

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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: <u>0051755</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>FIRESIDE HOUSE OF CENTRALIA</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2016</u> to <u>12/31/2016</u> 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.																							
Address: <u>1030 MARTN LUTHR KNG</u> <u>CENTRALIA</u> <u>62801</u>																									
Number City Zip Code																									
County: <u>MARION</u>																									
Telephone Number: <u>(618) 532-1833</u> Fax # <u>(618) 532-1308</u>																									
HFS ID Number: _____		<table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Type or Print Name) <u>DAREN DOUSTON</u></td></tr><tr><td>(Title) <u>MEMBER/CFO</u></td></tr><tr><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	Paid Preparer	(Type or Print Name) <u>DAREN DOUSTON</u>	(Title) <u>MEMBER/CFO</u>	(Signed) _____	(Date) _____														
Officer or Administrator of Provider	(Signed) _____																								
	(Date) _____																								
Paid Preparer	(Type or Print Name) <u>DAREN DOUSTON</u>																								
	(Title) <u>MEMBER/CFO</u>																								
	(Signed) _____																								
	(Date) _____																								
Date of Initial License for Current Owners: <u>02/01/2012</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☐ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.			☒ Limited Liability Co.			☐ Trust			☐ Other _____	
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	☐ "Sub-S" Corp.																								
	☒ Limited Liability Co.																								
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:		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																							
Name: <u>MATTHEW LARSON</u> Telephone Number: <u>(678) 381-2820</u>																									
Email Address: _____																									

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA

0051755 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	<u>51</u>	Skilled (SNF)	<u>51</u>	<u>18,615</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>47</u>	Intermediate (ICF)	<u>47</u>	<u>17,155</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>98</u>	TOTALS	<u>98</u>	<u>35,770</u>	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			<u>5,713</u>	<u>5,713</u>	8
9	SNF/PED					9
10	ICF	<u>19,334</u>	<u>6,864</u>	<u>10</u>	<u>26,208</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>19,334</u>	<u>6,864</u>	<u>5,723</u>	<u>31,921</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.24%

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

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

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES ☐ NO ☒

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

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 02/01/2012 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter number of beds certified 51 and days of care provided 5,435

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 2016 Fiscal Year: 2016

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

Facility Name & ID Number **FIRESIDE HOUSE OF CENTRALIA** # **0051755** Report Period Beginning: **01/01/2016** Ending: **12/31/2016**
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	169,591	17,515	8,711	195,817		195,817		195,817			1
2	Food Purchase		224,376		224,376		224,376	(5,598)	218,778			2
3	Housekeeping	94,976	20,720		115,696		115,696		115,696			3
4	Laundry	66,223	12,628		78,851		78,851		78,851			4
5	Heat and Other Utilities			118,988	118,988		118,988		118,988			5
6	Maintenance	35,146	9,243	56,032	100,421		100,421		100,421			6
7	Other (specify):*			7,271	7,271		7,271		7,271			7
8	TOTAL General Services	365,936	284,482	191,002	841,420		841,420	(5,598)	835,822			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,731,880	89,169	22,041	1,843,090		1,843,090		1,843,090			10
10a	Therapy	482,543	198		482,741		482,741		482,741			10a
11	Activities	50,551	2,235	2,348	55,134		55,134		55,134			11
12	Social Services	37,581		2,348	39,929		39,929		39,929			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,302,555	91,602	38,737	2,432,894		2,432,894		2,432,894			16
	C. General Administration											
17	Administrative	87,690			87,690		87,690		87,690			17
18	Directors Fees											18
19	Professional Services			463,275	463,275		463,275	(395,264)	68,011			19
20	Dues, Fees, Subscriptions & Promotions			24,624	24,624		24,624	(11,844)	12,780			20
21	Clerical & General Office Expenses	131,869	115,589	92,842	340,300		340,300	27,742	368,042			21
22	Employee Benefits & Payroll Taxes			485,357	485,357		485,357	157,567	642,924			22
23	Inservice Training & Education			5,843	5,843		5,843	1,213	7,056			23
24	Travel and Seminar			3,730	3,730		3,730	52,047	55,777			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			108,487	108,487		108,487	35,219	143,706			26
27	Other (specify):*			222,140	222,140		222,140	(217,940)	4,200			27
28	TOTAL General Administration	219,559	115,589	1,406,298	1,741,446		1,741,446	(351,260)	1,390,186			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,888,050	491,673	1,636,037	5,015,760		5,015,760	(356,858)	4,658,902			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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			36,887	36,887		36,887	4,240	41,127			30
31	Amortization of Pre-Op. & Org.			21,006	21,006		21,006	2,415	23,421			31
32	Interest			101,374	101,374		101,374	(43,349)	58,025			32
33	Real Estate Taxes			105,388	105,388		105,388	12,114	117,502			33
34	Rent-Facility & Grounds			405,925	405,925		405,925	(3,467)	402,458			34
35	Rent-Equipment & Vehicles			24,598	24,598		24,598	2,827	27,425			35
36	Other (specify):*			2,741	2,741		2,741		2,741			36
37	TOTAL Ownership			697,919	697,919		697,919	(25,220)	672,699			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	11,594	5,537		17,131		17,131		17,131			38
39	Ancillary Service Centers		252,131	4,586	256,717		256,717	(1,475)	255,242			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			217,237	217,237		217,237		217,237			42
43	Other (specify):*			17,168	17,168		17,168		17,168			43
44	TOTAL Special Cost Centers	11,594	257,668	238,991	508,253		508,253	(1,475)	506,778			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,899,644	749,341	2,572,947	6,221,932		6,221,932	(383,553)	5,838,379			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

