

Facility Name & ID Number Alpine Fireside Health Center

0018275 Report Period Beginning: 10/01/2005 Ending: 09/30/2006

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	32	Skilled (SNF)	32	11,680	1
2		Skilled Pediatric (SNF/PED)			2
3	34	Intermediate (ICF)	34	12,410	3
4		Intermediate/DD			4
5	33	Sheltered Care (SC)	33	12,045	5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other		Total
8	SNF	2,771	2,429	2,184	7,384	8
9	SNF/PED					9
10	ICF	3,002	5,792		8,794	10
11	ICF/DD					11
12	SC		10,464		10,464	12
13	DD 16 OR LESS					13
14	TOTALS	5,773	18,685	2,184	26,642	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.73%

D. How many bed-hold days during this year were paid by the Department?

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 32 and days of care provided 2,184

Medicare Intermediary AdminaStar Federal - Illinois

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 09/30/2006 Fiscal Year: 09/30/2006

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

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/01/2005 Ending: 09/30/2006

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	169,531	5,839	7,837	183,207		183,207		183,207		1
2	Food Purchase		189,533		189,533		189,533	(7,797)	181,736		2
3	Housekeeping	55,101	14,068		69,169		69,169		69,169		3
4	Laundry	48,082	20,985	22,740	91,807		91,807	(18,750)	73,057		4
5	Heat and Other Utilities			97,026	97,026		97,026	1,540	98,566		5
6	Maintenance	54,148	57,248	22,373	133,769		133,769		133,769		6
7	Other (specify):*										7
8	TOTAL General Services	326,862	287,673	149,976	764,511		764,511	(25,007)	739,504		8
	B. Health Care and Programs										
9	Medical Director			10,030	10,030		10,030		10,030		9
10	Nursing and Medical Records	1,085,183	104,755	87,858	1,277,796		1,277,796		1,277,796		10
10a	Therapy			90,503	90,503		90,503		90,503		10a
11	Activities	71,661	27,361	2,762	101,784		101,784		101,784		11
12	Social Services	32,200		3,082	35,282		35,282		35,282		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,189,044	132,116	194,235	1,515,395		1,515,395		1,515,395		16
	C. General Administration										
17	Administrative	96,377			96,377		96,377	25,000	121,377		17
18	Directors Fees										18
19	Professional Services			65,854	65,854		65,854		65,854		19
20	Dues, Fees, Subscriptions & Promotions			26,985	26,985		26,985		26,985		20
21	Clerical & General Office Expenses	51,123	14,227	26,883	92,233		92,233	312	92,545		21
22	Employee Benefits & Payroll Taxes			334,571	334,571		334,571	5,466	340,037		22
23	Inservice Training & Education										23
24	Travel and Seminar			20,980	20,980		20,980	(1,093)	19,887		24
25	Other Admin. Staff Transportation			26,162	26,162		26,162		26,162		25
26	Insurance-Prop.Liab.Malpractice			60,482	60,482		60,482		60,482		26
27	Other (specify):*										27
28	TOTAL General Administration	147,500	14,227	561,917	723,644		723,644	29,685	753,329		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,663,406	434,016	906,128	3,003,550		3,003,550	4,678	3,008,228		29

SEE ACCOUNTANTS' COMPILATION REPORT

*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.

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

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			83,372	83,372		83,372	50,967	134,339			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			13,256	13,256		13,256	21,876	35,132			32
33	Real Estate Taxes							59,304	59,304			33
34	Rent-Facility & Grounds			214,858	214,858		214,858	(214,858)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			311,486	311,486		311,486	(82,711)	228,775			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		69,370		69,370		69,370		69,370			39
40	Barber and Beauty Shops			13,588	13,588		13,588		13,588			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			36,135	36,135		36,135		36,135			42
43	Other (specify):* Nonallowable Cost			82,508	82,508		82,508	(82,508)				43
44	TOTAL Special Cost Centers		69,370	132,231	201,601		201,601	(82,508)	119,093			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,663,406	503,386	1,349,845	3,516,637		3,516,637	(160,541)	3,356,096			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

