		FOR BHF USE			

LL1

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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-LTC, LLC dba FIRESIDE HOUSE OF CENTRALIA

Address: 1030 MARTIN LUTHER KING DRIVE (Number) CENTRALIA (City) 628001 (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 01/01/2018 to 12/31/2018 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)	LTC BACK OFFICE, LLC 10945 State Bridge Rd., Ste 401-470 Alpharetta, GA 30022
	(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-LTC, LLC dba FIRESIDE HOUSE OF CENTRALIA # 0051755 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF		11	6,752	6,763	8
9	SNF/PED					9
10	ICF	16,649	5,457	229	22,335	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,649	5,468	6,981	29,098	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.35%

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 6,273

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: 2018 Fiscal Year: 2018

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

Facility Name & ID Number FIRESIDE-LTC, LLC dba FIRESIDE HOUS # 0051755 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	206,140	20,342	8,660	235,142		235,142		235,142			1
2	Food Purchase		233,964		233,964		233,964	(6,925)	227,039			2
3	Housekeeping	84,572	23,635		108,207		108,207		108,207			3
4	Laundry	59,048	14,926		73,974		73,974		73,974			4
5	Heat and Other Utilities			126,118	126,118		126,118		126,118			5
6	Maintenance	34,788	6,744	47,699	89,231		89,231		89,231			6
7	Other (specify):*			9,249	9,249		9,249		9,249			7
8	**TOTAL General Services**	384,548	299,611	191,726	875,885		875,885	(6,925)	868,960			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	2,015,028	223,542	12,407	2,250,977	2,108	2,253,085	(1,558)	2,251,527			10
10a	Therapy	538,577	52		538,629		538,629		538,629			10a
11	Activities	48,839	3,520	1,758	54,117		54,117		54,117			11
12	Social Services	35,879		1,758	37,637		37,637		37,637			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,638,323	227,114	27,923	2,893,360	2,108	2,895,468	(1,558)	2,893,910			16
	C. General Administration											
17	Administrative	83,537			83,537	10,686	94,223		94,223			17
18	Directors Fees											18
19	Professional Services			475,999	475,999		475,999	(407,814)	68,185			19
20	Dues, Fees, Subscriptions & Promotions			25,905	25,905		25,905	3,844	29,749			20
21	Clerical & General Office Expenses	118,849	6,430	202,976	328,255	(10,686)	317,569	(57,104)	260,465			21
22	Employee Benefits & Payroll Taxes			492,755	492,755	(2,108)	490,647	204,162	694,809			22
23	Inservice Training & Education			4,796	4,796		4,796	1,987	6,783			23
24	Travel and Seminar			2,394	2,394		2,394	992	3,386			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			117,139	117,139		117,139	48,534	165,673			26
27	Other (specify):*			227,617	227,617		227,617	(243,447)	(15,830)			27
28	**TOTAL General Administration**	202,386	6,430	1,549,581	1,758,397	(2,108)	1,756,289	(448,846)	1,307,443			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,225,257	533,155	1,769,230	5,527,642		5,527,642	(457,329)	5,070,313			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.

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			33,753	33,753		33,753	8,909	42,662			30
31	Amortization of Pre-Op. & Org.			24,140	24,140		24,140	2,726	26,866			31
32	Interest			100,142	100,142		100,142	(48)	100,094			32
33	Real Estate Taxes			105,235	105,235		105,235	11,884	117,119			33
34	Rent-Facility & Grounds			445,834	445,834		445,834	(4,488)	441,346			34
35	Rent-Equipment & Vehicles			19,156	19,156		19,156	2,163	21,319			35
36	Other (specify):*			3,034	3,034		3,034	(3,034)	(0)			36
37	TOTAL Ownership			731,294	731,294		731,294	18,111	749,405			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	20,162	10,565		30,727		30,727		30,727			38
39	Ancillary Service Centers		290,657	6,840	297,497		297,497	(3,972)	293,525			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			194,326	194,326		194,326		194,326			42
43	Other (specify):*			21,087	21,087		21,087		21,087			43
44	TOTAL Special Cost Centers	20,162	301,222	222,253	543,637		543,637	(3,972)	539,665			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,245,419	834,377	2,722,777	6,802,573		6,802,573	(443,190)	6,359,383			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-LTC, LLC dba FIRESIDE HOUSE OF CEN1 # 0051755 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	(189)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(116)	21		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	(11,357)	32		10
11	Discounts, Allowances, Rebates & Refunds	(6,736)	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)	(1,638)	27		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(27,759)	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	(232,577)	27		24
25	Fund Raising, Advertising and Promotional				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	(137,447)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (417,819)		$	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)	(24,901)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (24,901)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (442,720)		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-LTC, LLC dba FIRESIDE HOUSE OF CENTRALIA