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	(1,354)	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	(49,331)	32		10
11	Discounts, Allowances, Rebates & Refunds	(4,244)	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)	(57)	27		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(191,456)	27		24
25	Fund Raising, Advertising and Promotional	(5,477)	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	(98,063)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (349,982)		\$	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)	(33,571)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (33,571)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (383,553)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	NSF FEES	\$ (6,376)	21	1
2	CHAMBER OF COMMERCE DUES	(7,413)	20	2
3	SUBSCRIPTIONS	(838)	20	3
4	PERMITS	(171)	20	4
5	OVER/UNDER ADJUSTMENTS	(262)	27	5
6	PRIOR YEAR OPERATING EXPENSE	(26,165)	27	6
7	PRIOR YEAR ANCILLARY EXPENSE	(1,475)	39	7
8	MONEY RECEIVED FOR COPYING	(27)	20	8
9	DONATIONS	(1,050)	20	9
10	VENDOR LATE FEES	(44,014)	21	10
11	PENALTIES	(10,272)	21	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(98,063)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA # 0051755 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(5,598)	0	0	0	0	0	0	0	0	0	0	(5,598)	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	(5,598)	0	0	0	0	0	0	0	0	0	0	(5,598)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(395,264)	0	0	0	0	0	0	0	0	0	(395,264)	19
20	Fees, Subscriptions & Promotions	(14,976)	3,132	0	0	0	0	0	0	0	0	0	(11,844)	20
21	Clerical & General Office Expenses	(60,662)	88,404	0	0	0	0	0	0	0	0	0	27,742	21
22	Employee Benefits & Payroll Taxes	0	157,567	0	0	0	0	0	0	0	0	0	157,567	22
23	Inservice Training & Education	0	1,213	0	0	0	0	0	0	0	0	0	1,213	23
24	Travel and Seminar	0	52,047	0	0	0	0	0	0	0	0	0	52,047	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	35,219	0	0	0	0	0	0	0	0	0	35,219	26
27	Other (specify):*	(217,940)	0	0	0	0	0	0	0	0	0	0	(217,940)	27
28	TOTAL General Administration	(293,578)	(57,682)	0	0	0	0	0	0	0	0	0	(351,260)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(299,176)	(57,682)	0	0	0	0	0	0	0	0	0	(356,858)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA # 0051755 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	4,240	0	0	0	0	0	0	0	0	0	4,240	30
31	Amortization of Pre-Op. & Org.	0	2,415	0	0	0	0	0	0	0	0	0	2,415	31
32	Interest	(49,331)	5,982	0	0	0	0	0	0	0	0	0	(43,349)	32
33	Real Estate Taxes	0	12,114	0	0	0	0	0	0	0	0	0	12,114	33
34	Rent-Facility & Grounds	0	0	0	(3,467)	0	0	0	0	0	0	0	(3,467)	34
35	Rent-Equipment & Vehicles	0	0	0	2,827	0	0	0	0	0	0	0	2,827	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(49,331)	24,751	0	(640)	0	0	0	0	0	0	0	(25,220)	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	(1,475)	0	0	0	0	0	0	0	0	0	0	(1,475)	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	(1,475)	0	0	0	0	0	0	0	0	0	0	(1,475)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(349,982)	(32,931)	0	(640)	0	0	0	0	0	0	0	(383,553)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
DAREN DOUSTON	50%	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	\$ 43,590	Five Rivers Management, LLC	100.00%	\$	\$ (43,590)	1
2	V	19	Mananagement Fees	368,342	Five Rivers Management, LLC	100.00%		(368,342)	2
3	V	19	Non-Related Professional Fees		Five Rivers Management, LLC	100.00%	16,668	16,668	3
4	V	20	Dues, Fees, Subs and Promos		Five Rivers Management, LLC	100.00%	3,132	3,132	4
5	V	21	Clerical and Gen Office Exp		Five Rivers Management, LLC	100.00%	88,404	88,404	5
6	V	22	Employee Benefits & Taxes		Five Rivers Management, LLC	100.00%	157,567	157,567	6
7	V	23	In Svc Traning & Educ		Five Rivers Management, LLC	100.00%	1,213	1,213	7
8	V	24	Travel & Seminars		Five Rivers Management, LLC	100.00%	52,047	52,047	8
9	V	26	Liability Insurance		Five Rivers Management, LLC	100.00%	35,219	35,219	9
10	V	30	Depreciation		Five Rivers Management, LLC	100.00%	4,240	4,240	10
11	V	31	Amortization		Five Rivers Management, LLC	100.00%	2,415	2,415	11
12	V	32	Non-Related Interest		Five Rivers Management, LLC	100.00%	5,982	5,982	12
13	V	33	Real Estate Taxes		Five Rivers Management, LLC	100.00%	12,114	12,114	13
14	Total			\$ 411,932			\$ 379,001	\$ * (32,931)	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	35	Rental Equipment & Vehicles	\$	Five Rivers Management, LLC	100.00%	\$ 2,827	\$ 2,827	15
16	V	34	Building Lease	405,925	Fireside Property	100.00%		(405,925)	16
17	V	34	Building Lease		Fireside Property	100.00%	402,458	402,458	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			\$ 405,925			\$ 405,285	\$ * (640)	39

