051755 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	164,359	21,252	8,884	194,495		194,495		194,495			1
2	Food Purchase		230,715		230,715		230,715	(3,867)	226,848			2
3	Housekeeping	106,049	17,762		123,811		123,811		123,811			3
4	Laundry	68,762	13,639		82,401		82,401		82,401			4
5	Heat and Other Utilities			121,502	121,502		121,502	(25)	121,477			5
6	Maintenance	31,949	10,126	37,476	79,551		79,551		79,551			6
7	Other (specify):* Trash & Recycling			7,070	7,070		7,070		7,070			7
8	TOTAL General Services	371,119	293,494	174,932	839,545		839,545	(3,892)	835,653			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,560,302	75,795	13,610	1,649,707	962	1,650,669		1,650,669			10
10a	Therapy			684,906	684,906		684,906		684,906			10a
11	Activities	50,232	2,897	2,223	55,352		55,352	(746)	54,606			11
12	Social Services	41,135		2,223	43,358		43,358		43,358			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,651,669	78,692	714,962	2,445,323	962	2,446,285	(746)	2,445,539			16
	C. General Administration											
17	Administrative	90,796			90,796	4,575	95,371		95,371			17
18	Directors Fees											18
19	Professional Services			493,599	493,599		493,599	(288,353)	205,246			19
20	Dues, Fees, Subscriptions & Promotions			18,205	18,205		18,205	(3,288)	14,917			20
21	Clerical & General Office Expenses	109,962	90,643	51,031	251,636		251,636	47,329	298,965			21
22	Employee Benefits & Payroll Taxes			404,965	404,965	(4,575)	400,390	103,227	503,617			22
23	Inservice Training & Education			2,141	2,141	(962)	1,179	546	1,725			23
24	Travel and Seminar			3,909	3,909		3,909	39,306	43,215			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			78,297	78,297		78,297	19,958	98,255			26
27	Other (specify):*			25,094	25,094		25,094	(25,094)				27
28	TOTAL General Administration	200,758	90,643	1,077,241	1,368,642	(962)	1,367,680	(106,369)	1,261,311			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,223,546	462,829	1,967,135	4,653,510		4,653,510	(111,007)	4,542,503			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: 1/1/2014 Ending: 12/31/2014

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			18,951	18,951		18,951	2,782	21,733			30
31	Amortization of Pre-Op. & Org.			15,340	15,340		15,340	2,252	17,592			31
32	Interest			45,238	45,238		45,238	(20,867)	24,371			32
33	Real Estate Taxes			105,376	105,376		105,376	15,470	120,846			33
34	Rent-Facility & Grounds			455,460	455,460		455,460		455,460			34
35	Rent-Equipment & Vehicles			11,487	11,487		11,487	1,686	13,173			35
36	Other (specify):*			53,571	53,571		53,571	(53,571)	(0)			36
37	TOTAL Ownership			705,423	705,423		705,423	(52,248)	653,175			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	6,338	4,817	1,257	12,412		12,412	(1,257)	11,155			38
39	Ancillary Service Centers		272,560	6,965	279,525		279,525	(3,944)	275,581			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			218,965	218,965		218,965		218,965			42
43	Other (specify):* Radiology & Lab Services			14,261	14,261		14,261		14,261			43
44	TOTAL Special Cost Centers	6,338	277,377	241,448	525,163		525,163	(5,201)	519,962			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,229,884	740,206	2,914,006	5,884,096		5,884,096	(168,456)	5,715,640			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: 1/1/2014 Ending: 12/31/2014

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	(1,348)	2		4
5	Telephone, TV & Radio in Resident Rooms	(25)	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	(27,507)	32		10
11	Discounts, Allowances, Rebates & Refunds	(2,519)	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)	(30)	27		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(16,432)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(21,277)	27		24
25	Fund Raising, Advertising and Promotional	(6,016)	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	(65,600)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (140,754)		$	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)	(27,701)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (27,701)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (168,455)		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: 1/1/2014

Ending: 12/31/2014

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Activities Revenue	$ (140)	11	1
2	Donations	(606)	11	2
3	Chamber of Commerce Dues	(267)	20	3
4	Subscriptions	(1,043)	20	4
5	Permits	(75)	20	5
6	Money received for copying	(439)	21	6
7	Over/Under Adjustmetns	19	27	7
8	Prior Year Operationg Expenses	(3,806)	27	8
9	Transporation	(1,257)	38	9
10	Prior Year Ancillary Expenses	(3,944)	39	10
11	Prior Year Property Expenses	(53,571)	36	11
12	Dues - PAC	(470)	20	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**	(65,600)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA # 0051755 **Report Period Beginning:** 1/1/2014 **Ending:** 12/31/2014

