

		FOR OHF USE				

LL1

**2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)**

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.

<p>I. IDPH Facility ID Number: <u>0018275</u></p> <p>Facility Name: <u>Alpine Fireside Health Center</u></p> <p>Address: <u>3650 N. Alpine Road</u> <u>Rockford</u> <u>61114</u> Number City Zip Code</p> <p>County: <u>Winnebago</u></p> <p>Telephone Number: <u>(815) 877-7408</u> Fax # <u>(815) 877-9818</u></p> <p>IDPA ID Number: <u>362753251001</u></p> <p>Date of Initial License for Current Owners: <u>1973</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Charles J. Fischer</u> Telephone Number: <u>(312) 634-3400</u> Please send copies of desk review and audit adjustments to address on this page</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>10/1/2001</u> to <u>9/30/2002</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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td data-bbox="1155 673 1291 820">Officer or Administrator of Provider</td> <td data-bbox="1291 673 1950 738">(Signed) _____ (Date) _____</td> </tr> <tr> <td data-bbox="1155 738 1291 820"></td> <td data-bbox="1291 738 1950 803">(Type or Print Name) _____</td> </tr> <tr> <td data-bbox="1155 803 1291 820"></td> <td data-bbox="1291 803 1950 868">(Title) _____</td> </tr> <tr> <td data-bbox="1155 820 1291 1031">Paid Preparer</td> <td data-bbox="1291 820 1950 885">(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____</td> </tr> <tr> <td data-bbox="1155 885 1291 1031"></td> <td data-bbox="1291 885 1950 950">(Print Name and Title) _____</td> </tr> <tr> <td data-bbox="1155 950 1291 1031"></td> <td data-bbox="1291 950 1950 1015">(Firm Name & Address) <u>Altschuler, Melvoim and Glasser, LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u></td> </tr> <tr> <td data-bbox="1155 1015 1291 1031"></td> <td data-bbox="1291 1015 1950 1031">(Telephone) <u>(312) 634-3400</u> Fax # <u>(312) 634-5518</u></td> </tr> </table> <p align="right">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____		(Type or Print Name) _____		(Title) _____	Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____		(Print Name and Title) _____		(Firm Name & Address) <u>Altschuler, Melvoim and Glasser, LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u>		(Telephone) <u>(312) 634-3400</u> Fax # <u>(312) 634-5518</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																					
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																																					
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County																																					
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																																					
	<input checked="" type="checkbox"/> "Sub-S" Corp.																																						
	<input type="checkbox"/> Limited Liability Co.																																						
	<input type="checkbox"/> Trust																																						
	<input type="checkbox"/> Other _____																																						
Officer or Administrator of Provider	(Signed) _____ (Date) _____																																						
	(Type or Print Name) _____																																						
	(Title) _____																																						
Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____																																						
	(Print Name and Title) _____																																						
	(Firm Name & Address) <u>Altschuler, Melvoim and Glasser, LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u>																																						
	(Telephone) <u>(312) 634-3400</u> Fax # <u>(312) 634-5518</u>																																						

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Alpine Fireside Health Center

0018275 Report Period Beginning: 10/1/2001 Ending: 9/30/2002

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 N/A

	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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	63	Intermediate (ICF)	63	22,995	3
4		Intermediate/DD			4
5	31	Sheltered Care (SC)	31	11,315	5
6		ICF/DD 16 or Less			6
7	94	TOTALS	94	34,310	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		2 Public Aid Recipient	3 Private Pay	4 Other		
8	SNF					8
9	SNF/PED					9
10	ICF	9,262	8,690		17,952	10
11	ICF/DD					11
12	SC		9,219		9,219	12
13	DD 16 OR LESS					13
14	TOTALS	9,262	17,909		27,171	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.19%

D. How many bed-hold days during this year were paid by Public Aid? none (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 Non-allowable costs have been eliminated in Schedule V, Column 7.