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

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 FIREHOUSE OF CENTRALIA # 0051755 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA # 0051755 Report Period Beginning: 01/01/2016 Ending: 2/31/2016

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	16,833,971	10	\$ 959,756	\$ 626,601	6,213,492	\$ 354,250	1
2	32	CAPITAL	TOTAL COST	16,833,971	10	74,715		6,213,492	27,578	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					\$ 1,034,471	\$ 626,601		\$ 381,828	25

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								3,367	6
7	INSPIRA		X	AR FINANCING								84,696	7
8	EVERGREEN REHAB		X	THERAPY								7,242	8
9	TOTAL Facility Related						\$				\$	95,306	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$				\$		14
15	TOTALS (line 9+line14)						\$				\$	95,306	15

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

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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	RAPID ADVANCE		X	AR FINANCING								4,800	6
7	REGIONS BANK		X	CREDIT CARD INTEREST								1,267	7
8													8
9	TOTAL Facility Related						\$		\$			\$ 6,067	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$		\$			\$	14
15	TOTALS (line 9+line14)						\$		\$			\$ 6,067	15

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2015 report.			\$	105,349	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.)			\$	105,349	2
3. Under or (over) accrual (line 2 minus line 1).			\$		3
4. Real Estate Tax accrual used for 2016 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:		2011	99,035	8	
		2012	101,793	9	
		2013	102,988	10	
		2014	104,691	11	
		2015	105,349	12	
				FOR BHF USE ONLY	
		13	FROM R. E. TAX STATEMENT FOR 2015	\$	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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME FIRESIDE HOUSE OF CENTRALIA COUNTY MARION

FACILITY IDPH LICENSE NUMBER 0051755

CONTACT PERSON REGARDING THIS REPORT MATTHEW LARSON

TELEPHONE (678) 381-2820 FAX #: (678) 381-2821

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. 14-17-100-006	PT SW NE NW	\$ 105,349.00	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 105,349.00	\$

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation . Facilities located in Cook County are required to providecopies of their original second installment tax bill.