ID# 0051755

Report Period Beginning: 01/01/2018

Ending: 12/31/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	CSP-Non-Ancillary Personal Care Revenue	$ (1,558)	10	1
2	Donation Revenues	(285)	21	2
3	Bank Fees-NSF Fees	(28,812)	21	3
4	Bank Fees-NSF Fees (Vendors & Employees)	(2,748)	21	4
5	Vendor Late Fees	(82,274)	21	5
6	Debt Forgiveness	(15,830)	27	6
7	Over/Under Adjustments	(2)	27	7
8	Prior Year Operating Expenses	6,600	27	8
9	Gain/Loss on Disposal of Assets	5,097	30	9
10	Prior Year Property Expenses	(3,034)	36	10
11	Prior Year Ancillary Expenses	(3,972)	39	11
12	Promotional Adv-Print	(3,182)	20	12
13	Promotional Adv-Other	(2,446)	20	13
14	Non-Allowable Legal Fees	(5,000)	19	14
15	Dues - Political Action	(470)	20	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	(137,917)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number FIRESIDE-LTC, LLC dba FIRESIDE HOUSE OF CENTR/ # 0051755 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	(6,925)	0	0	0	0	0	0	0	0	0	0	(6,925)	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**	(6,925)	0	0	0	0	0	0	0	0	0	0	(6,925)	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	(1,558)	0	0	0	0	0	0	0	0	0	0	(1,558)	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**	(1,558)	0	0	0	0	0	0	0	0	0	0	(1,558)	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	(5,000)	(402,814)	0	0	0	0	0	0	0	0	0	(407,814)	19
20	Fees, Subscriptions & Promotions	(6,098)	9,942	0	0	0	0	0	0	0	0	0	3,844	20
21	Clerical & General Office Expenses	(141,994)	84,890	0	0	0	0	0	0	0	0	0	(57,104)	21
22	Employee Benefits & Payroll Taxes	0	204,162	0	0	0	0	0	0	0	0	0	204,162	22
23	Inservice Training & Education	0	1,987	0	0	0	0	0	0	0	0	0	1,987	23
24	Travel and Seminar	0	992	0	0	0	0	0	0	0	0	0	992	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	48,534	0	0	0	0	0	0	0	0	0	48,534	26
27	Other (specify):*	(243,447)	0	0	0	0	0	0	0	0	0	0	(243,447)	27
28	**TOTAL General Administration**	(396,539)	(52,307)	0	0	0	0	0	0	0	0	0	(448,846)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(405,022)	(52,307)	0	0	0	0	0	0	0	0	0	(457,329)	29

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	5,097	3,812	0	0	0	0	0	0	0	0	0	8,909	30
31	Amortization of Pre-Op. & Org.	0	2,726	0	0	0	0	0	0	0	0	0	2,726	31
32	Interest	(11,357)	11,309	0	0	0	0	0	0	0	0	0	(48)	32
33	Real Estate Taxes	0	11,884	0	0	0	0	0	0	0	0	0	11,884	33
34	Rent-Facility & Grounds	0	0	(4,488)	0	0	0	0	0	0	0	0	(4,488)	34
35	Rent-Equipment & Vehicles	0	0	2,163	0	0	0	0	0	0	0	0	2,163	35
36	Other (specify):*	(3,034)	0	0	0	0	0	0	0	0	0	0	(3,034)	36
37	**TOTAL Ownership**	(9,295)	29,731	(2,325)	0	0	0	0	0	0	0	0	18,111	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	(3,972)	0	0	0	0	0	0	0	0	0	0	(3,972)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(3,972)	0	0	0	0	0	0	0	0	0	0	(3,972)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(418,289)	(22,576)	(2,325)	0	0	0	0	0	0	0	0	(443,190)	45

