

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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>0055921</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>1/1/2020</u> to <u>12/31/2020</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.	
Address: <u>1030 Martin Lthr Kng</u> <u>Centralia</u> <u>62801</u>		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Marion</u>			
Telephone Number: <u>(618) 532-1833</u> Fax # <u>(618) 532-1308</u>			
HFS ID Number: _____			
Date of Initial License for Current Owners: <u>09/01/2019</u>			
Type of Ownership:			
☐ VOLUNTARY, NON-PROFIT		☐ PROPRIETARY	
☐ Charitable Corp.		☐ Individual	
☐ Trust		☐ Partnership	
IRS Exemption Code _____		☐ Corporation	
		☐ "Sub-S" Corp.	
		☒ Limited Liability Co.	
		☐ Trust	
		☐ Other _____	
In the event there are further questions about this report, please contact:			
Name: <u>Daren Douston</u>			
Telephone Number: <u>(678) 381-2810</u>			
Email Address: _____			
		Officer or Administrator of Provider	
		(Signed) _____ (Date) _____	
		(Type or Print Name) <u>Doug Mittleider</u>	
		(Title) <u>President of Managing Member</u>	
		(Signed) _____ (Date) _____	
		Paid Preparer	
		(Print Name and Title) _____	
		(Firm Name & Address) _____	
		(Telephone) <u>()</u> Fax # <u>()</u>	
		MAIL TO: BUREAU OF HEALTH FINANCE	
		ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES	
		201 S. Grand Avenue East	
		Springfield, IL 62763-0001	
		Phone # (217) 782-1630	

Facility Name & ID Number Fireside House of Centralia

0055921 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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>18,666</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>47</u>	Intermediate (ICF)	<u>47</u>	<u>17,202</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>35,868</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>4,704</u>	<u>4,704</u>	8
9	SNF/PED					9
10	ICF	<u>15,760</u>	<u>3,957</u>	<u>112</u>	<u>19,829</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>15,760</u>	<u>3,957</u>	<u>4,816</u>	<u>24,533</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.40%

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 ☒

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 / /

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 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

Medicare Intermediary Wisconsin Physical Services

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2020 Fiscal Year: 12/31/2020
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Fireside House of Centralia # 0055921 Report Period Beginning: 1/1/2020 Ending: 12/31/2020
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	198,817	22,691	5,405	226,913		226,913		226,913			1
2	Food Purchase		190,321		190,321		190,321	(1,658)	188,663			2
3	Housekeeping	87,880	23,154		111,034		111,034		111,034			3
4	Laundry	60,701	16,069		76,770		76,770		76,770			4
5	Heat and Other Utilities			114,761	114,761		114,761		114,761			5
6	Maintenance	37,255	3,257	76,080	116,592		116,592		116,592			6
7	Other (specify):*			14,100	14,100		14,100		14,100			7
8	TOTAL General Services	384,653	255,492	210,346	850,491		850,491	(1,658)	848,833			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,886,149	197,148	11,570	2,094,867		2,094,867	(3,089)	2,091,778			10
10a	Therapy	498,468	214		498,682		498,682		498,682			10a
11	Activities	51,356	3,245	2,025	56,626		56,626	(24)	56,602			11
12	Social Services	49,088		2,025	51,113		51,113		51,113			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,485,061	200,607	27,620	2,713,288		2,713,288	(3,113)	2,710,175			16
	C. General Administration											
17	Administrative	88,575			88,575		88,575		88,575			17
18	Directors Fees							(718)	(718)			18
19	Professional Services			456,130	456,130		456,130	(405,398)	50,732			19
20	Dues, Fees, Subscriptions & Promotions			25,570	25,570		25,570	18,482	44,052			20
21	Clerical & General Office Expenses	112,476	3,754	114,824	231,054		231,054	190,778	421,832			21
22	Employee Benefits & Payroll Taxes			430,164	430,164		430,164	305,336	735,500			22
23	Inservice Training & Education			1,824	1,824		1,824	761	2,585			23
24	Travel and Seminar			230	230		230	(1,016)	(786)			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			119,189	119,189		119,189	86,152	205,341			26
27	Other (specify):*			624,036	624,036		624,036	(622,447)	1,589			27
28	TOTAL General Administration	201,051	3,754	1,771,967	1,976,772		1,976,772	(428,070)	1,548,702			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,070,765	459,853	2,009,933	5,540,551		5,540,551	(432,842)	5,107,709			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			7,727	7,727		7,727	799	8,526			30
31	Amortization of Pre-Op. & Org.			3,089	3,089		3,089	319	3,408			31
32	Interest			7,788	7,788		7,788	709	8,497			32
33	Real Estate Taxes			108,000	108,000		108,000	11,165	119,165			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			253,955	253,955		253,955	1,911	255,866			35
36	Other (specify):*			9,120	9,120		9,120		9,120			36
37	TOTAL Ownership			389,679	389,679		389,679	14,903	404,582			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	15,778	7,798		23,576		23,576		23,576			38
39	Ancillary Service Centers		150,637	2,415	153,052		153,052		153,052			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			180,440	180,440		180,440		180,440			42
43	Other (specify):*			11,935	11,935		11,935		11,935			43
44	TOTAL Special Cost Centers	15,778	158,435	194,790	369,003		369,003		369,003			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	3,086,543	618,288	2,594,402	6,299,233		6,299,233	(417,939)	5,881,294			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				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	(96)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,658)	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)	(106)	27		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(23,680)	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	(622,341)	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	(47,362)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (695,243)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	234,959		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 234,959		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (460,284)		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

