FOR BHF USE

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2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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.

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 01/01/2017 to 12/31/2017 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, ALPHARETTA
(Telephone) (678) 381-2820 Fax # (678) 381-2820

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: 01/01/2017 Ending: 12/31/2017

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			6,414	6,414	8
9	SNF/PED					9
10	ICF	18,102	5,648	290	24,040	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,102	5,648	6,704	30,454	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.14%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

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

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

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

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

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/2012 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 PHYSICIAN SERVICES

IV. ACCOUNTING BASIS

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

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

Tax Year: 2017 Fiscal Year: 2017

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

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA # 0051755 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	172,732	20,931	9,993	203,656		203,656		203,656			1
2	Food Purchase		226,722		226,722		226,722	(5,502)	221,220			2
3	Housekeeping	98,115	21,756		119,871		119,871		119,871			3
4	Laundry	53,287	14,675		67,962		67,962		67,962			4
5	Heat and Other Utilities			132,915	132,915		132,915		132,915			5
6	Maintenance	34,579	5,483	49,506	89,568		89,568		89,568			6
7	Other (specify):*		9,485	7,625	17,110		17,110		17,110			7
8	**TOTAL General Services**	358,713	299,052	200,039	857,804		857,804	(5,502)	852,302			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,831,176	92,220	(1,219)	1,922,177	2,108	1,924,285	1,018	1,925,303			10
10a	Therapy	460,840	37		460,877		460,877		460,877			10a
11	Activities	46,479	3,462	2,119	52,060		52,060		52,060			11
12	Social Services	31,904		2,119	34,023		34,023		34,023			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,370,399	95,719	15,019	2,481,137	2,108	2,483,245	1,018	2,484,263			16
	C. General Administration											
17	Administrative	87,739			87,739	9,782	97,521		97,521			17
18	Directors Fees											18
19	Professional Services			470,666	470,666		470,666	(391,531)	79,135			19
20	Dues, Fees, Subscriptions & Promotions			25,616	25,616		25,616	(3,894)	21,722			20
21	Clerical & General Office Expenses	122,646	120,909	75,117	318,672	(9,782)	308,890	16,337	325,227			21
22	Employee Benefits & Payroll Taxes			495,698	495,698		495,698	235,857	731,555			22
23	Inservice Training & Education			4,028	4,028	(2,108)	1,920	1,922	3,842			23
24	Travel and Seminar			3,604	3,604		3,604	1,720	5,324			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			109,887	109,887		109,887	52,428	162,315			26
27	Other (specify):*			216,485	216,485		216,485	(45,104)	171,381			27
28	**TOTAL General Administration**	210,385	120,909	1,401,101	1,732,395	(2,108)	1,730,287	(132,265)	1,598,022			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,939,497	515,680	1,616,159	5,071,336		5,071,336	(136,749)	4,934,587			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: 01/01/2017 Ending: 12/31/2017

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			37,780	37,780		37,780	3,672	41,452			30
31	Amortization of Pre-Op. & Org.			29,074	29,074		29,074	2,826	31,900			31
32	Interest			106,077	106,077		106,077	(42,605)	63,472			32
33	Real Estate Taxes			105,392	105,392		105,392	10,243	115,635			33
34	Rent-Facility & Grounds			428,247	428,247		428,247	(8,247)	420,000			34
35	Rent-Equipment & Vehicles			22,091	22,091		22,091	2,147	24,238			35
36	Other (specify):*			9	9		9		9			36
37	**TOTAL Ownership**			728,670	728,670		728,670	(31,964)	696,706			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	13,979	8,949		22,928		22,928		22,928			38
39	Ancillary Service Centers		271,337	4,326	275,663		275,663	(1,027)	274,636			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			206,485	206,485		206,485		206,485			42
43	Other (specify):*			18,562	18,562		18,562		18,562			43
44	**TOTAL Special Cost Centers**	13,979	280,286	229,373	523,638		523,638	(1,027)	522,611			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,953,476	795,966	2,574,202	6,323,644		6,323,644	(169,740)	6,153,904			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: 01/01/2017 Ending: 12/31/2017

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	(1,650)	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	(52,915)	32		10
11	Discounts, Allowances, Rebates & Refunds	(3,852)	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)	(1,029)	27		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(11,915)	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	(133,090)	27		24
25	Fund Raising, Advertising and Promotional	(6,834)	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	48,814			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (162,471)		$	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)	(7,269)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (7,269)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (169,740)		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: 01/01/2017