Facility Name & ID Number FIRESIDE-LTC, LLC dba FIRESIDE HOUSE OF CENTRALIA # 0051755 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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. ☐ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Accounting Fees	$ 42,119	Five Rivers Management, LLC	100.00%	$	$ (42,119)	1
2	V	19	Mananagement Fees	399,845	Five Rivers Management, LLC	100.00%		(399,845)	2
3	V	19	Non-Related Professional Fees		Five Rivers Management, LLC	100.00%	39,150	39,150	3
4	V	20	Dues, Fees, Subs and Promos		Five Rivers Management, LLC	100.00%	9,942	9,942	4
5	V	21	Clerical and Gen Office Exp		Five Rivers Management, LLC	100.00%	84,890	84,890	5
6	V	22	Employee Benefits & Taxes		Five Rivers Management, LLC	100.00%	204,162	204,162	6
7	V	23	In Svc Traning & Educ		Five Rivers Management, LLC	100.00%	1,987	1,987	7
8	V	24	Travel & Seminars		Five Rivers Management, LLC	100.00%	992	992	8
9	V	26	Liability Insurance		Five Rivers Management, LLC	100.00%	48,534	48,534	9
10	V	30	Depreciation		Five Rivers Management, LLC	100.00%	3,812	3,812	10
11	V	31	Amortization		Five Rivers Management, LLC	100.00%	2,726	2,726	11
12	V	32	Non-Related Interest		Five Rivers Management, LLC	100.00%	11,309	11,309	12
13	V	33	Real Estate Taxes		Five Rivers Management, LLC	100.00%	11,884	11,884	13
14	Total			$ 441,964			$ 419,388	$ * (22,576)	14

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

Facility Name & ID Number FIRESIDE-LTC, LLC dba FIRESIDE HOUSE OF CENTRALIA # 0051755 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	35	Rental Equipment & Vehicles	$	Five Rivers Management, LLC	100.00%	$ 2,163	$ 2,163	15
16	V	34	Building Lease		Fireside Property	100.00%	441,346	441,346	16
17	V	34	Building Lease	445,834	Fireside Property	100.00%		(445,834)	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			$ 445,834			$ 443,509	$ * (2,325)	39

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

Facility Name & ID Number FIRESIDE-LTC, LLC dba FIRESIDE HOUSE OF CENTRALIA # 0051755 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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-LTC, LLC dba FIRESIDE HOU # 0051755 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number FIRESIDE-LTC, LLC dba FIRESIDE HOUSE OF CENTI # 0051755 Report Period Beginning: 01/01/2018 Ending: 2/31/2018

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	13,035,984	9	$ 808,522	$ 521,292	6,282,534	$ 389,657	1
2	32	CAPITAL	TOTAL COST	13,035,984	9	66,181		6,282,534	31,895	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					$ 874,703	$ 521,292		$ 421,552	25

Facility Name & ID Number FIRESIDE-LTC, LLC dba FIRESIDE HOUS # 0051755 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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, PROP&AUTO							3,034	6
7	INSPIRA		X	AR FINANCING							94,851	7
8	MEDICARE ERP		X	MEDICARE OVER PYMT							2,256	8
9	TOTAL Facility Related						$	$			$ 100,141	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 100,141	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-LTC, LLC dba FIRESIDE HOUSE OF CENTRALIA # 0051755 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2017 report.	$	106,684	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.)	$	106,684	2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2018 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:			
	2013	102,988	8
	2014	104,691	9
	2015	105,349	10
	2016	106,304	11
	2017	106,684	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME FIRESIDE-LTC, LLC dba FIRESIDE HOUSE OF CENTRA 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 2017 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 2017.