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 1973

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 0 and days of care provided 0

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 9/30/2002 Fiscal Year: 9/30/2002

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

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/1/2001 Ending: 9/30/2002**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	187,669	7,164	1,284	196,117		196,117		196,117		1
2	Food Purchase		160,713		160,713		160,713	(547)	160,166		2
3	Housekeeping	35,896	15,590		51,486		51,486		51,486		3
4	Laundry	28,129	14,049	6,366	48,544		48,544		48,544		4
5	Heat and Other Utilities			83,371	83,371		83,371		83,371		5
6	Maintenance	47,174	30,692	15,820	93,686		93,686		93,686		6
7	Other (specify):*										7
8	TOTAL General Services	298,868	228,208	106,841	633,917		633,917	(547)	633,370		8
	B. Health Care and Programs										
9	Medical Director			10,800	10,800		10,800		10,800		9
10	Nursing and Medical Records	948,894	39,566	1,972	990,432		990,432		990,432		10
10a	Therapy			1,713	1,713		1,713		1,713		10a
11	Activities	60,842	2,876	8,260	71,978		71,978	8	71,986		11
12	Social Services	19,764		2,925	22,689		22,689		22,689		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,029,500	42,442	25,670	1,097,612		1,097,612	8	1,097,620		16
	C. General Administration										
17	Administrative	105,110			105,110		105,110		105,110		17
18	Directors Fees										18
19	Professional Services			80,512	80,512		80,512	(11,310)	69,202		19
20	Dues, Fees, Subscriptions & Promotions			19,734	19,734		19,734	(451)	19,283		20
21	Clerical & General Office Expenses	54,049	5,041	26,806	85,896		85,896	(440)	85,456		21
22	Employee Benefits & Payroll Taxes			277,616	277,616		277,616		277,616		22
23	Inservice Training & Education										23
24	Travel and Seminar			10,030	10,030		10,030	1,003	11,033		24
25	Other Admin. Staff Transportation			7,783	7,783		7,783		7,783		25
26	Insurance-Prop.Liab.Malpractice			33,160	33,160		33,160		33,160		26
27	Other (specify):*										27
28	TOTAL General Administration	159,159	5,041	455,641	619,841		619,841	(11,198)	608,643		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,487,527	275,691	588,152	2,351,370		2,351,370	(11,737)	2,339,633		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

**See schedule of adjustments attached at end of cost report.

Alpine Fireside Health Center, Ltd.
Provider Number: 0018275
9/30/2002

PG 3, Line 25 detail (Acc# 8650)

AAA Financial	\$ 4,377
Casey muffler & brake	\$ 1,417
Ketut Setiawan	\$ 130
Zeibart	\$ 293
Maaco	\$ 248
Misc.	\$ 1,318
	<u>\$ 7,783</u>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Alpine Fireside Health Center

#0018275

Report Period Beginning:

10/1/2001

Ending:

9/30/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			8,443	8,443		8,443	60,816	69,259			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			10,140	10,140		10,140	44,766	54,906			32
33	Real Estate Taxes			50,998	50,998		50,998		50,998			33
34	Rent-Facility & Grounds			449,000	449,000		449,000	(449,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			518,581	518,581		518,581	(343,418)	175,163			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,820		1,820		1,820		1,820			39
40	Barber and Beauty Shops			14,026	14,026		14,026		14,026			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			34,922	34,922		34,922		34,922			42
43	Other (specify):* Nonallowable Costs			45,646	45,646		45,646	(45,646)				43
44	TOTAL Special Cost Centers		1,820	94,594	96,414		96,414	(45,646)	50,768			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,487,527	277,511	1,201,327	2,966,365		2,966,365	(400,801)	2,565,564			45

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

** See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Alpine Fireside Health Center

0018275

Report Period Beginning: 10/1/2001

Ending: 9/30/2002

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF 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	(547)	2		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	(1,571)	32		10
11	Discounts, Allowances, Rebates & Refunds				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)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(20)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(33,265)	43		24
25	Fund Raising, Advertising and Promotional	(16,960)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attached schedule 5A	(8,092)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (60,455)		\$	30

OHF 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	2	
		Amount	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)	(340,346)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (340,346)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (400,801)		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	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Alpine Fireside Health Center

ID# 0018275

Report Period Beginning: 10/1/2001

Ending: 9/30/2002

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Activity Income Offset	\$ 8	11	1
2	Non-Allowable legal fees	(11,310)	19	2
3	Miscellaneous Income Offset	(938)	21	3
4	Miscellaneous Dues Disallowed	(451)	20	4
5	Non-Allowable taxes	(210)	43	5
6	Miscellaneous non-allowable expenses	5,472	43	6
7	Loss on Sale of fixed assets	(663)	43	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
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	(8,092)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alpine Fireside Health Center# 0018275

Report Period Beginning:

10/1/2001

Ending:

9/30/2002

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(547)	0	0	0	0	0	0	0	0	0	0	(547)	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	(547)	0	0	0	0	0	0	0	0	0	0	(547)	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	8	0	0	0	0	0	0	0	0	0	0	8	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide 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	8	0	0	0	0	0	0	0	0	0	0	8	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	(11,310)	0	0	0	0	0	0	0	0	0	0	(11,310)	19
20	Fees, Subscriptions & Promotions	(451)	0	0	0	0	0	0	0	0	0	0	(451)	20
21	Clerical & General Office Expenses	(938)	498	0	0	0	0	0	0	0	0	0	(440)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,003	0	0	0	0	0	0	0	0	0	1,003	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	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(12,699)	1,501	0	(11,198)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(13,238)	1,501	0	(11,737)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Alpine Fireside Health Center# 0018275

Report Period Beginning:

10/1/2001

Ending:

9/30/2002

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	D. Ownership												
30	Depreciation	0	60,816	0	0	0	0	0	0	0	0	0	60,816 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(1,571)	46,337	0	0	0	0	0	0	0	0	0	44,766 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	(449,000)	0	0	0	0	0	0	0	0	0	(449,000) 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	(1,571)	(341,847)	0	(343,418) 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):*	(45,646)	0	0	0	0	0	0	0	0	0	0	(45,646) 43
44	TOTAL Special Cost Centers	(45,646)	0	0	0	0	0	0	0	0	0	0	(45,646) 44
	GRAND TOTAL COST												
45	(sum of lines 29, 37 & 44)	(60,455)	(340,346)	0	(400,801) 45								

Facility Name & ID Number Alpine Fireside Health Center

0018275

Report Period Beginning: 10/1/2001

Ending: 9/30/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Johs Oksnevad	100			Johs Oksnevad	Rockford, IL	Real Estate Lessor

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		\$			\$	\$	1
2	V							2
3	V	21 Office		Johs Oksnevad	100.00%	498	498	3
4	V	24 Travel and Seminar		Johs Oksnevad	100.00%	1,003	1,003	4
5	V	30 Depreciation		Johs Oksnevad	100.00%	60,816	60,816	5
6	V	32 Interest		Johs Oksnevad	100.00%	46,337	46,337	6
7	V	34 Rent-Facility & Grounds	449,000	Johs Oksnevad	100.00%		(449,000)	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 449,000			\$ 108,654	\$ * (340,346)	14

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

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/1/2001 Ending: 9/30/2002

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	Johs Oksnevad	President	Asst. Administr.	100.00	0	20	50.00	salary	\$ 25,000	L17, C1	1
2	Gordon Oksnevad	Administrator	Administrator	0.00	0	40+	100.00	salary	80,110	L17, C1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 105,110		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Alpine Fireside Health Center

0018275 Report Period Beginning: 10/1/2001

Ending: 3/30/2002

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

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					\$	\$		\$	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	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/1/2001 Ending: 9/30/2002

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	
						Original	Balance					
	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									
	A. Directly Facility Related											
	Long-Term											
1	Durand Bank		X	Improvements & work capital	\$10,000.00	12/01	\$ 915,387	\$ 874,605	2016	0.0575	\$ 46,337	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Johs Oksnevad	X		Working capital	none	9/30/99	169,000	204,520	Demand	0.0600	10,140	6
7												7
8												8
9	TOTAL Facility Related				\$10,000.00		\$ 1,084,387	\$ 1,079,125			\$ 56,477	9
	B. Non-Facility Related*											
10												10
11												11
12									Offset Interest Income		(1,571)	12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ (1,571)	14
15	TOTALS (line 9+line14)						\$ 1,084,387	\$ 1,079,125			\$ 54,906	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.) SEE ACCOUNTANTS' COMPILATION REPORT

** 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 2001 report.		\$ 39,000		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.)	2001	\$ 49,998		2
3.	Under or (over) accrual (line 2 minus line 1).		\$ 10,998		3
4.	Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 40,000		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.		\$ 50,998		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		1997	43,957	8	
		1998	45,628	9	
		1999	46,107	10	
		2000	48,992	11	
		2001	49,998	12	
Accrual Calculation:					
2001 Tax Bill		49,998			
% Increase		1.054%			
Estimated 2002 Taxes		52,698 X 9/12 = 39,523.50 use 40,000			
13.	FROM R. E. TAX STATEMENT FOR 2001	\$			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.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Alpine Fireside Health Cente COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0018275