Ending: 12/31/2017

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	NON-ANCILLARY PERSONAL CARE REV	$ 1,018	10	1
2	CHAMBER OF COMMERCE DUES	(7,488)	20	2
3	SUBSCRIPTIONS	(1,173)	20	3
4	PERMITS	(75)	20	4
5	OVER/UNDER ADJUSTMENTS	(1)	27	5
6	PRIOR YEAR OPERATING EXPENSE	89,015	27	6
7	PRIOR YEAR ANCILLARY EXPENSE	(1,027)	39	7
8	PRIOR YEAR WORKERS COMP	(646)	22	8
9	DONATIONS	(75)	20	9
10	VENDOR LATE FEES	(22,295)	21	10
11	NSF FEES	(7,969)	21	11
12	HCA 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**	48,814		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA # 0051755 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

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	(5,502)	0	0	0	0	0	0	0	0	0	0	(5,502)	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**	(5,502)	0	0	0	0	0	0	0	0	0	0	(5,502)	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	1,018	0	0	0	0	0	0	0	0	0	0	1,018	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**	1,018	0	0	0	0	0	0	0	0	0	0	1,018	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	(391,531)	0	0	0	0	0	0	0	0	0	(391,531)	19
20	Fees, Subscriptions & Promotions	(16,115)	12,222	0	0	0	0	0	0	0	0	0	(3,893)	20
21	Clerical & General Office Expenses	(42,179)	58,516	0	0	0	0	0	0	0	0	0	16,337	21
22	Employee Benefits & Payroll Taxes	(646)	236,503	0	0	0	0	0	0	0	0	0	235,857	22
23	Inservice Training & Education	0	1,922	0	0	0	0	0	0	0	0	0	1,922	23
24	Travel and Seminar	0	1,720	0	0	0	0	0	0	0	0	0	1,720	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	52,428	0	0	0	0	0	0	0	0	0	52,428	26
27	Other (specify):*	(45,105)	0	0	0	0	0	0	0	0	0	0	(45,105)	27
28	**TOTAL General Administration**	(104,045)	(28,220)	0	0	0	0	0	0	0	0	0	(132,265)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(108,529)	(28,220)	0	0	0	0	0	0	0	0	0	(136,749)	29

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA # 0051755 **Report Period Beginning:** 01/01/2017 **Ending:** 12/31/2017

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	3,672	0	0	0	0	0	0	0	0	0	3,672	30
31	Amortization of Pre-Op. & Org.	0	2,826	0	0	0	0	0	0	0	0	0	2,826	31
32	Interest	(52,915)	10,310	0	0	0	0	0	0	0	0	0	(42,605)	32
33	Real Estate Taxes	0	10,243	0	0	0	0	0	0	0	0	0	10,243	33
34	Rent-Facility & Grounds	0	0	(8,247)	0	0	0	0	0	0	0	0	(8,247)	34
35	Rent-Equipment & Vehicles	0	0	2,147	0	0	0	0	0	0	0	0	2,147	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(52,915)	27,051	(6,100)	0	0	0	0	0	0	0	0	(31,964)	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	(1,027)	0	0	0	0	0	0	0	0	0	0	(1,027)	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**	(1,027)	0	0	0	0	0	0	0	0	0	0	(1,027)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(162,471)	(1,169)	(6,100)	0	0	0	0	0	0	0	0	(169,740)	45

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA # 0051755 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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%	RIVERWOOD HEALTHCARE	MADISONVILLE	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	$ 45,766	Five Rivers Management, LLC	100.00%	$	$ (45,766)	1
2	V	19	Mananagement Fees	371,326	Five Rivers Management, LLC	100.00%		(371,326)	2
3	V	19	Non-Related Professional Fees		Five Rivers Management, LLC	100.00%	25,561	25,561	3
4	V	20	Dues, Fees, Subs and Promos		Five Rivers Management, LLC	100.00%	12,222	12,222	4
5	V	21	Clerical and Gen Office Exp		Five Rivers Management, LLC	100.00%	58,516	58,516	5
6	V	22	Employee Benefits & Taxes		Five Rivers Management, LLC	100.00%	236,503	236,503	6
7	V	23	In Svc Traning & Educ		Five Rivers Management, LLC	100.00%	1,922	1,922	7
8	V	24	Travel & Seminars		Five Rivers Management, LLC	100.00%	1,720	1,720	8
9	V	26	Liability Insurance		Five Rivers Management, LLC	100.00%	52,428	52,428	9
10	V	30	Depreciation		Five Rivers Management, LLC	100.00%	3,672	3,672	10
11	V	31	Amortization		Five Rivers Management, LLC	100.00%	2,826	2,826	11
12	V	32	Non-Related Interest		Five Rivers Management, LLC	100.00%	10,310	10,310	12
13	V	33	Real Estate Taxes		Five Rivers Management, LLC	100.00%	10,243	10,243	13
14	Total			$ 417,092			$ 415,923	$ * (1,169)	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: 01/01/2017 Ending: 12/31/2017