	(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	$ 106,684.00	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 106,684.00	$

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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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.

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-LTC, LLC dba FIRESIDE HOUSE OF CENTRALIA # 0051755 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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		5			1,731	9
10	10-ton HVAC Unit 225,000 BTU on roof			2012	8,139	814	10	814		5,562	10
11	Replace & Install East Wing Water Heater (State Brand; 80 Gallon)			2012	13,900	695	10	695		8,803	11
12	Painting of Upper Half of West Wing Walls			2012	2,864		5			2,864	12
13	Kitchen disposal drain and valve outlet replaced			2012	1,118		5			1,118	13
14	Augered and moved floor drain,replaced bad pipe in Maint room			2012	1,988		5			1,988	14
15	Thru-Wall Air Conditioner, UniFit 11,500/11,200 BTU Resident rooms			2012	2,027		5			2,027	15
16	Gas Pack Unit 225k BUT 10 Ton Cooling Unit on roof			2012	8,139	814	10	814		5,291	16
17	Repalce 3 Ton AC Unit with 5 ton unit on roof			2012	1,891		5			1,891	17
18	Kitchen Grease Trap replacement			2012	3,350		5			3,350	18
19	Replace Water Heater for Laundry and Kitchen w/			2013	12,460	1,246	10	1,246		7,476	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		2,068	21
22	Fire Suppression throughout building (includes extension of 6" line)			2013	28,181	1,127	25	1,127		6,294	22
23	Fire Sprinkler renovations throughout building			2013	34,700	1,388	25	1,388		7,634	23
24	Thru-Wall Air Conditioner, UniFit 11,500/11,200 BTU Resident rooms			2013	2,694	314	5	314		2,694	24
25	Purchase & installation of Nurse Call System in building			2013	1,500	250	5	250		1,500	25
26	Augered pipe in Mechine room & Beauty Shop, Replaced 1-1/2" pipe in			2014	3,006	601	5	601		3,006	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		1,461	28
29	14'x28' Storage shed located in behind of building			2014	5,514	1,103	5	1,103		4,778	29
30	Dining room serving shelf w/ glass protector for 5 well food table			2014	719	144	5	144		611	30
31	Thru-Wall Air Conditioner, UniFit 11,500/11,200 BTU Resident rooms			2014	1,989	398	5	398		1,624	31
32	Commercial Disposal in Kitchen Stainless Steel (3/4 HP 17iH)			2015	1,098	220	5	220		878	32
33	replaced 1200 sq ft of Sidewalk in back of building and			2015	11,000	733	15	733		2,506	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		2,885	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-LTC, LLC dba FIRESIDE HOUSE OF CENTRALIA # 0051755 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	$	$ 4,715	37
38	Air Conditioner and Heat Unit (220 Volt, 10,000 BTU) Resident R	2015	1,516	303	5	303		1,036	38
39	Air Conditioner and Heat Unit (220 Volt, 10,000 BTU) Resident R	2015	1,516	303	5	303		1,036	39
40	Painting of rooms, incl. bathrooms & halls in East & West Wings	2016	26,100	5,220	5	5,220		14,355	40
41	TheraPure Tub & 1900 Bathing Lift Package installed in shower r	2016	13,673	1,367	10	1,367		3,646	41
42	Supplied & installed walkin tub in shower room	2016	7,556	756	10	756		2,015	42
43	Fire Suppression repairs to cap line not being used	2017	2,800	112	25	112		224	43
44	AC and Heat Unit (10000 BTU 230 V R-410A Heat) Laundry Roo	2017	540	108	5	108		162	44
45	Friedrich Uni-Fit Thru Wall Air Conditioner (10,000 BTU, Heat/C	2018	506	101	5	101		101	45
46	Friedrich Uni-Fit Thru Wall Air Conditioner (10,000 BTU, Heat/C	2018	528	106	5	106		106	46
47	Commercial Water Heater A.O. Smith BTH 500,000N 100 gal	2018	15,500	775	10	775		775	47
48	Commercial Disposal Stainless Steel (1 HP 17"H)	2108	1,138	57	10	57		57	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)		$ 238,982	$ 21,921		$ 21,921	$	$ 108,268	70

