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.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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: 02/01/2012

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: MATTHEW LARSON **Telephone Number:** (678) 381-2820
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2015 to 12/31/2015 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 ALPHARETT
(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: 1/1/2015 Ending: 12/31/2015

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 98

	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			6,650	6,650	8
9	SNF/PED					9
10	ICF	21,744	4,640	9	26,393	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,744	4,640	6,659	33,043	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.38%

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 5,844

Medicare Intermediary WPS GHA

IV. ACCOUNTING BASIS

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

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

Tax Year: 2015 Fiscal Year: 2015

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

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA # 0051755 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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	166,163	20,415	10,531	197,109		197,109		197,109			1
2	Food Purchase		235,482		235,482		235,482	(5,816)	229,666			2
3	Housekeeping	110,399	21,013		131,412		131,412		131,412			3
4	Laundry	75,491	11,942		87,433		87,433		87,433			4
5	Heat and Other Utilities			118,169	118,169		118,169		118,169			5
6	Maintenance	33,545	7,923	55,792	97,260		97,260		97,260			6
7	Other (specify):*			7,937	7,937		7,937		7,937			7
8	TOTAL General Services	385,598	296,775	192,429	874,802		874,802	(5,816)	868,986			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,704,031	71,446	24,892	1,800,369	1,061	1,801,430		1,801,430			10
10a	Therapy	443,544		111,126	554,670		554,670		554,670			10a
11	Activities	57,112	2,644	1,875	61,631		61,631		61,631			11
12	Social Services	36,578	29	1,875	38,482		38,482		38,482			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,241,265	74,119	151,768	2,467,152	1,061	2,468,213		2,468,213			16
	C. General Administration											
17	Administrative	89,700			89,700	3,684	93,384		93,384			17
18	Directors Fees											18
19	Professional Services			468,389	468,389		468,389	(290,193)	178,196			19
20	Dues, Fees, Subscriptions & Promotions			22,126	22,126		22,126	(10,390)	11,736			20
21	Clerical & General Office Expenses	128,123	101,203	63,636	292,962	(3,684)	289,278	50,587	339,865			21
22	Employee Benefits & Payroll Taxes			479,077	479,077		479,077	145,003	624,080			22
23	Inservice Training & Education			2,189	2,189	(1,061)	1,128	328	1,456			23
24	Travel and Seminar			4,325	4,325		4,325	1,259	5,584			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			108,635	108,635		108,635	31,626	140,261			26
27	Other (specify):*			298,650	298,650		298,650	(250,591)	48,059			27
28	TOTAL General Administration	217,823	101,203	1,447,027	1,766,053	(1,061)	1,764,992	(322,371)	1,442,621			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,844,686	472,097	1,791,224	5,108,007		5,108,007	(328,187)	4,779,820			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: 1/1/2015 Ending: 12/31/2015

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			26,710	26,710		26,710	2,735	29,445			30
31	Amortization of Pre-Op. & Org.			18,990	18,990		18,990	1,944	20,934			31
32	Interest			161,152	161,152		161,152	(39,791)	121,361			32
33	Real Estate Taxes			105,000	105,000		105,000	10,751	115,751			33
34	Rent-Facility & Grounds			406,800	406,800		406,800	(406,800)				34
35	Rent-Equipment & Vehicles			13,659	13,659		13,659	1,399	15,058			35
36	Other (specify):*			(309)	(309)		(309)		(309)			36
37	**TOTAL Ownership**			732,002	732,002		732,002	(429,762)	302,240			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	8,283	2,885		11,168		11,168		11,168			38
39	Ancillary Service Centers		272,505	3,929	276,434		276,434	(665)	275,769			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			218,025	218,025		218,025		218,025			42
43	Other (specify):*			18,151	18,151		18,151		18,151			43
44	**TOTAL Special Cost Centers**	8,283	275,390	240,105	523,778		523,778	(665)	523,113			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,852,969	747,487	2,763,331	6,363,787		6,363,787	(758,614)	5,605,173			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: 1/1/2015 Ending: 12/31/2015