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%	$ 2,147	$ 2,147	15
16	V	34	Building Lease	428,247	Fireside Property	100.00%		(428,247)	16
17	V	34	Building Lease		Fireside Property	100.00%	420,000	420,000	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			$ 428,247			$ 422,147	$ * (6,100)	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: 01/01/2017 Ending: 12/31/2017

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: 01/01/2017 Ending: 12/31/2017

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: 01/01/2017 Ending: 2/31/2017

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	15,423,862	8	$ 949,065	$ 632,554	6,319,790	$ 388,871	1
2	32	CAPITAL	TOTAL COST	15,423,862	8	71,256		6,319,790	29,197	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					$ 1,020,321	$ 632,554		$ 418,068	25

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA # 0051755 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	1ST INSURANCE FUNDING		X	LIAB, WC, PROP&AUTO							3,223	6
7	INSPIRA		X	AR FINANCING							101,889	7
8	EVERGREEN REHAB		X	THERAPY							965	8
9	TOTAL Facility Related						$	$			$ 106,077	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 106,077	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: 01/01/2017 Ending: 12/31/2017

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 106,304	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.)		$ 106,304	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 210,000	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		$ 210,000	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	101,793	8
	2013	102,988	9
	2014	104,691	10
	2015	105,349	11
	2016	106,304	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 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) 381-2820

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(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	$ 106,304.00	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 106,304.00	$

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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: 01/01/2017 Ending: 12/31/2017

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: 01/01/2017 Ending: 12/31/2017

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 throughout building			2012	1,731	29	5	29		1,702	9
10	10-ton HVAC Unit 225,000 BTU on roof			2012	8,139	814	10	814		3,934	10
11	Replace & Install East Wing Water Heater (State Brand; 80 Gallon)			2012	13,900	1,390	10	1,390		6,718	11
12	Painting of Upper Half of West Wing Walls			2012	2,864	191	5	191		2,673	12
13	Kitchen disposal drain and valve outlet replaced			2012	1,118	93	5	93		1,025	13
14	Augered and moved floor drain,replaced bad pipe in Maint room			2012	1,988	166	5	166		1,822	14
15	Thru-Wall Air Conditioner, UniFit 11,500/11,200 BTU Resident rooms			2012	2,027	169	5	169		1,858	15
16	Gas Pack Unit 225k BUT 10 Ton Cooling Unit on roof			2012	8,139	814	10	814		3,663	16
17	Repalce 3 Ton AC Unit with 5 ton unit on roof			2012	1,891	189	5	189		1,702	17
18	Kitchen Grease Trap replacement			2012	3,350	391	5	391		2,959	18
19	Replace Water Heater for Laundry and Kitchen w/			2013	12,460	1,246	10	1,246		4,984	19
20	A.O. Smith BTH 130 gal Water Heater										20
21	Grade and Compact Service Driveway in rear of building			2013	2,796	350	8	350		1,369	21
22	Fire Suppression throughout building (includes extension of 6" line			2013	28,181	1,127	25	1,127		4,039	22
23	Fire Sprinkler renovations throughout building			2013	34,700	1,388	25	1,388		4,858	23
24	Thru-Wall Air Conditioner, UniFit 11,500/11,200 BTU Resident rooms			2013	2,694	539	5	539		1,841	24
25	Purchase & installation of Nurse Call System in building			2013	1,500	300	5	300		950	25
26	Augered pipe in Mechine room & Beauty Shop, Replaced 1-1/2" pipe in			2014	3,006	601	5	601		2,405	26
27	Mechine room, replace cast Iron pipe in pantry										27
28	10'x10' Storage shed located in behind of building			2014	1,461	292	5	292		1,169	28
29	14'x28' Storage shed located in behind of building			2014	5,514	1,103	5	1,103		3,676	29
30	Dining room serving shelf w/ glass protector for 5 well food table			2014	719	144	5	144		467	30
31	Thru-Wall Air Conditioner, UniFit 11,500/11,200 BTU Resident rooms			2014	1,989	398	5	398		1,227	31
32	Commercial Disposal in Kitchen Stainless Steel (3/4 HP 17iH)			2015	1,098	220	5	220		659	32
33	replaced 1200 sq ft of Sidewalk in back of building and			2015	11,000	733	15	733		1,772	33
34	applied seal coat and striping to parking lot										34
35	5'x8' illuminated Facility sign out in front of building			2015	8,443	844	10	844		2,040	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: 01/01/2017 Ending: 12/31/2017