ID#0055921

Report Period Beginning:1/1/2020

Ending:12/31/2020

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Promotional Adv-Print	\$ (3,089)	10	1
2	Promotional Adv-Internet	(24)	11	2
3	Promotional Adv-Food & Meals	(76)	16	3
4	Promotional Adv-Other	(718)	18	4
5	CSP-Non-Ancillary Personal Care Revenue	0	18	5
6	Donation Revenues	(989)	24	6
7	Bank Fees-NSF Fees	(193)	24	7
8	Bank Fees-NSF Fees (Vendors & Employees)	0	29	8
9	Vendor Late Fees	(9,625)	29	9
10	Debt Forgiveness	0	29	10
11	Over/Under Adjustments	(20)	29	11
12	Prior Year Operating Expenses	(1,569)	29	12
13	Legal Fees	(13,014)	29	13
14	Gain/Loss on Disposal of Assets	0	29	14
15	Prior Year Property Expenses	(9,120)	29	15
16	Dues	(8,925)	29	16
17	Prior Year Ancillary Expenses	0	29	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	(47,362)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Fireside House of Centralia# 0055921

Report Period Beginning:

1/1/2020

Ending:

12/31/2020**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	(1,658)	0	0	0	0	0	0	0	0	0	0	(1,658)	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	(1,658)	0	0	0	0	0	0	0	0	0	0	(1,658)	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	(3,089)	0	0	0	0	0	0	0	0	0	0	(3,089)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(24)	0	0	0	0	0	0	0	0	0	0	(24)	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	(3,113)	0	0	0	0	0	0	0	0	0	0	(3,113)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	(718)	0	0	0	0	0	0	0	0	0	0	(718)	18
19	Professional Services	0	(405,398)	0	0	0	0	0	0	0	0	0	(405,398)	19
20	Fees, Subscriptions & Promotions	0	18,482	0	0	0	0	0	0	0	0	0	18,482	20
21	Clerical & General Office Expenses	(23,680)	214,458	0	0	0	0	0	0	0	0	0	190,778	21
22	Employee Benefits & Payroll Taxes	0	305,336	0	0	0	0	0	0	0	0	0	305,336	22
23	Inservice Training & Education	0	761	0	0	0	0	0	0	0	0	0	761	23
24	Travel and Seminar	(1,182)	166	0	0	0	0	0	0	0	0	0	(1,016)	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	86,152	0	0	0	0	0	0	0	0	0	86,152	26
27	Other (specify):*	(622,447)	0	0	0	0	0	0	0	0	0	0	(622,447)	27
28	TOTAL General Administration	(648,027)	219,957	0	0	0	0	0	0	0	0	0	(428,070)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(652,799)	219,957	0	0	0	0	0	0	0	0	0	(432,842)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Fireside House of Centralia # 0055921 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	799	0	0	0	0	0	0	0	0	0	799	30
31	Amortization of Pre-Op. & Org.	0	319	0	0	0	0	0	0	0	0	0	319	31
32	Interest	(96)	805	0	0	0	0	0	0	0	0	0	709	32
33	Real Estate Taxes	0	11,165	0	0	0	0	0	0	0	0	0	11,165	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	1,911	0	0	0	0	0	0	0	0	0	1,911	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(96)	14,999	0	0	0	0	0	0	0	0	0	14,903	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	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(652,895)	234,956	0	0	0	0	0	0	0	0	0	(417,939)	45