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	(2,331)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(11,820)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(144)	43		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	(2,563)	43		19
20	Contributions	(2,660)	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	(50,468)	43		24
25	Fund Raising, Advertising and Promotional	(15,328)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(881)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(565)	43		28
29	Other-Attach Schedule <u>See attached Sch 5a</u>	(31,498)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (118,258)		\$	30

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)	(42,283)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (42,283)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (160,541)		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

BHF USE ONLY					
48		49		50	
				51	
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Alpine Fireside Health Center

Provider #: 0018275

10/01/2005 to 09/30/2006

Schedule 5A

VI. Adjustment Detail

Line 29 - Other

<u>Non-allowable expenses</u>	<u>Amount</u>	<u>Reference</u>
Laundry income offset	(18,750)	4
Non-allowable out of state seminars	(2,849)	24
Radiology	(1,266)	43
Laboratory	(10,151)	43
Ambulance	1,518	43
	<u>(31,498)</u>	

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alpine Fireside Health Center# 0018275

Report Period Beginning:

10/01/2005

Ending:

09/30/2006

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	(2,331)	0	0	0	0	0	0	0	0	0	0	(2,331)	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	1,540	0	0	0	0	0	0	0	0	0	1,540	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	(2,331)	1,540	0	(791)	8								
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	25,000	0	0	0	0	0	0	0	0	0	25,000	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	312	0	0	0	0	0	0	0	0	0	312	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	1,756	0	0	0	0	0	0	0	0	0	1,756	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	0	27,068	0	27,068	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(2,331)	28,608	0	26,277	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Alpine Fireside Health Center# 0018275

Report Period Beginning:

10/01/2005 Ending:

09/30/2006

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	50,967	0	0	0	0	0	0	0	0	0	50,967	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(11,820)	33,696	0	0	0	0	0	0	0	0	0	21,876	32
33	Real Estate Taxes	0	59,304	0	0	0	0	0	0	0	0	0	59,304	33
34	Rent-Facility & Grounds	0	(214,858)	0	0	0	0	0	0	0	0	0	(214,858)	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	(11,820)	(70,891)	0	(82,711)	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):*	(72,609)	0	0	0	0	0	0	0	0	0	0	(72,609)	43
44	TOTAL Special Cost Centers	(72,609)	0	0	0	0	0	0	0	0	0	0	(72,609)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(86,760)	(42,283)	0	(129,043)	45								

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	5 Heat and other utilities	\$	Johs Oksnevad	100.00%	\$ 1,540	\$ 1,540	1
2	V	21 Office		Johs Oksnevad	100.00%	312	312	2
3	V	24 Travel and seminar		Johs Oksnevad	100.00%	1,756	1,756	3
4	V	30 Depreciation		Johs Oksnevad	100.00%	50,967	50,967	4
5	V	32 Interest		Johs Oksnevad	100.00%	33,696	33,696	5
6	V	33 Real estate taxes		Johs Oksnevad	100.00%	59,304	59,304	6
7	V	34 Rent - facility and grounds	214,858	Johs Oksnevad	100.00%		(214,858)	7
8	V	17 Assistant Administrator Salary		Johs Oksnevad	100.00%	25,000	25,000	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 214,858			\$ 172,575	\$ * (42,283)	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:

10/01/2005

Ending:

09/30/2006

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 Administrator	100.00	0	20	50.00	Salary	\$ 25,000	L17, C8	1
2	Gordon Oksnevad	Administrator	Administrator	0.00	0	40+	100.00	Salary	96,377	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	\$ 121,377		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: 10/01/2005

Ending: 9/30/2006

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:

10/01/2005

Ending:

09/30/2006

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	Durand Bank		x	Working capital & impvmnts	\$10,000.00	12/01	\$ 915,387	\$ 560,187	2016	0.0575	\$ 33,696	1								
2	US Bank		x	Auto	\$454.98	9/3/05	27,660		9/3/10	0.0675	453	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	11,820	6								
7	Durand State Bank		x	Working capital	None	5/23/06		50,000	5/23/07	0.0825	983	7								
8												8								
9	TOTAL Facility Related				\$10,454.98		\$ 1,112,047	\$ 814,707			\$ 46,952	9								
B. Non-Facility Related*																				
10												10								
11												11								
12										Eliminate related party interest	(11,820)	12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ (11,820)	14								
15	TOTALS (line 9+line14)						\$ 1,112,047	\$ 814,707			\$ 35,132	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

* 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.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Alpine Fireside Health Center 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 Cost

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(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>\$ 58,304.00</u>	<u>\$ 58,304.00</u>
2. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
3. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
4. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
5. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
6. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
7. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
8. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
9. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
10. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
TOTALS		<u>\$ 58,304.00</u>	<u>\$ 58,304.00</u>

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

Facility Name & ID Number Alpine Fireside Health Center

0018275 Report Period Beginning:

10/01/2005 Ending:

09/30/2006

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 40,000 B. General Construction Type: Exterior Brick Frame Concrete/Steel 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).