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	Installation of 2 Rooftop units below For East wing and South hall	2015	$ 6,900	$ 1,380	5	$ 1,380	$	$ 3,335	37
38	Air Conditioner and Heat Unit (220 Volt, 10,000 BTU) Resident R	2015	1,516	303	5	303		733	38
39	Air Conditioner and Heat Unit (220 Volt, 10,000 BTU) Resident R	2015	1,516	303	5	303		733	39
40	Painting of rooms, incl. bathrooms & halls in East & West Wings	2016	26,100	5,220	5	5,220		9,135	40
41	TheraPure Tub & 1900 Bathing Lift Package installed in shower r	2016	13,673	1,367	10	1,367		2,279	41
42	Supplied & installed walkin tub in shower room	2016	7,556	756	10	756		1,259	42
43	Fire Suppression repairs to cap line not being used	2017	2,800	112	25	112		112	43
44	AC and Heat Unit (10000 BTU 230 V R-410A Heat) Laundry Roon	2017	540	54	5	54		54	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)		$ 221,310	$ 23,025		$ 23,025	$	$ 77,152	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: 01/01/2017 Ending: 12/31/2017

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	$ 44,082	$ 8,918	$ 8,918	$	3-15	$ 24,934	71
72	Current Year Purchases	18,607	1,236	1,236		3-15	1,236	72
73	Fully Depreciated Assets	27,290	4,601	4,601		3-15	27,290	73
74								74
75	TOTALS	$ 89,979	$ 14,755	$ 14,755	$		$ 53,459	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 311,289	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 37,780	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 37,780	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)	$ 130,612	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: 01/01/2017 Ending: 12/31/2017

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: FIRESIDE PROPERTY, LLC
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

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.	/2018	$
13.	/2019	$
14.	/2020	$

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

9. Option to Buy: [ ] YES [ ] NO Terms: *

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

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

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA # 0051755 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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.

Employeed CNA's are already certified when hired.

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: 01/01/2017 Ending: 12/31/2017

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	5534.36 hrs	$ 205,641		$	$	5,534	$ 205,641	1
2	Licensed Speech and Language Development Therapist	10A	1909.92 hrs	98,884				1,910	98,884	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A	4828.8 hrs	156,315			37	4,829	156,352	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			$ 460,840		$	$ 37	12,273	$ 460,877	14

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

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA # 0051755 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2017 (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	$ (24,084)	$	1
2	Cash-Patient Deposits	22,382		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,208,245		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	20,039		6
7	Other Prepaid Expenses	9,079		7
8	Accounts Receivable (owners or related parties)	1,354,307		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,589,968	$	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 Cos	126,347		15
16	Equipment, at Historical Cost	220,691		16
17	Accumulated Depreciation (book methods)	(170,068)		17
18	Deferred Charges	11,151		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)**	$ 188,121	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,778,089	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,223,403	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	22,382		28
29	Short-Term Notes Payable	735,811		29
30	Accrued Salaries Payable	199,146		30
31	Accrued Taxes Payable (excluding real estate taxes)	447,621		31
32	Accrued Real Estate Taxes(Sch.IX-B)	210,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	ACCRUED TAXES AND FEES	60,422		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,898,785	$	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)**	$ 2,898,785	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (120,696)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,778,089	$	48

***(See instructions.)**

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA # 0051755 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (42,586)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (42,586)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(78,110)	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)**	$ (78,110)	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)**	$ (120,696)	24 *