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,867)	0	0	0	0	0	0	0	0	0	0	(3,867)	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	(25)	0	0	0	0	0	0	0	0	0	0	(25)	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**	(3,892)	0	0	0	0	0	0	0	0	0	0	(3,892)	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	(746)	0	0	0	0	0	0	0	0	0	0	(746)	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**	(746)	0	0	0	0	0	0	0	0	0	0	(746)	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	(401,593)	0	0	0	0	0	0	0	0	0	(401,593)	19
20	Fees, Subscriptions & Promotions	(7,871)	4,583	0	0	0	0	0	0	0	0	0	(3,288)	20
21	Clerical & General Office Expenses	(16,871)	64,201	0	0	0	0	0	0	0	0	0	47,330	21
22	Employee Benefits & Payroll Taxes	0	103,227	0	0	0	0	0	0	0	0	0	103,227	22
23	Inservice Training & Education	0	546	0	0	0	0	0	0	0	0	0	546	23
24	Travel and Seminar	0	39,306	0	0	0	0	0	0	0	0	0	39,306	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	19,958	0	0	0	0	0	0	0	0	0	19,958	26
27	Other (specify):*	(25,094)	0	0	0	0	0	0	0	0	0	0	(25,094)	27
28	**TOTAL General Administration**	(49,836)	(169,772)	0	0	0	0	0	0	0	0	0	(219,608)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(54,474)	(169,772)	0	0	0	0	0	0	0	0	0	(224,246)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA # 0051755 **Report Period Beginning:** 1/1/2014 **Ending:** 12/31/2014

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	2,782	0	0	0	0	0	0	0	0	0	2,782	30
31	Amortization of Pre-Op. & Org.	0	2,252	0	0	0	0	0	0	0	0	0	2,252	31
32	Interest	(27,507)	6,641	0	0	0	0	0	0	0	0	0	(20,866)	32
33	Real Estate Taxes	0	15,470	0	0	0	0	0	0	0	0	0	15,470	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	1,686	0	0	0	0	0	0	0	1,686	35
36	Other (specify):*	(53,571)	0	0	0	0	0	0	0	0	0	0	(53,571)	36
37	**TOTAL Ownership**	(81,078)	27,145	0	1,686	0	0	0	0	0	0	0	(52,247)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	(1,257)	0	0	0	0	0	0	0	0	0	0	(1,257)	38
39	Ancillary Service Centers	(3,944)	0	0	0	0	0	0	0	0	0	0	(3,944)	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**	(5,201)	0	0	0	0	0	0	0	0	0	0	(5,201)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(140,754)	(142,627)	0	1,686	0	0	0	0	0	0	0	(281,695)	45

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA # 0051755 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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%	Great Bend Health & Rehab Center	Great Bend	Five Rivers Manageme	Alpharetta	LTC Mgt/Accting
Kerry Gibson	50%			Woodland - LTC, LLC	Shepherd	LTC Operator
				Rosewood - LTC, LLC	Converse	LTC Operator
				Fireside Property, LL	Alpharetta	Property

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	$ 39,538	Five Rivers Management, LLC	100.00%	$	$ (39,538)	1
2	V	19	Mananagement Fees	374,635	Five Rivers Management, LLC	100.00%		(374,635)	2
3	V	19	Non-Related Professional Fees		Five Rivers Management, LLC	100.00%	12,580	12,580	3
4	V	20	Dues, Fees, Subs and Promos		Five Rivers Management, LLC	100.00%	4,583	4,583	4
5	V	21	Clerical and Gen Office Exp		Five Rivers Management, LLC	100.00%	64,201	64,201	5
6	V	22	Employee Benefits & Taxes		Five Rivers Management, LLC	100.00%	103,227	103,227	6
7	V	23	In Svc Traning & Educ		Five Rivers Management, LLC	100.00%	546	546	7
8	V	24	Travel & Seminars		Five Rivers Management, LLC	100.00%	39,306	39,306	8
9	V	26	Liability Insurance		Five Rivers Management, LLC	100.00%	19,958	19,958	9
10	V	30	Depreciation		Five Rivers Management, LLC	100.00%	2,782	2,782	10
11	V	31	Amortization		Five Rivers Management, LLC	100.00%	2,252	2,252	11
12	V	32	Non-Related Interest		Five Rivers Management, LLC	100.00%	6,641	6,641	12
13	V	33	Real Estate Taxes		Five Rivers Management, LLC	100.00%	15,470	15,470	13
14	Total			$ 414,173			$ 271,546	$ * (142,627)	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: 1/1/2014 Ending: 12/31/2014