Facility Name & ID Number Fireside House of Centralia # 0055921 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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
Sentry Healthcare Aquirors, Inc.	99			Franklin Healthcare	Alpharetta, GA	MGT
				AltaCare Corporation	Alpharetta, GA	MGT
				Long Term Care Servi	Alpharetta, GA	MGT

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Management Fees	\$ 426,683	AltaCare\Franklin Healthcare	100.00%	\$	(426,683)	1
2	V	19	Non-Related Party Professional Services		AltaCare\Franklin Healthcare	100.00%	21,285	21,285	2
3	V	20	Dues, Fess, Subscriptions and Promotions		AltaCare\Franklin Healthcare	100.00%	18,482	18,482	3
4	V	21	Clerical and General Office Expenses		AltaCare\Franklin Healthcare	100.00%	214,458	214,458	4
5	V	22	Employee Benefits and Payroll Taxes		AltaCare\Franklin Healthcare	100.00%	305,336	305,336	5
6	V	23	InService Training & Education		AltaCare\Franklin Healthcare	100.00%	761	761	6
7	V	24	Travel and Seminars		AltaCare\Franklin Healthcare	100.00%	166	166	7
8	V	26	Insurance Liability		AltaCare\Franklin Healthcare	100.00%	86,152	86,152	8
9	V	30	Depreciation		AltaCare\Franklin Healthcare	100.00%	799	799	9
10	V	31	Amortization		AltaCare\Franklin Healthcare	100.00%	319	319	10
11	V	32	Non Related Party Interest		AltaCare\Franklin Healthcare	100.00%	805	805	11
12	V	33	Real Estate Taxes		AltaCare\Franklin Healthcare	100.00%	11,165	11,165	12
13	V	35	Rent Equipment and Vehicles		AltaCare\Franklin Healthcare	100.00%	1,911	1,911	13
14	Total			\$ 426,683			\$ 661,639	\$ * 234,956	14

* 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 Fireside House of Centralia # 0055921 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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 # 0055921 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

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 Altacare Corporation
Street Address 3050 Royal Blvd STE 195
City / State / Zip Code Alpharetta GA 30022
Phone Number (470) 282-3275
Fax Number ()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	Management Fees	Total Cost	20,017,394	4	\$ 2,054,936	\$ 367,924	6,299,024	\$ 646,642	1
2	32	Capital	Total Cost	20,017,394	4	47,669		6,299,024	15,000	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					\$ 2,102,605	\$ 367,924		\$ 661,642	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	First Insurance		No	W/C, Liability, and Property								2,089	6
7	Illinois Depost of Employment Service	No		SUTA								5,699	7
8													8
9	TOTAL Facility Related						\$					\$ 7,788	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$					\$	14
15	TOTALS (line 9+line14)						\$					\$ 7,788	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 2019 report.		\$		1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	105,224	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	105,224	3	
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	108,000	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.		\$	213,224	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2015	105,349	8		
	2016	106,304	9		
	2017	106,684	10		
	2018	107,023	11		
	2019	105,233	12		
Estimated based on prior years					

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.