A. Square Feet: 29,800

B. General Construction Type: Exterior BRICKFrame CONCRETENumber of Stories 1

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☐ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA

0051755

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

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	346	5	346		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	573	5	573		2,673	12
13		Kitchen disposal drain and valve outlet replaced		2012	1,118	224	5	224		1,025	13
14		Augered and moved floor drain,replaced bad pipe in Maint room		2012	1,988	398	5	398		1,822	14
15		Thru-Wall Air Conditioner, UniFit 11,500/11,200 BTU Resident rooms		2012	2,027	405	5	405		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	378	5	378		1,702	17
18		Kitchen Grease Trap replacement		2012	3,350	670	5	670		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											26
27											27
28		Augered pipe in Mechine room & Beauty Shop, Replaced 1-1/2" pipe in		2014	3,006	601	5	601		1,804	28
29		Mechine room, replace cast Iron pipe in pantry									29
30		10'x10' Storage shed located in behind of building		2014	1,461	292	5	292		877	30
31		14'x28' Storage shed located in behind of building		2014	5,514	1,103	5	1,103		2,573	31
32		Dining room serving shelf w/ glass protector for 5 well food table		2014	719	144	5	144		323	32
33		Thru-Wall Air Conditioner, UniFit 11,500/11,200 BTU Resident rooms		2014	1,989	398	5	398		829	33
34		Commercial Disposal in Kitchen Stainless Steel (3/4 HP 17iH)		2015	1,098	220	5	220		439	34
35		replaced 1200 sq ft of Sidewalk in back of building and		2015	11,000	733	15	733		1,039	35
36		applied seal coat and striping to parking lot									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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 5'x8' illuminated Facility sign out in front of building	2015	\$ 8,443	\$ 844	10	\$ 844	\$	\$ 1,196	37
38 Installation of 2 Rooftop units below For East wing and South hall	2015	6,900	1,380	5	1,380		1,955	38
39 Air Conditioner and Heat Unit (220 Volt, 10,000 BTU) Resident Rooms	2015	1,516	303	5	303		430	39
40 Air Conditioner and Heat Unit (220 Volt, 10,000 BTU) Resident Rooms	2015	1,516	303	5	303		430	40
41 Painting of rooms, incl. bathrooms & halls in East & West Wings	2016	26,100	3,915	5	3,915		3,915	41
42 TheraPure Tub & 1900 Bathing Lift Package installed in shower r	2016	13,673	912	10	912		912	42
43 Supplied & installed walkin tub in shower room	2016	7,556	504	10	504		504	43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 217,970	\$ 22,613		\$ 22,613	\$	\$ 63,323	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 71,372	\$ 14,204	\$ 14,204	\$	5-10	\$ 38,705	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 71,372	\$ 14,204	\$ 14,204	\$		\$ 38,705	75

D. Vehicle Costs. (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76	Transport Residents	Van, Dodge 1999	2013	\$ 500	\$ 69	\$ 69	\$	3	\$ 500
77									
78									
79									
80	TOTALS			\$ 500	\$ 69	\$ 69	\$		\$ 500

E. Summary of Care-Related Assets					1	2
		Reference			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)			\$	289,842
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	36,886
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	36,886
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	102,528

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		\$	\$	
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☒ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1963	98	06/30/2014	\$	25		3
4	Additions							4
5								5
6								6
7	TOTAL		98		\$			7

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

9. Option to Buy: ☐ YES ☐ 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.

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

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

C. CONTRACTUAL INCOME

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)	\$			

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		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
1	Licensed Occupational Therapist	10A	4801.45	hrs	\$ 181,746		\$	4,801	\$ 181,746	1	
2	Licensed Speech and Language Development Therapist	10A	1148.72	hrs	99,203			1,149	99,203	2	
3	Licensed Recreational Therapist			hrs						3	
4	Licensed Physical Therapist	10A	5971.96	hrs	201,595			198	5,972	201,793	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				\$ 482,544		\$	198	11,922	\$ 482,742	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.

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	\$ 3,013	\$	1
2	Cash-Patient Deposits	24,147		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,192,281		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	18,372		6
7	Other Prepaid Expenses	8,247		7
8	Accounts Receivable (owners or related parties)	894,283		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,140,343	\$	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	123,547		15
16	Equipment, at Historical Cost	202,044		16
17	Accumulated Depreciation (book methods)	(121,616)		17
18	Deferred Charges	20,053		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)	\$ 224,028	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,364,371	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,056,364	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	24,147		28
29	Short-Term Notes Payable	790,630		29
30	Accrued Salaries Payable	185,796		30
31	Accrued Taxes Payable (excluding real estate taxes)	193,956		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				36
37		51,065		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,406,958	\$	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)	\$ 2,406,958	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (42,587)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,364,371	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (12,083)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (12,083)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(30,504)	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)	\$ (30,504)	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)	\$ (42,587)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number FIRESIDE HOUSE OF CENTRALIA