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,177)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(51,063)	32		10
11	Discounts, Allowances, Rebates & Refunds	(3,639)	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)	(68)	27		16
17	Non-Care Related Fees				17
18	Fines and Penalties				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	(255,009)	27		24
25	Fund Raising, Advertising and Promotional	(4,775)	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	(26,548)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (343,279)		$	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)	(12,778)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (12,778)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (356,057)		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: 1/1/2015

Ending: 12/31/2015

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	NSF FEES	$ (3,332)	21	1
2	CHAMBER OF COMMERCE DUES	(6,711)	20	2
3	SUBSCRIPTIONS	(795)	20	3
4	PERMITS	(75)	20	4
5	PRIOR YEAR OPERATING EXPENSE	4,486	27	5
6	PRIOR YEAR ANCILLARY EXPENSE	(665)	39	6
7	PRIOR YEAR WORKER'S COMP	5,533	22	7
8	DONATIONS	(680)	20	8
9	VENDOR LATE FEES	(18,527)	21	9
10	PENALTIES	(5,782)	21	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(26,548)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA # 0051755 **Report Period Beginning:** 1/1/2015 **Ending:** 12/31/2015

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(5,816)	0	0	0	0	0	0	0	0	0	0	(5,816)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(5,816)	0	0	0	0	0	0	0	0	0	0	(5,816)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(290,193)	0	0	0	0	0	0	0	0	0	(290,193)	19
20	Fees, Subscriptions & Promotions	(13,036)	2,646	0	0	0	0	0	0	0	0	0	(10,390)	20
21	Clerical & General Office Expenses	(27,641)	78,228	0	0	0	0	0	0	0	0	0	50,587	21
22	Employee Benefits & Payroll Taxes	5,533	139,470	0	0	0	0	0	0	0	0	0	145,003	22
23	Inservice Training & Education	0	328	0	0	0	0	0	0	0	0	0	328	23
24	Travel and Seminar	0	1,259	0	0	0	0	0	0	0	0	0	1,259	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	31,626	0	0	0	0	0	0	0	0	0	31,626	26
27	Other (specify):*	(250,591)	0	0	0	0	0	0	0	0	0	0	(250,591)	27
28	**TOTAL General Administration**	(285,735)	(36,636)	0	0	0	0	0	0	0	0	0	(322,371)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(291,551)	(36,636)	0	0	0	0	0	0	0	0	0	(328,187)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA # 0051755 **Report Period Beginning:** 1/1/2015 **Ending:** 12/31/2015

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	0	2,735	0	0	0	0	0	0	0	0	0	2,735	30
31	Amortization of Pre-Op. & Org.	0	1,944	0	0	0	0	0	0	0	0	0	1,944	31
32	Interest	(51,063)	11,272	0	0	0	0	0	0	0	0	0	(39,791)	32
33	Real Estate Taxes	0	10,751	0	0	0	0	0	0	0	0	0	10,751	33
34	Rent-Facility & Grounds	0	0	0	(406,800)	0	0	0	0	0	0	0	(406,800)	34
35	Rent-Equipment & Vehicles	0	0	0	1,399	0	0	0	0	0	0	0	1,399	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(51,063)	26,702	0	(405,401)	0	0	0	0	0	0	0	(429,762)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(665)	0	0	0	0	0	0	0	0	0	0	(665)	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	(665)	0	0	0	0	0	0	0	0	0	0	(665)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(343,279)	(9,934)	0	(405,401)	0	0	0	0	0	0	0	(758,614)	45