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	35	Rental Equipment & Vehicles	$	Five Rivers Management, LLC	100.00%	$ 1,686	$ 1,686	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 1,686	$ * 1,686	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:** 1/1/2014 **Ending:** 12/31/2014

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA # 0051755 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA # 0051755 Report Period Beginning: 1/1/2014 Ending: 2/31/2014

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
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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	Managmeent Fees	Total Costs	22,097,857	14	$ 1,343,710	$ 92,885	5,881,576	$ 357,642	1
2	32	Capital	Total Costs	22,097,857	14	108,324		5,881,576	28,832	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					$ 1,452,034	$ 92,885		$ 386,474	25

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA # 0051755 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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	1st Insurance Funding		X	Liability, WC, Prop & Auto Ins.			Vairiable				2,736	6
7	Gemino Finacial		X	AR Financing		2/1/2012	Vairiable				42,138	7
8	Regions & Jade Rental		X	Credit card and storage shed			Vairiable				364	8
9	TOTAL Facility Related						$	$			$ 45,238	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 45,238	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:** 1/1/2014 **Ending:** 12/31/2014

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 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 2014 report. (Detail and explain your calculation of this accrual on the lines below.)	$	105,000	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.	$	105,000	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2009		8
2010		9
2011	99,035	10
2012	101,793	11
2013	102,988	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 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 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-17-100-006	PT SW NE NW	$ 102,988.32	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 102,988.32	$

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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: 1/1/2014 Ending: 12/31/2014

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 [X] (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 [X] (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 [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: 1/1/2014 Ending: 12/31/2014

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	Drain Upgrades			2014	3,006	601	5	601		601	9
10	Storage Unit			2014	1,461	292	5	292		292	10
11	Storage Unit			2014	5,514	368	5	368		368	11
12	Serving Shelf			2014	719	36	5	36		36	12
13	Thru-Wall Conditioner Heat/Cool Unifit			2014	1,989	33	5	33		33	13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA # 0051755 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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)		$ 12,688	$ 1,330		$ 1,330	$	$ 1,330	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: 1/1/2014 Ending: 12/31/2014

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	$ 159,263	$ 17,769	$ 17,769	$	3-25	$ 38,638	71
72	Current Year Purchases	2,874	430	430		3-10	430	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 162,137	$ 18,199	$ 18,199	$		$ 39,068	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	$ 167	$ 167	$	3	$ 264	76
77										77
78										78
79										79
80	TOTALS			$ 500	$ 167	$ 167	$		$ 264	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)	$ 175,326	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 19,695	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 19,695	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)	$ 40,662	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: 1/1/2014 Ending: 12/31/2014

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [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	6/30/2014	$	25		3
4	Additions							4
5								5
6								6
7	TOTAL		98		$ **			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 06/30/2014
Ending 06/29/2039

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

	Fiscal Year Ending	Annual Rent
12.	/2015	$
13.	/2016	$
14.	/2017	$

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: 1/1/2014 Ending: 12/31/2014

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: 1/1/2014 Ending: 12/31/2014

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$ 298,278	$		$ 298,278	1
2	Licensed Speech and Language Development Therapist		hrs			88,264			88,264	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			298,364			298,364	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			$		$ 684,906	$		$ 684,906	14

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

STATE OF ILLINOIS

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA # 0051755 **Report Period Beginning:** 1/1/2014 **Ending:** 12/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2014 (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	$ (108,044)	$	1
2	Cash-Patient Deposits	26,996		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,340,810		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	13,847		6
7	Other Prepaid Expenses	7,375		7
8	Accounts Receivable (owners or related parties)	673,296		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,954,280	$	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	78,004		15
16	Equipment, at Historical Cost	97,322		16
17	Accumulated Depreciation (book methods)	(40,662)		17
18	Deferred Charges	1,216		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)**	$ 135,880	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,090,160	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 942,196	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	26,996		28
29	Short-Term Notes Payable	429,359		29
30	Accrued Salaries Payable	157,300		30
31	Accrued Taxes Payable (excluding real estate taxes)	29,973		31
32	Accrued Real Estate Taxes(Sch.IX-B)	105,000		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 Occupance Tax	19,660		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,710,484	$	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)**	$ 1,710,484	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 379,676	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,090,160	$	48