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

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA # 0051755 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	$ 5,038,850	1
2	Discounts and Allowances for all Levels	1,064,186	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,103,036	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	115,348	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 115,348	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	1,650	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	4,781	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	625	19
20	Radiology and X-Ray	(41,891)	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ (34,835)	23
	D. Non-Operating Revenue		
24	Contributions	75	24
25	Interest and Other Investment Income***	52,915	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 52,990	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28		8,996	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 8,996	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,245,534	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	857,801	31
32	Health Care	2,481,136	32
33	General Administration	1,732,395	33
	B. Capital Expense		
34	Ownership	728,670	34
	C. Ancillary Expense		
35	Special Cost Centers	317,154	35
36	Provider Participation Fee	206,485	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,323,644	40
41	**Income before Income Taxes (line 30 minus line 40)****	(78,110)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (78,110)	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: 01/01/2017 Ending: 12/31/2017

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	7,337	8,244	$ 243,715	$ 29.56	1
2	Assistant Director of Nursing					2
3	Registered Nurses	15,207	16,349	435,493	26.64	3
4	Licensed Practical Nurses	14,773	16,152	347,410	21.51	4
5	CNAs & Orderlies	61,018	66,315	718,534	10.84	5
6	CNA Trainees					6
7	Licensed Therapist	11,335	12,273	460,840	37.55	7
8	Rehab/Therapy Aides					8
9	Activity Director	3,973	4,313	46,479	10.78	9
10	Activity Assistants					10
11	Social Service Workers	1,873	2,030	31,904	15.72	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,225	16,727	172,732	10.33	15
16	Dishwashers					16
17	Maintenance Workers	1,936	2,108	34,579	16.40	17
18	Housekeepers	9,938	10,804	98,115	9.08	18
19	Laundry	5,674	5,993	53,287	8.89	19
20	Administrator	1,888	2,080	97,521	46.89	20
21	Assistant Administrator					21
22	Other Administrative	4,413	4,947	112,864	22.81	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	652	718	9,192	12.80	31
32	Other Health Ca MDS Coordinator	1,933	2,192	58,979	26.91	32
33	Other(specify) Transportation	1,218	1,228	13,917	11.33	33
34	TOTAL (lines 1 - 33)	158,393	172,473	$ 2,935,561 *	$ 17.02	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	213	$ 9,993	1-3	35
36	Medical Director	n/a	12,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	n/a	2,766	39-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	39	2,119	11-3	44
45	Social Service Consultant	39	2,119	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	290	$ 28,996		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: 01/01/2017 Ending: 12/31/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
KATHY BERCK	ADMINISTRATOR	0	$ 97,521
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 97,521

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	$ 598
Five Rivers Management, LLC	Accounting	45,766
Five Rivers Management, LLC	Management	371,326
Proliant	Payroll Processing	14,212
BB&T	Banking Fees	5,120
Taylor English Duma LLP	Legal Fees	508
McNair, McLemore, Middlebrook	Tax Prep Fees	900
Inspira	Lockbox Fees	32,236
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 470,666

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 123,569
Unemployment Compensation Insurance	
FICA Taxes	250,151
Employee Health Insurance	97,065
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Vison insurance	330
Life Insurance	5,869
Dental Insurance	(453)
Employee Appreciation/Holiday Party	3,682
	14,839
TOTAL (agree to Schedule V, line 22, col.8)	$ 495,051

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	$ 7,179
Advertising: Employee Recruitment	253
Health Care Worker Background Check	708
(Indicate # of checks performed 17)	
Patient Background Checks 128	1,905
Dues	7,018
Subscriptions	1,173
Permits	75
Home Office Allocation	12,222
Promotional Advertising	6,834
Less: Public Relations Expense	(8,811)
Non-allowable advertising	(6,834)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 21,722

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Milage	2,721
Meals	174
Lodging	679
Seminar Expense	
	30
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,604

**See instructions.

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA # 0051755 Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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**

(3) Did the nursing home make political contributions or payments to a politica 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 expens and the location of this expense on Sch. V. $ Line

(7) Have all costs reported on this form been determined using accounting procedure 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 fo 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 Departmen 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 classifiec 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 fo 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 benefit on Schedule V. $ **0** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **1,650**

(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 fo 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 othe times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjustec 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 ou 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