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA # 0051755 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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 MANA	ALPHARETTA	LTC Mgt
KERRY GIBSON	50%			WOODLAND-LTC, L	SHEPHERD	LTC OPERATOR
				FIRESIDE PROPERT	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	$ 41,511	Five Rivers Management, LLC	100.00%	$	$ (41,511)	1
2	V	19	Mananagement Fees	385,041	Five Rivers Management, LLC	100.00%		(385,041)	2
3	V	19	Non-Related Professional Fees		Five Rivers Management, LLC	100.00%	136,359	136,359	3
4	V	20	Dues, Fees, Subs and Promos		Five Rivers Management, LLC	100.00%	2,646	2,646	4
5	V	21	Clerical and Gen Office Exp		Five Rivers Management, LLC	100.00%	78,228	78,228	5
6	V	22	Employee Benefits & Taxes		Five Rivers Management, LLC	100.00%	139,470	139,470	6
7	V	23	In Svc Traning & Educ		Five Rivers Management, LLC	100.00%	328	328	7
8	V	24	Travel & Seminars		Five Rivers Management, LLC	100.00%	1,259	1,259	8
9	V	26	Liability Insurance		Five Rivers Management, LLC	100.00%	31,626	31,626	9
10	V	30	Depreciation		Five Rivers Management, LLC	100.00%	2,735	2,735	10
11	V	31	Amortization		Five Rivers Management, LLC	100.00%	1,944	1,944	11
12	V	32	Non-Related Interest		Five Rivers Management, LLC	100.00%	11,272	11,272	12
13	V	33	Real Estate Taxes		Five Rivers Management, LLC	100.00%	10,751	10,751	13
14	Total			$ 426,552			$ 416,618	$ * (9,934)	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: 1/1/2015 Ending: 12/31/2015

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%	$ 1,399	$ 1,399	15
16	V	34	Building Lease	406,800	Fireside Property	100.00%		(406,800)	16
17	V		Building Lease		Fireside Property		402,557	402,557	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			$ 406,800			$ 403,956	$ * (2,844)	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: 1/1/2015 Ending: 12/31/2015

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: 1/1/2015 Ending: 12/31/2015

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: 1/1/2015 Ending: 2/31/2015

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 ☐

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	MANAGEMENT FEES	TOTAL COST	18,711,909	12	$ 1,147,159	$ 752,826	6,360,146	$ 389,917	1
2	32	CAPITAL	TOTAL COST	18,711,909	12	82,676		6,360,146	28,101	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					$ 1,229,835	$ 752,826		$ 418,018	25

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA # 0051755 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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	Liab, WC, Property & Auto Ins.			variable				3,228	6
7	Gemino		X	AR Financing		2/1/2012	variable				55,875	7
8	Evergreen Rehab		X	Therapy		3/1/2015	variable				15,890	8
9	TOTAL Facility Related						$	$			$ 74,993	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 74,993	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: 1/1/2015 Ending: 12/31/2015

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Rapid Advance		X	AR Financing	8/17/2015		variable				45,121	6
7	Rosewood		X	Financing	1/1/2015		variable				40,250	7
8	Regions		X	Credit Card			variable				788	8
9	TOTAL Facility Related				$84,238.00		$ 0	$ 0			$ 86,159	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ 0	14
15	TOTALS (line 9+line14)						$ 0	$ 0			$ 86,159	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: 1/1/2015 Ending: 12/31/2015

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 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 2015 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:		
2010		8
2011	99,035	9
2012	101,793	10
2013	102,988	11
2014	104,691	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 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 2014 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 2014.

	(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	$ 104,690.78	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 104,690.78	$

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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: 1/1/2015 Ending: 12/31/2015

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: 1/1/2015 Ending: 12/31/2015