CONTACT PERSON REGARDING THIS REPORT Gordon Oksnevad

TELEPHONE 815-877-7408 FAX #: 815-877-9818

A. Summary of Real Estate Tax Cos

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2001

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>12-05-376-003</u>	<u>Nursing Home</u>	<u>\$ 49,997.74</u>	<u>\$ 49,997.74</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		<u>\$ 49,997.74</u>	<u>\$ 49,997.74</u>

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (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 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Alpine Fireside Health Center# 0018275 Report Period Beginning:10/1/2001 Ending:9/30/2002**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 40,000 B. General Construction Type: Exterior Brick Frame Concrete/Steel Number of Stories 1C. 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 ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide 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: N/A 2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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	Patient Care	2.8 Acres	1961	\$ 10,000	1
2					2
3	TOTALS	2.8 Acres		\$ 10,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Alpine Fireside Health Center

0018275

Report Period Beginning:

10/1/2001 Ending: 9/30/2002

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	94	1973	1973	\$ 717,727	\$	30	\$	\$	\$ 717,727	4
5										5
6										6
7										7
8										8
Improvement Type**										
9		1973		1,277		10			1,277	9
10		1973		3,172		20			3,172	10
11		1973		694		40	17	17	510	11
12		1973		201		25			201	12
13		1973		93,791		11			93,791	13
14		1973		96,886		34	2,850	2,850	70,822	14
15		1974		8,366		11			8,366	15
16		1975		3,593		10			3,593	16
17		1977		10,055		10			10,055	17
18		1981		2,656		15			2,656	18
19		1982		5,132		11			5,132	19
20		1982		1,063		15			1,063	20
21		1984		21,939		15			21,939	21
22	Smoke detectors	1984		1,145		10			1,145	22
23		1985		3,300		15			3,300	23
24	Roof	1986		19,094		15			19,094	24
25	Kitchen addition & storm sewers	1988		235,818		20	11,791	11,791	170,969	25
26	Kitchen improvements	1989		9,541		20	477	477	6,678	26
27	Black top	1990		5,000		10			5,000	27
28	Broiler	1991		29,033		20	1,452	1,452	16,698	28
29	Lawn sprinkler	1992		5,000		15	333	333	3,331	29
30	Leasehold improvements	1993		13,972		15	931	931	8,845	30
31	Roof improvements	1994		57,648		15	3,843	3,843	32,844	31
32	Generator	1995		34,924		15	2,328	2,328	17,460	32
33	Air Conditioning System	1999		280,820		15	18,721	18,721	65,524	33
34	Carpeting/Flooring/Wall Covering	1999		81,812		15	5,454	5,454	19,089	34
35	Parking Lot Lights	1999		16,900		15	1,126	1,126	3,941	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Alpine Fireside Health Center

0018275

Report Period Beginning:

10/1/2001

Ending:

9/30/2002

XI. OWNERSHIP COSTS (continued)

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

1	2	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	Air Conditioning	2000	\$ 24,655	\$	15	\$ 1,644	\$ 1,644	\$ 2,466	37
38	Parking lot	2002	42,683	1,423	15	1,423		1,423	38
39	Boiler electrical improvements	2002	11,560	289	20	289		289	39
40	Gazebo pad	2002	12,657	316	20	316		316	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)		\$ 1,852,114	\$ 2,028		\$ 52,995	\$ 50,967	\$ 1,318,716	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 223,117	\$ 1,369	\$ 1,369	\$	3-10 yrs	\$ 222,625	71
72	Current Year Purchases	23,876	2,809	2,809		3-5 yrs	2,809	72
73	Fully Depreciated Assets	303,476					303,476	73
74								74
75	TOTALS	\$ 550,469	\$ 4,178	\$ 4,178	\$		\$ 528,910	75

D. Vehicle Depreciation (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	From Schedule 13A			\$ 3,631	\$ 1,689	\$ 1,689	\$	5	\$ 1,689	76
77	Maintenance Truck	1988 GMC Truck	1990	9,700				5	9,700	77
78	Patient Transportation	1998 Chevy Venture M/V	2002	5,480	548	548		5	548	78
79	Patient Transportation	1998 Ford Supreme Bus	1999	49,247		9,849	9,849	5	34,472	79
80	TOTALS			\$ 68,058	\$ 2,237	\$ 12,086	\$ 9,849		\$ 46,409	80

E. Summary of Care-Related Assets

	1	Reference	2	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$	2,480,641	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	8,443	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	69,259	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	60,816	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	1,894,035	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

Alpine Fireside Healthcare, LTD.