FACILITY NAME Fireside House of Centralia COUNTY Marion

FACILITY IDPH LICENSE NUMBER 0055921

CONTACT PERSON REGARDING THIS REPORT Daren Douston

TELEPHONE (678) 381-2810 FAX #: (678) 381-2810

Enter the tax index number and real estate tax assessed for 2019 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 2019.

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 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.)

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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.

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

☐

(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

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Rock For Back Parking Lot			2020	2,415	402	5	402	(0)	402
10	Extension of Sidewalk to Trash Dumpster			2020	2,940	196	5	196		196
11	Alarm System			2019	17,362	3,472	5	3,472		4,341
12	Alarm System			2019	1,028	206	5	206		257
13	Door			2020	3,225	54	5	54		54
14	5-Ton AC over Kitchen			2020	5,750	1,150	5	1,150		2,108
15	AC Unit Dining			2020	1,929	386	5	386		611
16	AC Unit			2020	874	175	5	175		175
17	AC Unit			2020	874	175	5	175		175
18	2 AC Units			2019	1,747	175	5	175		175
19	AC Unit			2020	873	87	5	87		87
20	2 AC Units			2020	1,747	175	5	175		175
21	Invacare Patient Lift Digital Scale			2019	799	160	5	160		200
22	Reliant 600 lb Digital Scale			2020	1,008	17	5	17		17
23	4 Beds and Motors			2020	3,906	65	10	65		65
24	4 HP ProBooks 455 G5			2019	2,078	416	5	416	0	737
25	6 Dell OptiPlex 3070			2020	3,585	179	5	179		179
26	10 Dell Optiplex 380			2020	7,151	238	5	238		238
27	PCC Intergration			2019	5,488	1,829	3	1,829		2,286
28	Database Mitgration			2019	2,500	833	3	833		1,042
29	Pharmacy Intergration			2020	1,917	426	3	426		426
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

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		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 69,196	\$ 10,816		\$ 10,816	\$ (0)	\$ 13,946	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	\$ 36,933	\$ 8,452	\$ 8,452	\$		\$ 11,572	71
72	Current Year Purchases	21,935	1,362	1,362			1,362	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 58,868	\$ 9,814	\$ 9,814	\$		\$ 12,934	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				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

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)			\$	128,064
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	20,630
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	20,630
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	(0)
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	26,880

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: 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.

☐ 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	12/1/2018	\$ 235,467	10		3
4	Additions							4
5								5
6								6
7	TOTAL		98		\$ 235,467			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	Resident Trans.	2015 Dodge Van	\$ 513.88	\$ 6,167	17
18					18
19					19
20					20
21	TOTAL		\$ 513.88	\$ 6,167	21

10. Effective dates of current rental agreement:

Beginning 12/1/2018

Ending 11/30/2028

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

Fiscal Year Ending Annual Rent

12. /2021 \$ _____

13. /2022 \$ _____

14. /2023 \$ _____

* 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

ALLOCATION OF COSTS (d)

		1	2	3	4
		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)	\$			

- (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.

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	

- (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		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10A	5363	hrs	\$ 211,566		\$	\$	5,363	\$ 211,566	1
2	Licensed Speech and Language Development Therapist	10A	854	hrs	44,748				854	44,748	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10A	6138	hrs	247,952				6,138	247,952	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				\$ 504,266		\$	\$	12,355	\$ 504,266	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	\$ 28,559	\$	1
2	Cash-Patient Deposits	44,043		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 945,075)	698,666		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	45,150		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	670,086		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,486,504	\$	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			15
16	Equipment, at Historical Cost	69,195		16
17	Accumulated Depreciation (book methods)	(13,935)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	8,050		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 63,310	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,549,814	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 512,295	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	44,042		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	233,948		30
31	Accrued Taxes Payable (excluding real estate taxes)	417,727		31
32	Accrued Real Estate Taxes(Sch.IX-B)	108,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,316,012	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,316,012	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 233,802	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,549,814	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (31,319)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (31,319)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	265,121	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)	\$ 265,121	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)	\$ 233,802	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Fireside House of Centralia