None

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>	<u>2.8 acres</u>	<u>1961</u>	<u>\$ 10,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 10,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Alpine Fireside Health Center# 0018275

Report Period Beginning:

10/01/2005 Ending: 09/30/2006**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 BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	99		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	578	11
12			1973		201		25			201	12
13			1973		93,791		11			93,791	13
14			1973		96,886		34	2,850	2,850	82,222	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 and storm sewers		1988		235,818		20	11,791	11,791	218,133	25
26	Kitchen improvements		1989		9,541		20	477	477	8,586	26
27	Black top		1990		5,000		10			5,000	27
28	Broiler		1991		29,033		20	1,452	1,452	22,506	28
29	Lawn sprinkler		1992		5,000		15	333	333	4,663	29
30	Leasehold improvements		1993		13,972		15	931	931	12,569	30
31	Roof improvements		1994		57,648		15	3,843	3,843	48,216	31
32	Generator		1995		34,924		15	2,328	2,328	26,772	32
33	Air conditioning system		1999		280,820		15	18,721	18,721	140,408	33
34	Carpeting / flooring / wall covering		1999		81,812		15	5,454	5,454	40,905	34
35	Parking lot lights		1999		16,900		15	1,126	1,126	8,445	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

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	\$ 9,042	37
38	Parking lot	2002	42,683	2,846	15	2,846		12,807	38
39	Boiler electrical improvements	2002	11,560	578	20	578		2,601	39
40	Gazebo pad	2002	12,657	633	20	633		2,848	40
41	Painting and wallpapering hallways	2003	27,403	1,370	20	1,370		4,795	41
42	Gazebo	2003	35,825	1,792	20	1,792		6,272	42
43	Fence	2003	3,400	170	20	170		595	43
44	Sign	2003	1,675	84	20	84		294	44
45	Garage	2003	3,077	154	20	154		538	45
46	Fire alarm	2003	30,208	1,510	20	1,510		5,285	46
47	Boiler	2004	31,880	1,594	20	1,594		3,988	47
48	Sign	2004	3,487	174	20	174		435	48
49	Smoke detectors	2004	2,153	108	20	108		270	49
50	Boiler	2005	7,060	352	20	352		528	50
51	Commercial disposal	2005	826	42	20	42		63	51
52	Fire supression system	2005	1,866	94	20	94		141	52
53	Pond	2006	11,930	298	20	298	(0)	298	53
54	Fire alarm system	2006	2,738	68	20	68	(0)	68	54
55	Floor tile, baseboards	2006	5,759	144	20	144	0	144	55
56	Air conditioning	2006	13,634	341	20	341	0	341	56
57	Sidewalk	2006	1,196	30	20	30	0	30	57
58	Remodel grieving room	2006	2,198	55	20	55	0	55	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)		\$ 2,038,429	\$ 12,437		\$ 63,404	\$ 50,967	\$ 1,562,952	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	\$ 386,713	\$ 44,404	\$ 44,404	\$	3-10 yrs	\$ 324,753	71
72	Current Year Purchases	37,515	3,751	3,751		5 yrs	3,751	72
73	Fully Depreciated Assets	303,476					303,476	73
74								74
75	TOTALS	\$ 727,704	\$ 48,155	\$ 48,155	\$		\$ 631,980	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	Administrative	2004 Yukon	2004	\$ 53,115	\$ 10,623	\$ 10,623	\$	5	\$ 26,558	76
77	Maintenance truck	2006 GMC Sierra	2005	48,333	9,667	9,667		5	14,500	77
78	Administrative	2006 Chrysler 300	2006	24,902	2,490	2,490		5	6,326	78
79	Resident transportation	1998 Ford Supreme Bus	1999	49,247				5	49,247	79
80	TOTALS			\$ 175,597	\$ 22,780	\$ 22,780	\$		\$ 96,631	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)	\$ 2,951,730	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 83,372	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 134,339	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 50,967	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,291,563	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	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Sprinkler system and fireplace	\$ 175,459	92
93			93
94			94
95		\$ 175,459	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.