Provider # 0018275

9/30/2002

	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	Administrator	1995 Nissan Sentra	1998	\$	\$ 1,326	\$ 1,326	\$ 0	5	\$ 1,326	76
77	disposed of during 2002						0			77
78	Administrator	1996 Sonoma Truck	2002	3,631	363	363	0	5	363	78
79							0			79
80	TOTALS			\$ 3,631	\$ 1,689	\$ 1,689	\$ 0		\$ 1,689	80

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
 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 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:			\$			3
4	Additions						4
5							5
6							6
7	TOTAL			\$			7

10. Effective dates of current rental agreement:
 Beginning _____
 Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	<u> </u> /2003	\$ <u> </u>
13.	<u> </u> /2004	\$ <u> </u>
14.	<u> </u> /2005	\$ <u> </u>

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 aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	<p>2. CLASSROOM PORTION:</p> IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	<p>3. CLINICAL PORTION:</p> IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1 Drop-outs	2 Completed	3 Contract	
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	Nurse Aide 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 aide 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 aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES 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 aides 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 aides.

SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8		
			Units of Service	Cost	Outside Practitioner (other than consultant)		Total Cost (Col. 3 + 5 + 6)								
					Units	Cost									
1	Licensed Occupational Therapist		hrs	\$		\$		\$				\$		1	
2	Licensed Speech and Language Development Therapist		hrs											2	
3	Licensed Recreational Therapist		hrs											3	
4	Licensed Physical Therapist		hrs											4	
5	Physician Care		visits											5	
6	Dental Care		visits											6	
7	Work Related Program		hrs											7	
8	Habilitation		hrs											8	
9	Pharmacy	L39, C2	# of prescripts							1,820				1,820	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs											10	
11	Academic Education		hrs											11	
12	Exceptional Care Program													12	
13	Other (specify):													13	
14	TOTAL			\$		\$		\$	1,820		\$	1,820		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 nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Alpine Fireside Health Center
Provider #: 0018275
10/1/2001 to 9/30/2002

Schedule 16A

XIV. Special Services
Line 13 Other (specify):

<u>Service</u>	<u>Line Reference</u>	<u>Outside Practioner Units</u>	<u>Cost</u>	<u>Supplies</u>
	L39, C3			
Total			<u>0</u>	<u>0</u>

See Accountants' Compilation Report

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Alpine Fireside Health Center

0018275

Report Period Beginning: 10/1/2001

Ending:

9/30/2002

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/30/2002

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 30,000)	256,176	256,176	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	132,107	132,107	6
7	Other Prepaid Expenses	16,719	16,719	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 405,002	\$ 405,002	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		10,000	13
14	Buildings, at Historical Cost	66,900	1,852,114	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	135,516	618,527	16
17	Accumulated Depreciation (book methods)	(107,785)	(1,894,035)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 94,631	\$ 586,606	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 499,633	\$ 991,608	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 132,727	\$ 132,727	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	204,520	204,520	29
30	Accrued Salaries Payable	79,817	79,817	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,708	3,708	31
32	Accrued Real Estate Taxes(Sch.IX-B)	40,000	40,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	1,685	1,685	35
	Other Current Liabilities(specify):			
36	<u>Accrued Rent</u>	1,551,652	1,551,652	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,014,109	\$ 2,014,109	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		874,605	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)	\$	\$ 874,605	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,014,109	\$ 2,888,714	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,514,476)	\$ (1,897,106)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 499,633	\$ 991,608	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,420,486)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,420,486)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(93,990)	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)	\$ (93,990)	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)	\$ (1,514,476)	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Alpine Fireside Health Center

0018275

Report Period Beginning: 10/1/2001

Ending: 9/30/2002

VII. 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	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,835,900	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,835,900	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	25,922	13
14	Non-Patient Meals	547	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 26,469	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,571	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,571	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached Schedule 19A	8,435	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 8,435	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,872,375	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	633,917	31
32	Health Care	1,097,612	32
33	General Administration	619,841	33
B. Capital Expense			
34	Ownership	518,581	34
C. Ancillary Expense			
35	Special Cost Centers	61,492	35
36	Provider Participation Fee	34,922	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,966,365	40
41	Income before Income Taxes (line 30 minus line 40)**	(93,990)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (93,990)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. Tax return is filed on a cash basis.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

**** Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Alpine Fireside Healthcare, LTD.

Provider # 0018275

9/30/2002

Schedule 19A

XVII. Income Statement

Line 28

<u>Revenue</u>	<u>Amount</u>
Activities & Outings Income	-8
Store & Misc. Sales	5,676
Misc. Income	2,767
Total	<u><u>8,435</u></u>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Alpine Fireside Health Center**

0018275

Report Period Beginning: **10/1/2001**

Ending: **9/30/2002**

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	1,916	\$ 51,534	\$ 26.90	1
2	Assistant Director of Nursing	936	18,830	18.32	2
3	Registered Nurses	4,577	95,891	20.11	3
4	Licensed Practical Nurses	13,951	233,891	16.25	4
5	Nurse Aides & Orderlies	38,926	442,059	11.03	5
6	Nurse Aide Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director	892	10,448	9.93	9
10	Activity Assistants	5,758	50,394	8.40	10
11	Social Service Workers	1,995	19,764	9.31	11
12	Dietician				12
13	Food Service Supervisor	1,920	35,916	18.71	13
14	Head Cook	7,215	54,458	7.26	14
15	Cook Helpers/Assistants	15,145	97,295	6.33	15
16	Dishwashers				16
17	Maintenance Workers	3,367	47,174	13.02	17
18	Housekeepers	5,380	35,896	6.41	18
19	Laundry	2,794	28,129	9.30	19
20	Administrator	2,080	80,110	38.51	20
21	Assistant Administrator	1,040	25,000	24.04	21
22	Other Administrative				22
23	Office Manager	1,994	31,058	14.58	23
24	Clerical	2,122	22,991	10.52	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				31
32	Other Health C: SCH 20A	6,505	106,689	15.26	32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	118,513	\$ 1,487,527 *	\$ 12.11	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	25	\$ 1,284	L1, C3	35
36	Medical Director	Monthly	10,800	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	812	1,972	L10, C3	39
40	Physical Therapy Consultant	29	1,463	L10a, C3	40
41	Occupational Therapy Consultant	5	250	L10a, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	118	1,556	L11, C3	44
45	Social Service Consultant	118	2,925	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,107	\$ 20,250		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	Nurse Aides			52
53	TOTAL (lines 50 - 52)	\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Alpine Fireside Healthcare, LTD.

Provider # 0018275

9/30/2002

Schedule 20A

Line 32, Page 20

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Resident Services Coordinator	1,810	1,976	31,909	16.15
Rehabilitation Aides	2,730	2,906	37,175	12.79
Care Plan Coordinator	1,965	2,108	37,605	17.84
Total Line 32, page 20	6,505	6,990	106,689	

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Johns Oksnevad	Asst. Adminstr.	100	\$ 25,000	Workers' Compensation Insurance	\$ 89,317	IDPH License Fee	\$ 200		
Gordon Oksnevad	Administrator	0	80,110	Unemployment Compensation Insurance	13,464	Advertising: Employee Recruitment	7,202		
				FICA Taxes	100,593	Health Care Worker Background Check (Indicate # of checks performed <u>108</u>)	1,310		
				Employee Health Insurance	60,589	Illinois Health Care Assoc. Dues	6,235		
				Employee Meals		Misc. Subscriptions	3,031		
				Illinois Municipal Retirement Fund (IMRF)*		Misc. Licenses	1,305		
				Pre-employment Physicals	11,432				
				Uniforms	2,221				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 105,110	TOTAL (agree to Schedule V, line 22, col.8)		\$ 19,283			
B. Administrative - Other						Less: Public Relations Expense ()			
Description			Amount			Non-allowable advertising ()			
			\$			Yellow page advertising ()			
						TOTAL (agree to Sch. V, line 20, col. 8)			
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	\$ 277,616		\$			
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type	Amount	Description	Line #	Amount	Description	Amount		
Williams & McCarthy	Legal	\$ 2,138			\$	Out-of-State Travel	\$		
Duane, Morris & Heckscher LLP	legal	24,738							
American Express Tax & Bus. Svc.	Accounting	28,219				In-State Travel	1,798		
Altschuler, Melvoin									
& Glasser LLP	Accounting	3,300				Seminar Expense	9,235		
R. E. Harrington	U/C Consulting	300							
Keane Care, Inc.	Computer Consulting	18,849				Entertainment Expense ()			
AAA Financial	Computer Consulting	2,488				(agree to Sch. V, line 24, col. 8)			
Acruz Integrated Solution	Computer Consulting	480				TOTAL	\$ 11,033		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 80,512	TOTAL		\$			