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

Facility Name & ID Number FIRESIDE-LTC, LLC dba FIRESIDE HOUSE OF (# 0051755 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	$ 57,090	$ 10,302	$ 10,302	$	5-15	$ 31,259	71
72	Current Year Purchases	8,153	1,144	1,144		5	1,144	72
73	Fully Depreciated Assets	32,889	386	386		3-5	32,889	73
74								74
75	TOTALS	$ 98,132	$ 11,832	$ 11,832	$		$ 65,292	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)	$ 337,114	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 33,753	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 33,753	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)	$ 173,560	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-LTC, LLC dba FIRESIDE HOUSE OF CENTR # 0051755 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	$ 445,834	25		3
4	Additions							4
5								5
6								6
7	TOTAL		98		$ 445,834 **			7

10. Effective dates of current rental agreement:
    Beginning 6/30/2014
    Ending 6/29/2039

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

	Fiscal Year Ending	Annual Rent
12.	/2019	$
13.	/2020	$
14.	/2021	$

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.

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.

   Facility hires only trained and licensed C.N.A.s

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.

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	5750.99	hrs	$ 221,062		$	$	5,751	$ 221,062	1
2	Licensed Speech and Language Development Therapist	10A	1855.89	hrs	96,441				1,856	96,441	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10A	6031.12	hrs	221,075			52	6,031	221,127	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				$ 538,578		$	$ 52	13,638	$ 538,630	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-LTC, LLC dba FIRESIDE HOUSE OF CENTR # 0051755 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2018 (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	$ (1,204)	$	1
2	Cash-Patient Deposits	24,676		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,361,885		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	21,564		6
7	Other Prepaid Expenses	3,624		7
8	Accounts Receivable (owners or related parties)	1,182,714		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,593,259	$	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	126,347		15
16	Equipment, at Historical Cost	232,617		16
17	Accumulated Depreciation (book methods)	(200,506)		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)**	$ 158,458	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,751,717	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,469,287	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	24,676		28
29	Short-Term Notes Payable	689,035		29
30	Accrued Salaries Payable	221,561		30
31	Accrued Taxes Payable (excluding real estate taxes)	845,652		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	Accued Taxes and Audit Fees	119,340		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,474,551	$	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)**	$ 3,474,551	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (722,834)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,751,717	$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (120,694)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (120,694)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(602,140)	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)**	$ (602,140)	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)**	$ (722,834)	24 *

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

Facility Name & ID Number FIRESIDE-LTC, LLC dba FIRESIDE HOUSE OF # 0051755 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,814,250	1
2	Discounts and Allowances for all Levels	1,285,112	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,099,362	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	123,673	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 123,673	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	189	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	5,407	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	563	19
20	Radiology and X-Ray	(57,990)	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ (51,831)	23
	D. Non-Operating Revenue		
24	Contributions	285	24
25	Interest and Other Investment Income***	6,260	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 6,545	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Rebates, Copies and Debt Forgiveness	22,682	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 22,682	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,200,431	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	875,883	31
32	Health Care	2,893,361	32
33	General Administration	1,758,397	33
	B. Capital Expense		
34	Ownership	731,294	34
	C. Ancillary Expense		
35	Special Cost Centers	349,310	35
36	Provider Participation Fee	194,326	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,802,571	40
41	**Income before Income Taxes (line 30 minus line 40)****	(602,140)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (602,140)	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-LTC, LLC dba FIRESIDE HOUSE OF CENTR # 0051755 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	7,008	7,733	$ 243,205	$ 31.45	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,394	14,395	431,927	30.01	3
4	Licensed Practical Nurses	18,418	19,961	476,753	23.88	4
5	CNAs & Orderlies	60,592	65,487	793,233	12.11	5
6	CNA Trainees					6
7	Licensed Therapist	12,544	13,638	538,577	39.49	7
8	Rehab/Therapy Aides					8
9	Activity Director	3,712	4,187	48,839	11.66	9
10	Activity Assistants					10
11	Social Service Workers	1,988	2,242	35,879	16.00	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,651	16,966	206,140	12.15	15
16	Dishwashers					16
17	Maintenance Workers	1,892	2,091	34,788	16.64	17
18	Housekeepers	8,598	9,371	84,572	9.02	18
19	Laundry	5,893	6,463	59,048	9.14	19
20	Administrator	1,793	2,009	94,223	46.91	20
21	Assistant Administrator					21
22	Other Administrative	4,096	4,485	108,163	24.12	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	692	770	10,022	13.01	31
32	Other Health Care(specify)	1,887	2,130	59,606	27.99	32
33	Other(specify)	1,504	1,504	20,162	13.40	33
34	TOTAL (lines 1 - 33)	159,662	173,431	$ 3,245,137 *	$ 18.71	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	184	$ 8,660	1-3	35
36	Medical Director		12,000	9-3	36
37	Medical Records Consultant	42	2,108	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,868	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	32	1,758	11-3	44
45	Social Service Consultant	32	1,758	12-3	45
46	Other(specify)				46
47					47
48	A&G CONSULTANT		26,878	21-3	48
49	TOTAL (lines 35 - 48)	290	$ 56,030		49