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 Original Lease Date	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

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

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. _____ /2007 \$ _____

13. _____ /2008 \$ _____

14. _____ /2009 \$ _____

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

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

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>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>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10A, C3	hrs	\$	672	\$ 33,581	\$	672	\$ 33,581	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		174	8,695		174	8,695	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		965	48,227		965	48,227	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 prescrpts				69,370		69,370	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			\$	1,811	\$ 90,503	\$ 69,370	1,811	\$ 159,873	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Alpine Fireside Health Center**# **0018275**Report Period Beginning: **10/01/2005**

Ending:

09/30/2006**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **09/30/2006**

(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	\$ (28,152)	\$ (28,152)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>30,000</u>)	544,828	544,828	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	51,796	51,796	6
7	Other Prepaid Expenses	16,500	16,500	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Deposits</u>	13,616	13,616	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 598,588	\$ 598,588	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	253,214	2,038,429	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	486,539	903,301	16
17	Accumulated Depreciation (book methods)	(308,575)	(2,291,563)	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 (spec <u>Const in progress</u>)	175,459	175,459	22
23	Other(specify): _____			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 606,637	\$ 835,626	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,205,225	\$ 1,434,214	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 104,257	\$ 104,257	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	254,520	254,520	29
30	Accrued Salaries Payable	36,507	36,507	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,321	11,321	31
32	Accrued Real Estate Taxes(Sch.IX-B)	46,000	46,000	32
33	Accrued Interest Payable	44,656	44,656	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	1,635	1,635	35
	Other Current Liabilities(specify):			
36	<u>401(k) withheld</u>	708	708	36
37	_____			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 499,604	\$ 499,604	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		560,187	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)	\$	\$ 560,187	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 499,604	\$ 1,059,791	46
47	TOTAL EQUITY(page 18, line 24)	\$ 705,621	\$ 374,423	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,205,225	\$ 1,434,214	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 514,722	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 514,722	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	190,899	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)	\$ 190,899	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)	\$ 705,621	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,548,387	1
2	Discounts and Allowances for all Levels	(263,458)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,284,929	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	153,220	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 153,220	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	24,811	13
14	Non-Patient Meals	2,331	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	164,311	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	27,738	19
20	Radiology and X-Ray	3,068	20
21	Other Medical Services	12,746	21
22	Laundry	18,750	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 253,755	23
	D. Non-Operating Revenue		
24	Contributions	3,000	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,000	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous store sales	12,632	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 12,632	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,707,536	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	764,511	31
32	Health Care	1,515,395	32
33	General Administration	723,644	33
	B. Capital Expense		
34	Ownership	311,486	34
	C. Ancillary Expense		
35	Special Cost Centers	165,466	35
36	Provider Participation Fee	36,135	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,516,637	40
41	Income before Income Taxes (line 30 minus line 40)**	190,899	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 190,899	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 prepared on the cash basis of accounting.