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	Comdial DX-120 Key Telephone System			2012	1,731	346	5	346		1,356	9
10	10-ton HVAC Unit 225,000 BTU			2012	8,139	814	10	814		3,120	10
11	Water Heater (State Brand; 80 Gallon)			2012	13,900	1,390	10	1,390		5,328	11
12	Painting of Upper Half of West Wing Walls			2012	2,864	573	5	573		2,100	12
13	Drain Upgrades			2012	1,118	224	5	224		801	13
14	Drain Upgrades			2012	1,988	398	5	398		1,424	14
15	Thru-Wall Air Conditioner, Heat/Cool, UniFit 11,500/11,200 BTU			2012	2,027	405	5	405		1,453	15
16	Gas Pack Unit 225k BUT 10 Ton Cooling Unit			2012	8,139	814	10	814		2,849	16
17	3 Ton AC Unit			2012	1,891	378	5	378		1,324	17
18	Kitchen Great Trap replacement			2012	3,350	670	5	670		2,289	18
19	Water Heater			2013	12,460	1,246	10	1,246		3,738	19
20	Grade and Compact Service Drive			2013	2,796	350	8	350		1,019	20
21	Fire Suppression (includes extension of 6" line)			2013	28,181	1,127	25	1,127		2,912	21
22	Fire Sprinkler renovations (1/2 billing per invoice)			2013	34,700	1,388	25	1,388		3,470	22
23	Thru-Wall Air Conditioner, Heat/Cool, UniFit 11,500/11,200 BTU			2013	2,694	539	5	539		1,302	23
24	Nurse Call System			2013	1,500	300	5	300		650	24
25	Drain Upgrades			2014	3,006	601	5	601		1,202	25
26	Storage Unit #4980			2014	1,461	292	5	292		584	26
27	Storage Unit #8976			2014	5,514	1,103	5	1,103		1,470	27
28	Serving Shelf			2014	719	144	5	144		180	28
29	Thru-Wall Air Conditioner, Heat/Cool, UniFit 10,000/9,800 BTU			2014	1,989	398	5	398		431	29
30	Commercial Disposal Stainless Steel (3/4 HP 17iH)			2015	1,098	220	5	220		220	30
31	Sidewalk and Driveway work			2015	11,000	306	15	306		306	31
32	Facility sign			2015	8,443	352	10	352		352	32
33	Rooftop A/C unit			2015	6,900	575	5	575		575	33
34	(2) Air Conditioner and Heat Unit (220 Volt, 10,000 BTU)			2015	1,516	126	5	126		126	34
35	(2) Air Conditioner and Heat Unit (220 Volt, 10,000 BTU)			2015	1,516	126	5	126		126	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: 1/1/2015 Ending: 12/31/2015

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)		$ 170,642	$ 15,204		$ 15,204	$	$ 40,709	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: 1/1/2015 Ending: 12/31/2015

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	$ 32,426	$ 5,879	$ 5,879	$	5-10	$ 19,040	71
72	Current Year Purchases	38,946	5,461	5,461		5-10	5,461	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 71,372	$ 11,340	$ 11,340	$		$ 24,500	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	$ 97	76
77										77
78										78
79										79
80	TOTALS			$ 500	$ 167	$ 167	$		$ 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)	$ 242,513	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 26,711	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 26,711	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)	$ 65,307	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: 1/1/2015 Ending: 12/31/2015

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	06/30/2014	$	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.	/2016	$
13.	/2017	$
14.	/2018	$

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: 1/1/2015 Ending: 12/31/2015

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: 1/1/2015 Ending: 12/31/2015

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A	4923.84 hrs	$ 175,880		$ 44,624	$	4,924	$ 220,504	1
2	Licensed Speech and Language Development Therapist	10A	1779.99 hrs	91,848		22,688		1,780	114,536	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A	5400.79 hrs	175,815		43,814		5,401	219,629	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			$ 443,543		$ 111,126	$	12,105	$ 554,669	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: 1/1/2015 Ending: 12/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2015 (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	$ (15,814)	$	1
2	Cash-Patient Deposits	27,875		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	881,754		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	17,272		6
7	Other Prepaid Expenses	5,155		7
8	Accounts Receivable (owners or related parties)	919,869		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,836,111	$	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	97,447		15
16	Equipment, at Historical Cost	178,315		16
17	Accumulated Depreciation (book methods)	(73,748)		17
18	Deferred Charges			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)**	$ 202,014	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,038,125	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 852,839	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	27,875		28
29	Short-Term Notes Payable	579,271		29
30	Accrued Salaries Payable	192,911		30
31	Accrued Taxes Payable (excluding real estate taxes)	239,290		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	ACCRUALS	53,022		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,050,208	$	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)**	$ 2,050,208	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (12,083)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,038,125	$	48

***(See instructions.)**

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA # 0051755 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 368,989	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 368,989	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	108,239	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants	10,687	11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	(500,000)	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)**	$ (381,074)	17	
	B. Transfers (Itemize):			
18	ROUNDING	2	18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$ 2	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (12,083)	24	*