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

**Alpine Fireside Health Center
Provider #: 0018275
10/1/2001 to 9/30/2002**

Schedule 21A

**XIX. SUPPORT SCHEDULE
C. Professional Services**

Total from page 21, part C 80,512

Less: Out-of-Period legal fees

Duane, Morris & Heckscher (11,310)

Total (agree to Schedule V, line 19, column 8) 69,202

See Accountants' Compilation Report

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2	N/A											
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Alpine Fireside Health Center# 0018275Report Period Beginning: 10/1/2001Ending: 9/30/2002**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. Illinois Health Care Association, \$6,235
- (3) Did the nursing home make political contributions or payments to a political organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (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? N/A
- (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? 4 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 6,442 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. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 34,922
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 of Public Aid, 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 benefit: on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 547
- (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. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
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. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT

RECONCILIATION REPORT

Alpine Fireside Health C

02:04 PM 11/04/05

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-400,801	equal to	-400,801	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	54,906	equal to	54,906	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	50,998	equal to	50,998	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	69,259	equal to	69,259	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	0	equal to	0	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages	0	equal to	0	0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	1,713	equal to	1,713	0	O.K.	Pg16 Z12+Z14...	N/A/B	1-4,40-43	8:2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	1,820	equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	633,917	equal to	633,917	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	1,097,612	equal to	1,097,612	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Administration	619,841	equal to	619,841	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	518,581	equal to	518,581	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	61,492	equal to	61,492	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24++	N/A	38b41+43	4
Income Stat. Prov. Partic.	34,922	equal to	34,922	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	842,205	equal to	948,894	-106,689	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to	0	0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensee Therapist	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	60,842	equal to	60,842	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	19,764	equal to	19,764	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	187,669	equal to	187,669	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	47,174	equal to	47,174	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	35,896	equal to	35,896	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	28,129	equal to	28,129	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	105,110	equal to	105,110	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	54,049	equal to	54,049	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to	0	0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	1,487,527	equal to	1,487,527	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	1,284	< or = to	1,284	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	10,800	< or = to	10,800	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	1,972	< or = to	1,972	0	O.K.	Pg20 X14..X16+	B. & C.	37b39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	1,556	< or = to	8,260	-6,704	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	2,925	< or = to	2,925	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	105,110	equal to	105,110	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	0	equal to	0	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	80,512	equal to	80,512	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	277,616	equal to	277,616	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	19,283	equal to	19,283	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	11,033	equal to	11,033	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	34,922	equal to	34,922	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	< or = to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to	0	0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	0	equal to	0	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-340,346	equal to	-340,346	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6l Y4f	B.	14	8
Total loan balance	1,079,125	equal to	1,079,125	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	40,000	equal to	40,000	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	10,000	equal to	10,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	1,852,114	equal to	1,852,114	0	O.K.	Pg12 to 12l L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	618,527	equal to	618,527	0	O.K.	Pg13 O22+L13	C. & D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	1,894,035	equal to	1,894,035	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	-1,514,476	equal to	-1,514,476	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	-93,990	equal to	-93,990	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to	0	0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	499,633	equal to	499,633	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	187,669	7,164	1,284	196,117	0	196,117	0	196,117
2. Food Purchase	0	160,713	0	160,713	0	160,713	-547	160,166
3. Housekeeping	35,896	15,590	0	51,486	0	51,486	0	51,486
4. Laundry	28,129	14,049	6,366	48,544	0	48,544	0	48,544
5. Heat and Other Utilities	0	0	83,371	83,371	0	83,371	0	83,371
6. Maintenance	47,174	30,692	15,820	93,686	0	93,686	0	93,686
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	298,868	228,208	106,841	633,917	0	633,917	-547	633,370
9. Medical Director	0	0	10,800	10,800	0	10,800	0	10,800
10. Nursing & Medical Records	948,894	39,566	1,972	990,432	0	990,432	0	990,432
10a. Therapy	0	0	1,713	1,713	0	1,713	0	1,713
11. Activities	60,842	2,876	8,260	71,978	0	71,978	8	71,986
12. Social Services	19,764	0	2,925	22,689	0	22,689	0	22,689
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	1,029,500	42,442	25,670	1,097,612	0	1,097,612	8	1,097,620
17. Administrative	105,110	0	0	105,110	0	105,110	0	105,110
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	80,512	80,512	0	80,512	-11,310	69,202
20. Fees, Subscriptions & Promotion	0	0	19,734	19,734	0	19,734	-451	19,283
21. Clerical & General Office	54,049	5,041	26,806	85,896	0	85,896	-440	85,456
22. Employee Benefits & Payroll	0	0	277,616	277,616	0	277,616	0	277,616
23. Inservice Training & Education	0	0	0	0	0	0	0	0
24. Travel and Seminar	0	0	10,030	10,030	0	10,030	1,003	11,033
25. Other Admin. Staff Trans	0	0	7,783	7,783	0	7,783	0	7,783
26. Insurance-Prop.Liab.Malpractice	0	0	33,160	33,160	0	33,160	0	33,160
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	159,159	5,041	455,641	619,841	0	619,841	-11,198	608,643
29. Total General Administrative	1,487,527	275,691	588,152	2,351,370	0	2,351,370	-11,737	2,339,633
30. Depreciation	0	0	8,443	8,443	0	8,443	60,816	69,259
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	10,140	10,140	0	10,140	44,766	54,906
33. Real Estate	0	0	50,998	50,998	0	50,998	0	50,998
34. Rent - Facility & Grounds	0	0	449,000	449,000	0	449,000	-449,000	0
35. Rent - Equipment & Vehicles	0	0	0	0	0	0	0	0
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	518,581	518,581	0	518,581	-343,418	175,163
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	1,820	0	1,820	0	1,820	0	1,820
40. Barber and Beauty Shop	0	0	14,026	14,026	0	14,026	0	14,026
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	34,922	34,922	0	34,922	0	34,922
43. Other (specify):*	0	0	45,646	45,646	0	45,646	-45,646	0
44. Total Special Cost Ce	0	1,820	94,594	96,414	0	96,414	-45,646	50,768
45. Grand Total	1,487,527	277,511	1,201,327	2,966,365	0	2,966,365	-400,801	2,565,564