***(See instructions.)**

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA # 0051755 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (20,768)	1
2	Restatements (describe):		2
3	**Capital Contributions**	10,688	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (10,080)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	389,756	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)**	$ 389,756	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)**	$ 379,676	24 *

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

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA # 0051755 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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	$ 4,842,339	1
2	Discounts and Allowances for all Levels	1,153,955	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,996,293	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	232,914	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 232,914	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	1,348	14
15	Telephone, Television and Radio	25	15
16	Rental of Facility Space		16
17	Sale of Drugs	7,007	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	625	19
20	Radiology and X-Ray	126	20
21	Other Medical Services	4,422	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 13,553	23
	D. Non-Operating Revenue		
24	Contributions	606	24
25	Interest and Other Investment Income***	27,508	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 28,114	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Food Rebate, NSF Rev, Copying Fees	2,978	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,978	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,273,851	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	839,545	31
32	Health Care	2,445,321	32
33	General Administration	1,368,641	33
	B. Capital Expense		
34	Ownership	705,424	34
	C. Ancillary Expense		
35	Special Cost Centers	306,198	35
36	Provider Participation Fee	218,965	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,884,094	40
41	**Income before Income Taxes (line 30 minus line 40)****	389,757	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 389,757	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: 1/1/2014 Ending: 12/31/2014

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	5,482	6,168	$ 171,417	$ 27.79	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,745	9,480	218,522	23.05	3
4	Licensed Practical Nurses	20,456	22,277	444,945	19.97	4
5	CNAs & Orderlies	59,148	63,756	655,832	10.29	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,930	4,150	50,223	12.10	9
10	Activity Assistants					10
11	Social Service Workers	2,022	2,469	41,135	16.66	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,502	16,773	164,359	9.80	15
16	Dishwashers					16
17	Maintenance Workers	1,946	2,109	31,949	15.15	17
18	Housekeepers	10,997	11,780	106,049	9.00	18
19	Laundry	6,730	7,747	68,762	8.88	19
20	Administrator	1,988	2,080	95,371	45.85	20
21	Assistant Administrator					21
22	Other Administrative	5,283	5,697	105,387	18.50	22
23	Office Manager					23
24	Clerical					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	1,329	1,501	20,610	13.73	31
32	Other Health C: MDS Coordinator	2,114	2,371	48,925	20.63	32
33	Other(specify) Tranportation	556	556	6,338	11.40	33
34	TOTAL (lines 1 - 33)	146,228	158,914	$ 2,229,824 *	$ 14.03	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	197	$ 8,884	1-3	35
36	Medical Director		12,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,021	39-3	39
40	Physical Therapy Consultant		298,364	10A-3	40
41	Occupational Therapy Consultant		298,278	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant		88,264	10A-3	43
44	Activity Consultant	40	2,223	11-3	44
45	Social Service Consultant	40	2,223	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	277	$ 713,256		49

C. CONTRACT NURSES

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

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA # 0051755 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kathy Berck	Administrator		$ 95,371
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 95,371

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
CT Corporation	Registered Agent	$ 611
Five Rivers Management, LLC	Accounting	39,538
Five Rivers Management, LLC	Management	374,635
Proliant	Payroll Processing	13,987
Region Bank	Service Fees	596
Gemino	Service Fees	3,549
Gemino	Legal Fees	17,747
Gemino	Audit Fees	10,773
Gemino	Lockbox Mgt Fees	28,244
McNair, McLemore, Middlebrook	Financial & Tax Prep	3,600
Bovis, Kyle, Burch & Medlin	Legal Fees	320
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 493,599

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 81,792
Unemployment Compensation Insurance	
FICA Taxes	214,966
Employee Health Insurance	95,266
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Appreciation	5,859
Dental Insurance	286
Life insurance	6,797
TOTAL (agree to Schedule V, line 22, col.8)	$ 404,965

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,134
Advertising: Employee Recruitment	344
Health Care Worker Background Check	2,898
(Indicate # of checks performed 38)	
Home Office	4,583
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,958

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
Milage-Clinical Train @ Home Office	617
Lodging-Clinical Train @ Home Office	315
In-State Travel	
Milage-various meeting and erands	2,605
Lodging-Restorative Training	321
Meals	51
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,909

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA # 0051755 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

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: 1/1/2014 Ending: 12/31/2014

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA - $4958.80**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(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. $ **1,225**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **3791**
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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **N/A**
Attach invoices and a summary of services for all architect and appraisal fees