0055921

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

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	\$ 4,515,507	1
2	Discounts and Allowances for all Levels	1,282,023	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,797,530	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	130,401	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 130,401	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	624,741	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	6,214	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	808	19
20	Radiology and X-Ray		20
21	Other Medical Services	3,578	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 635,341	23
	D. Non-Operating Revenue		
24	Contributions	989	24
25	Interest and Other Investment Income***	96	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,085	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,564,357	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	852,151	31
32	Health Care	2,721,799	32
33	General Administration	1,966,749	33
	B. Capital Expense		
34	Ownership	389,892	34
	C. Ancillary Expense		
35	Special Cost Centers	188,205	35
36	Provider Participation Fee	180,440	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,299,236	40
41	Income before Income Taxes (line 30 minus line 40)**	265,121	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 265,121	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.

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	6,693	7,664	\$ 240,613	\$ 31.40	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,749	8,694	278,684	32.05	3
4	Licensed Practical Nurses	22,413	24,835	626,584	25.23	4
5	CNAs & Orderlies	49,252	52,881	730,105	13.81	5
6	CNA Trainees					6
7	Licensed Therapist	10,887	12,355	498,468	40.35	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,668	4,318	51,356	11.89	10
11	Social Service Workers	2,061	2,247	49,088	21.85	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,162	16,388	198,817	12.13	15
16	Dishwashers					16
17	Maintenance Workers	1,931	2,185	37,256	17.05	17
18	Housekeepers	8,161	9,014	87,880	9.75	18
19	Laundry	5,379	6,114	60,701	9.93	19
20	Administrator	1,897	2,112	88,575	41.94	20
21	Assistant Administrator					21
22	Other Administrative	3,772	5,519	128,255	23.24	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	622	647	8,882	13.73	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	139,647	154,973	\$ 3,085,264 *	\$ 19.91	34

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	83	\$ 5,405	1-3	35
36	Medical Director	120	12,000	9-3	36
37	Medical Records Consultant	8	535	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	98	2,415	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	36	2,025	11-3	44
45	Social Service Consultant	36	2,025	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	380	\$ 24,405		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

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

** See instructions.

STATE OF ILLINOIS

Page 21

Facility Name & ID Number

Fireside House of Centralia

0055921

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
KATHEY BERCK	ADMINISTRATOR	0	\$ 88,575
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 88,575

B. Administrative - Other

Description	Amount
	\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$

C. Professional Services

Vendor/Payee	Type	Amount
CT Corporation	Registered Agent	\$ 150
Proliant	Payroll Processing	13,261
First Horizon	Bank Fees	3,023
Legal Fees	Legal Fees	13,014
Franklin Healthcare	Management Fees	426,683
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 456,131

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 39,836
Unemployment Compensation Insurance	42,077
FICA Taxes	226,997
Employee Health Insurance	95,920
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Vision Insurance	(14)
Life Insurance	3,774
Dental Insurance	4
Employee Appreciations	20,084
Employee Vaccinations	1,723
Coninueing Education	1,588
TOTAL (agree to Schedule V, line 22, col.8)	\$ 431,989

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

Description	Line #	Amount
		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$ 5,713
Advertising: Employee Recruitment	141
Health Care Worker Background Check (Indicate # of checks performed)	
Patient Background Checks	79 1,300
Dues	8,924
Subscriptions	6,807
License/Permits	75
Promotional Adve	3,908
Home Office Allocation	
Less: Public Relations Expense	()
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 26,868

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Mileage	205
Lodging	0
Meals	25
Seminar Expense	
Entertainment Expense	()
TOTAL (agree to Sch. V, line 24, col. 8)	\$ 230

* Attach copy of IMRF notifications

**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.

(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.

\$ 33,411

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?

X

YES

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.

\$ 180,440

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?

NO

Indicate the amount.

\$

(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