*** 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.

Facility Name & ID Number Alpine Fireside Health Center

0018275

Report Period Beginning: 10/01/2005

Ending: 09/30/2006

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	2,080	2,104	\$ 65,755	\$ 31.25	1
2	Assistant Director of Nursing	885	901	25,088	27.84	2
3	Registered Nurses	5,132	5,316	116,805	21.97	3
4	Licensed Practical Nurses	11,174	11,363	237,028	20.86	4
5	CNAs & Orderlies	47,210	48,755	519,165	10.65	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,668	2,839	38,910	13.71	8
9	Activity Director	2,541	2,576	31,143	12.09	9
10	Activity Assistants	5,542	5,588	40,518	7.25	10
11	Social Service Workers	2,080	2,241	32,200	14.37	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,413	25,800	10.69	13
14	Head Cook	3,321	3,885	30,109	7.75	14
15	Cook Helpers/Assistants	17,466	18,025	113,622	6.30	15
16	Dishwashers					16
17	Maintenance Workers	3,544	3,622	54,148	14.95	17
18	Housekeepers	6,926	7,311	55,101	7.54	18
19	Laundry	5,001	5,176	48,082	9.29	19
20	Administrator	2,086	2,251	96,377	42.82	20
21	Assistant Administrator	1,040	1,040	25,000	24.04	21
22	Other Administrative					22
23	Office Manager	2,048	2,224	40,955	18.42	23
24	Clerical	1,056	1,060	10,168	9.59	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: <u>See Sch 20a</u>	3,741	3,976	82,432	20.73	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	127,621	132,666	\$ 1,688,406 *	\$ 12.73	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	96	\$ 7,837	L1, C3	35
36	Medical Director	Monthly	10,030	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,782	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	47	2,762	L11, C3	44
45	Social Service Consultant	51	3,082	L12,C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	194	\$ 25,493		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	942	\$ 38,128	L10, C3	50
51	Licensed Practical Nurses	1,881	47,948	L10, C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	2,823	\$ 86,076		53

SEE ACCOUNTANTS' COMPILATION REPORT

Alpine Fireside Health Center, Ltd.
PROVIDER # 0018275
September 30, 2006

Schedule 20A

XVIII. STAFFING AND SALARY COSTS

LINE 31 - Other (specify)

	<u>Hours Worked</u>	<u>Hours Paid</u>	<u>Salary</u>	<u>Avg Hr Wage</u>
MDS Plan Coordinator	2,012	2,188	49,516	22.63
Admissions	1,729	1,788	32,916	18.41
Total Line 31 - Other	<u>3,741</u>	<u>3,976</u>	<u>\$ 82,432</u>	<u>\$ 20.73</u>

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			
Johs Oksnevad	Asst Administrator	100	\$ 25,000	Workers' Compensation Insurance	\$ 49,701	IDPH License Fee	\$ 2,400			
Gordon Oksnevad	Administrator	0	96,377	Unemployment Compensation Insurance	40,681	Advertising: Employee Recruitment	8,666			
				FICA Taxes	125,921	Health Care Worker Background Check (Indicate # of checks performed <u>84</u>)	2,110			
				Employee Health Insurance	88,050					
				Employee Meals	5,466					
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous licenses	1,644			
				Pre-employment physicals	12,523	Miscellaneous subscriptions	5,585			
				Uniforms	6,526	Illinois Health Care Association dues	6,580			
				401(k)	11,169					
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 121,377	TOTAL (agree to Schedule V, line 22, col.8)		\$ 340,037	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 26,985	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
Description			Amount	Description		Line #	Amount	Description		Amount
N/A			\$				\$	Out-of-State Travel		\$
								In-State Travel		5,055
								Seminar Expense		14,832
								Entertainment Expense (agree to Sch. V, line 24, col. 8)		()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	TOTAL		\$ 19,887	
C. Professional Services				G. Schedule of Travel and Seminar**						
Vendor/Payee		Type	Amount	Description		Line #	Amount	Description		Amount
Duane Morris LLP		Legal	\$ 5,701				\$	Out-of-State Travel		\$
Williams & McCarthy		Legal	540					In-State Travel		5,055
Talx Corp		Accounting	863					Seminar Expense		14,832
Altschuler Melvoin & Glasser		Accounting	18,200					Entertainment Expense (agree to Sch. V, line 24, col. 8)		()
RSM McGladrey Inc		Accounting	20,560					TOTAL		\$ 19,887
Business Management Svce		Computer consulting	4,797							
Keane Care Inc		Computer consulting	10,396							
E-Health Data		Computer consulting	1,588							
Resource Systems		Computer consulting	609							
Insight Communications		Computer consulting	2,600							
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 65,854	TOTAL		\$	TOTAL		\$ 19,887	

* Attach copy of IMRF notifications
 SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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	Amount of Expense Amortized Per Year								
FY2003					FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
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14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Alpine Fireside Health Center# 0018275Report Period Beginning: 10/01/2005Ending: 09/30/2006**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 Assn - \$ 6,580
- (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? 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? 5
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 6,316 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 during this cost report period. \$ 36,135
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. \$ 5,466 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,331
- (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