0051755

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,984,363	1
2	Discounts and Allowances for all Levels	1,014,420	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,998,782	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	113,602	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 113,602	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	1,354	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	9,371	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,122	19
20	Radiology and X-Ray		20
21	Other Medical Services	12,550	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 24,397	23
	D. Non-Operating Revenue		
24	Contributions	1,050	24
25	Interest and Other Investment Income***	49,331	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 50,381	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28		4,271	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,271	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,191,433	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	684,833	31
32	Health Care	2,432,896	32
33	General Administration	1,898,035	33
	B. Capital Expense		
34	Ownership	697,919	34
	C. Ancillary Expense		
35	Special Cost Centers	291,017	35
36	Provider Participation Fee	217,237	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,221,937	40
41	Income before Income Taxes (line 30 minus line 40)**	(30,504)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (30,504)	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.

		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	7,433	8,260	\$ 231,806	\$ 28.06	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,789	14,850	366,240	24.66	3
4	Licensed Practical Nurses	15,976	17,605	357,095	20.28	4
5	CNAs & Orderlies	61,578	66,612	708,857	10.64	5
6	CNA Trainees					6
7	Licensed Therapist	11,629	12,677	482,544	38.06	7
8	Rehab/Therapy Aides					8
9	Activity Director	4,348	4,627	50,551	10.93	9
10	Activity Assistants					10
11	Social Service Workers	2,091	2,233	37,581	16.83	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,165	17,188	169,591	9.87	15
16	Dishwashers					16
17	Maintenance Workers	2,012	2,178	35,146	16.14	17
18	Housekeepers	9,958	10,697	94,976	8.88	18
19	Laundry	6,564	7,152	66,223	9.26	19
20	Administrator	1,912	2,073	95,017	45.84	20
21	Assistant Administrator					21
22	Other Administrative	5,750	6,389	124,542	19.49	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	569	630	7,923	12.58	31
32	Other Health Care MDS	1,888	2,129	56,710	26.64	32
33	Other(specify) Transportation/Certification	1,436	1,486	14,388	9.68	33
34	TOTAL (lines 1 - 33)	163,098	176,786	\$ 2,899,190 *	\$ 16.40	34

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

** See instructions.

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	185	\$ 8,711	1-3	35
36	Medical Director		12,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	43	2,348	11-3	44
45	Social Service Consultant	43	2,348	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	271	\$ 25,407		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

XX. GENERAL INFORMATION:

- | | |
|--|---|
| <p>(1) Are nursing employees (RN,LPN,NA) represented by a union? <u>NO</u></p> <p>(2) Are there any dues to nursing home associations included on the cost report? <u>YES</u>
If YES, give association name and amount. <u>IHCA</u></p> <p>(3) Did the nursing home make political contributions or payments to a political action organization? <u>NO</u> If YES, have these costs been properly adjusted out of the cost report? _____</p> <p>(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? <u>NO</u> If YES, what is the capacity? _____</p> <p>(5) Have you properly capitalized all major repairs and equipment purchases? <u>YES</u>
What was the average life used for new equipment added during this period? <u>3-10 YEARS</u></p> <p>(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ _____ Line _____</p> <p>(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? <u>YES</u> If NO, attach a complete explanation.</p> <p>(8) Are you presently operating under a sale and leaseback arrangement? <u>NO</u>
If YES, give effective date of lease. _____</p> <p>(9) Are you presently operating under a sublease agreement? YES <u>X</u> NO</p> <p>(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
_____</p> <p>(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.</p> <p>(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? <u>NO</u> If YES, attach an explanation of the allocation.</p> | <p>(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? <u>YES</u></p> <p>(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? <u>NO</u> 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.</p> <p>(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ <u>0</u> Has any meal income been offset against related costs? <u>YES</u> Indicate the amount. \$ <u>1,354</u></p> <p>(16) Travel and Transportation
a. Are there costs included for out-of-state travel? <u>NO</u>
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? <u>NO</u> 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? <u>0</u>
d. Have vehicle usage logs been maintained? <u>N/A</u>
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? <u>N/A</u>
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? <u>NO</u>
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____</p> <p>(17) Has an audit been performed by an independent certified public accounting firm? <u>NO</u>
Firm Name: _____</p> <p>(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? <u>YES</u></p> <p>(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. <u>N/A</u>
Attach invoices and a summary of services for all architect and appraisal fees</p> |
|--|---|