		After
	Operating	Consolidation
General Service Cost Center		
1. Cash on hand and in banks	0	0
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Receivable	256,176	256,176
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	132,107	132,107
7. Other Prepaid Expenses	16,719	16,719
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	0	0
10. Total current assets	285,274	285,274
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	10,000
14. Buildings, at Historical Cost	66,900	1,852,114
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	135,516	618,527
17. Accumulated Depreciation (book methods)	-107,785	-1,894,035
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	94,631	586,606
25. Total Assets	379,905	871,880
CURRENT LIABILITIES		
26. Accounts Payable	132,727	132,727
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	204,520	204,520
30. Accrued Salaries Payable	79,817	79,817
31. Accrued Taxes Payable	3,708	3,708
32. Accrued Real Estate Taxes	40,000	40,000
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	1,685	1,685
36. Other Current Liabilities (specify):	1,551,652	1,551,652
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	1,894,384	1,894,384
LONG TERM LIABILITES		
39. Long-Term Notes Payable	0	0
40. Mortgage Payable	0	874,605
41. Bonds Payable	0	0
42. Deferred Compensation	0	0
43. Other Long-Term Liabilities (specify):	0	0
44. Other Long-Term Liabilities (specify):	0	0
45. Total Long-Term Liabilities	0	874,605
46. Total Liabilities	1,894,384	2,768,989
47. Total Equity	-1,514,479	-1,897,109
48. Total Liabilities and Equity	379,905	871,880

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,835,900
2. Discounts and Allowances for all Levels	0
Subtotal - Inpatient Care	2,835,900
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	0
7. Oxygen	0
Subtotal - Ancillary Revenue	0
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	25,922
14. Non-Patient Meals	547
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	0
21. Other Medical Services	0
22. Laundry	0
Subtotal - Other Operating Revenue	26,469
24. Contributions	0
25. Interest and Other Investments Income	1,571
Subtotal - Non-Operating Revenue	1,571
27. Other Revenue (specify):	8,435
28. Other Revenue (specify):	0
Subtotal - Other Revenue	8,435
30. Total Revenue	2,872,375
31. General Services	633,917
32. Health Care	1,097,612
33. General Administration	619,841
34. Ownership	518,581
35. Special Cost Centers	61,492
35. Provider Participation Fee	34,922
37. Other	0
40. Total Expenses	2,966,365
41. Income Before Income Taxes	-93,990
42. Income Taxes	0
43. Net Income or Loss for the Year	-93,990

Page

1

2

3

4

5

6

7

8

9 Line 16 for mortgage insurance.

10

11

12

13

14

15

16

17

18

19

20

21

22

23