C. CONTRACT NURSES

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

Facility Name & ID Number FIRESIDE-LTC, LLC dba FIRESIDE HOUSE OF C # 0051755 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
KATHY BERCK	ADMINSTRATOR	0	$ 83,537
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 83,537

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	A&G-Registered Agent Fees	$ 431
FIVE RIVERS MGT	A&G-Accounting Fees	42,119
PROLIANT	A&G-Payroll Processing	14,048
BB&T BANK	Analysis & Service Fees	5,155
UNION BANK	Analysis & Service Fees (RAM)	570
WHAN&WHAN LAWYERS	Legal Fees	10,462
McNair, McLemore, Middlebrook	Auditing Fees	900
FIVE RIVERS MGT	Management Fees (Mgmt Co)	369,617
INSPIRA	LOCKBOX FEES	32,697
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 475,999

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 99,050
Unemployment Compensation Insurance	
FICA Taxes	275,076
Employee Health Insurance	106,782
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Vison insurance	25
Life Insurance	4,544
Dental Insurance	(102)
Employee Appreciation/Holiday Party	3,807
Employee Vaccinations	3,574
TOTAL (agree to Schedule V, line 22, col.8)	$ 492,755

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		$
Advertising: Employee Recruitment		2,621
Health Care Worker Background Check		
(Indicate # of checks performed)		
Patient Background Checks	121	1,910
DUES		7,429
SUBSCRIPTIONS		917
LICENSES/PERMITS		7,400
PROMOTIONAL ADVERTING		5,628
HOME OFFICE ALLOCATION		9,942
Less: Public Relations Expense		( )
Non-allowable advertising		(5,628)
Yellow page advertising		( )
TOTAL (agree to Sch. V, line 20, col. 8)		$ 30,219

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
HO REGIONAL PERSONEL	992
In-State Travel	
MILAGE	1,625
LODGING	547
MEALS/OTHER	222
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,386

**See instructions.

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 $7003 AND CoC $426**

(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. $ **30,931** Line **10**

(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. $ **189**

(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

Legal Fees

Invoice Date	Law Firm	Allowable Ar	Non-Allowable Amount	Description of Services	
2/12/2018	Wham & Wham Lawyers	1,126.93		Resident case	0.00
2/28/2018	Larson Financia	5,000.00	5,000.00	Tax Issues	0.00
3/20/2018	Wham & Wham Lawyers	2,200.00		Vendor Case	0.00
11/15/2018	Wham & Wham Lawyers	400.00		Resident Case	0.00
12/18/2018	Wham & Wham Lawyers	160.00		Vendor Case	0.00
11/28/2018	Wham & Wham Lawyers	1,574.80		Vendor Case	0.00