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

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA # 0051755 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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	$ 5,057,550	1
2	Discounts and Allowances for all Levels	1,270,991	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,328,541	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	187,728	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 187,728	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	2,177	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	4,620	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	806	19
20	Radiology and X-Ray		20
21	Other Medical Services	(107,228)	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ (99,624)	23
	D. Non-Operating Revenue		
24	Contributions	680	24
25	Interest and Other Investment Income***	51,063	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 51,743	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	RAW FOOD REBATE	3,639	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,639	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,472,026	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	874,802	31
32	Health Care	2,467,152	32
33	General Administration	1,766,053	33
	B. Capital Expense		
34	Ownership	732,002	34
	C. Ancillary Expense		
35	Special Cost Centers	523,778	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,363,787	40
41	**Income before Income Taxes (line 30 minus line 40)****	108,239	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 108,239	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: 1/1/2015 Ending: 12/31/2015

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	4,561	6,255	$ 175,656	$ 28.08	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,704	11,478	269,468	23.48	3
4	Licensed Practical Nurses	21,520	23,247	466,834	20.08	4
5	CNAs & Orderlies	61,599	66,749	689,372	10.33	5
6	CNA Trainees					6
7	Licensed Therapist	11,209	12,105	443,544	36.64	7
8	Rehab/Therapy Aides					8
9	Activity Director	4,382	4,751	57,112	12.02	9
10	Activity Assistants					10
11	Social Service Workers	2,081	2,066	36,578	17.70	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,591	16,957	166,163	9.80	15
16	Dishwashers					16
17	Maintenance Workers	1,976	2,143	33,545	15.65	17
18	Housekeepers	11,150	11,770	110,399	9.38	18
19	Laundry	7,419	8,407	75,491	8.98	19
20	Administrator	1,964	2,037	93,385	45.84	20
21	Assistant Administrator					21
22	Other Administrative	5,698	6,850	124,438	18.17	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	327	366	5,505	15.04	31
32	Other Health C: MDS	3,771	4,151	97,195	23.41	32
33	Other(specify) Transportation	820	820	8,283	10.10	33
34	TOTAL (lines 1 - 33)	164,772	180,152	$ 2,852,968 *	$ 15.84	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	224	$ 10,531	1-3	35
36	Medical Director		12,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,264	39-3	39
40	Physical Therapy Consultant		43,814	10A-3	40
41	Occupational Therapy Consultant		44,624	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant		22,688	10A-3	43
44	Activity Consultant	34	1,875	11-3	44
45	Social Service Consultant	34	1,875	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	292	$ 140,671		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: 1/1/2015 Ending: 12/31/2015

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
KATHY BERCK	ADMINISTRATOR		$ 93,384
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 93,384

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	$ 677
Five Rivers Management, LLC	Accounting	41,511
Five Rivers Management, LLC	Management	385,041
Proliant	Payroll Processing	17,785
Gemino	Financing	2,370
BB&T	Banking Audits	2,472
Gemino	Legal Fees	1,412
McNair, McLemore, Middlebrook	Legal Fees	3,881
Taylor English Duma LLP	Legal Fees	828
McNair, McLemore, Middlebrook	Financial & Tax Prep	5,745
AltaCare	Guarantee Fee	6,667
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 468,389

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 115,175
Unemployment Compensation Insurance	
FICA Taxes	239,481
Employee Health Insurance	119,049
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Appreciation	3,271
Dental Insurance	837
Life insurance	6,414
Vision Insurance	238
Club Membership	145
Prior Year Workers Comp	(5,533)
TOTAL (agree to Schedule V, line 22, col.8)	$ 479,077

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 4,486
Advertising: Employee Recruitment	575
Health Care Worker Background Check	4,886
(Indicate # of checks performed)	
Patient Background Checks	
Permits	75
Subscriptions	795
Dues	6,711
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,527

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Meals	201
Lodging for training	1,124
Milage-various meeting and erands	2,999
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,325

**See instructions.

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA # 0051755 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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: 1/1/2015 Ending: 12/31/2015

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 - $6,350**

(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. $ **3,639**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
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.