



Facility Name & ID Number Alpine Fireside Health Center

# 0018275 Report Period Beginning: 10/01/06 Ending: 09/30/07

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	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	2,510	4,319	1,760	8,589	8
9	SNF/PED					9
10	ICF	5,386	4,951		10,337	10
11	ICF/DD					11
12	SC		11,412		11,412	12
13	DD 16 OR LESS					13
14	TOTALS	7,896	20,682	1,760	30,338	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.96%

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

Note: 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 1,760

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 9/30/07 Fiscal Year: 9/30/07

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

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/01/06 Ending: 09/30/07

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	195,209	8,522	8,001	211,732		211,732		211,732		1
2	Food Purchase		203,198		203,198		203,198	(14,580)	188,618		2
3	Housekeeping	66,827	24,807		91,634		91,634		91,634		3
4	Laundry	41,899	8,435	35,881	86,215		86,215	(16,900)	69,315		4
5	Heat and Other Utilities			104,886	104,886		104,886	2,041	106,927		5
6	Maintenance	62,512	38,399	30,224	131,135		131,135		131,135		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	366,447	283,361	178,992	828,800		828,800	(29,439)	799,361		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			20,604	20,604		20,604		20,604		9
10	Nursing and Medical Records	1,165,410	136,376	166,027	1,467,813		1,467,813		1,467,813		10
10a	Therapy			170,813	170,813		170,813		170,813		10a
11	Activities	69,413	21,708	3,502	94,623		94,623		94,623		11
12	Social Services	39,011		3,090	42,101		42,101		42,101		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,273,834	158,084	364,036	1,795,954		1,795,954		1,795,954		16
	<b>C. General Administration</b>										
17	Administrative	101,557			101,557		101,557	25,000	126,557		17
18	Directors Fees										18
19	Professional Services			99,162	99,162		99,162		99,162		19
20	Dues, Fees, Subscriptions & Promotions			24,474	24,474		24,474		24,474		20
21	Clerical & General Office Expenses	56,958	12,798	30,902	100,658		100,658	470	101,128		21
22	Employee Benefits & Payroll Taxes			447,060	447,060		447,060	5,376	452,436		22
23	Inservice Training & Education										23
24	Travel and Seminar			31,201	31,201		31,201	(998)	30,203		24
25	Other Admin. Staff Transportation			27,481	27,481		27,481		27,481		25
26	Insurance-Prop.Liab.Malpractice			54,076	54,076		54,076		54,076		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	158,515	12,798	714,356	885,669		885,669	29,848	915,517		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,798,796	454,243	1,257,384	3,510,423		3,510,423	409	3,510,832		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.

Facility Name & ID Number Alpine Fireside Health Center

#0018275

Report Period Beginning:

10/01/06

Ending:

09/30/07

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			106,533	106,533		106,533	50,965	157,498			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			32,854	32,854		32,854	20,461	53,315			32
33	Real Estate Taxes							60,701	60,701			33
34	Rent-Facility & Grounds			246,929	246,929		246,929	(246,929)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			386,316	386,316		386,316	(114,802)	271,514			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		59,081		59,081		59,081		59,081			39
40	Barber and Beauty Shops			15,470	15,470		15,470		15,470			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			36,135	36,135		36,135		36,135			42
43	Other (specify):* <b>Non-allowable Cos</b>			37,999	37,999		37,999	(37,999)				43
44	<b>TOTAL Special Cost Centers</b>		59,081	89,604	148,685		148,685	(37,999)	110,686			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,798,796	513,324	1,733,304	4,045,424		4,045,424	(152,392)	3,893,032			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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(9,204)	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	(16,525)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(148)	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	(506)	43		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(14,116)	43		24
25	Fund Raising, Advertising and Promotional	(11,190)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(4,500)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(4,179)	43		28
29	Other-Attach Schedule <u>See Pg. 5A</u>	(23,259)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (83,627)		\$	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)	(68,765)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (68,765)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (152,392)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

BHF USE ONLY					
48		49		50	
				51	
					52

SEE ACCOUNTANTS' COMPILATION REPORT

**Alpine Fireside Health Center**

**Provider #: 0018275**

**10/01/06 to 09/30/07**

**Schedule 5A**

VI. Adjustment Detail

Line 29 - Other

<u>Non-allowable expenses</u>	<u>Amount</u>	<u>Reference</u>
Laundry income offset	(16,900)	4
Non-allowable out of period seminars	(2,999)	24
Radiology	(2,508)	43
Laboratory	(1,502)	43
Ambulance	650	43
	<u>(23,259)</u>	

**SEE ACCOUNTANTS' COMPILATION REPORT**

Alpine Fireside Health Center

ID# 0018275

Report Period Beginning: 10/01/06

Ending: 09/30/07

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			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	<b>Total</b>	0	49

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alpine Fireside Health Center# 0018275

Report Period Beginning:

10/01/06

Ending:

09/30/07

## 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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(9,204)	0	0	0	0	0	0	0	0	0	0	(9,204)	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	2,041	0	0	0	0	0	0	0	0	0	2,041	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	<b>TOTAL General Services</b>	<b>(9,204)</b>	<b>2,041</b>	<b>0</b>	<b>(7,163)</b>	<b>8</b>								
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
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	470	0	0	0	0	0	0	0	0	0	470	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	2,001	0	0	0	0	0	0	0	0	0	2,001	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	<b>TOTAL General Administration</b>	<b>0</b>	<b>27,471</b>	<b>0</b>	<b>27,471</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(9,204)</b>	<b>29,512</b>	<b>0</b>	<b>20,308</b>	<b>29</b>								

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Alpine Fireside Health Center# 0018275

Report Period Beginning:

10/01/06

Ending:

09/30/07

## 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	50,965	0	0	0	0	0	0	0	0	0	50,965	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(16,525)	36,986	0	0	0	0	0	0	0	0	0	20,461	32
33	Real Estate Taxes	0	60,701	0	0	0	0	0	0	0	0	0	60,701	33
34	Rent-Facility & Grounds	0	(246,929)	0	0	0	0	0	0	0	0	0	(246,929)	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	<b>TOTAL Ownership</b>	<b>(16,525)</b>	<b>(98,277)</b>	<b>0</b>	<b>(114,802)</b>	<b>37</b>								
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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):*	(34,639)	0	0	0	0	0	0	0	0	0	0	(34,639)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(34,639)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(34,639)</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(60,368)</b>	<b>(68,765)</b>	<b>0</b>	<b>(129,133)</b>	<b>45</b>								

**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%	\$ 2,041	\$ 2,041	1
2	V	21 Office		Johs Oksnevad	100.00%	470	470	2
3	V	24 Travel and seminar		Johs Oksnevad	100.00%	2,001	2,001	3
4	V	30 Depreciation		Johs Oksnevad	100.00%	50,965	50,965	4
5	V	32 Interest		Johs Oksnevad	100.00%	36,986	36,986	5
6	V	33 Real estate taxes		Johs Oksnevad	100.00%	60,701	60,701	6
7	V	34 Rent - facility and grounds	246,929	Johs Oksnevad	100.00%		(246,929)	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		\$ 246,929			\$ 178,164	\$ * (68,765)	14

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

Facility Name &amp; ID Number

Alpine Fireside Health Center

# 0018275

Report Period Beginning:

10/01/06

Ending:

09/30/07

## 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	40+	100.00	Salary	101,557	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	\$ 126,557		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: 10/01/06 Ending: 09/30/07

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

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

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

1	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



**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 2006 report.		\$	<b>46,000</b>	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.)	2006	\$	<b>59,701</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>13,701</b>	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>47,000</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		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. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>60,701</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	<b>51,615</b>	8
	2003	<b>52,043</b>	9
	2004	<b>55,725</b>	10
	2005	<b>58,304</b>	11
	2006	<b>59,701</b>	12

**FOR BHF USE ONLY**

<b>Accrual calculation</b>				
<b>2006 tax bill</b>	<b>59,701</b>			
<b>% increase</b>	<b>x 1.05</b>			
<b>Estimate of 2007 taxes</b>	<b>62,686 X 9/12=\$47,000</b>			
		13	FROM R. E. TAX STATEMENT FOR 2006 \$	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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

**2006 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 2006 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 2006.

(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>59,701.00</u>	\$ <u>59,701.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>59,701.00</u>	\$ <u>59,701.00</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

**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:

10/01/06 Ending:

09/30/07

**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:**

A. Land.

	1	2	3	4	
	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	<b>TOTALS</b>	<b>#VALUE!</b>		<b>\$ 10,000</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Alpine Fireside Health Center# 0018275

Report Period Beginning:

10/01/06

Ending:

09/30/07**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
	<b>Improvement Type**</b>										
9			1973		1,277		10			1,277	9
10			1973		3,172		20			3,172	10
11			1973		694		40	17	17	595	11
12			1973		201		25			201	12
13			1973		93,791		11			93,791	13
14			1973		96,886		34	2,850	2,850	85,072	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	229,924	25
26	Kitchen improvements		1989		9,541		20	477	477	9,063	26
27	Black top		1990		5,000		10			5,000	27
28	Broiler		1991		29,033		20	1,452	1,452	23,958	28
29	Lawn sprinkler		1992		5,000		15	332	332	4,996	29
30	Leasehold improvements		1993		13,972		15	931	931	13,500	30
31	Roof improvements		1994		57,648		15	3,843	3,843	52,059	31
32	Generator		1995		34,924		15	2,328	2,328	29,100	32
33	Air conditioning system		1999		280,820		15	18,721	18,721	159,129	33
34	Carpeting / flooring / wallcovering		1999		81,812		15	5,454	5,454	46,359	34
35	Parking lot lights		1999		16,900		15	1,126	1,126	9,571	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:

10/01/06

Ending:

09/30/07**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	\$ 10,685	37
38	Parking lot	2002	42,683	2,846	15	2,846		15,653	38
39	Boiler electrical improvements	2002	11,560	578	20	578		3,179	39
40	Gazebo pad	2002	12,657	633	20	633		3,481	40
41	Painting and wallpapering hallways	2003	27,403	1,370	20	1,370		6,165	41
42	Gazebo	2003	35,825	1,792	20	1,792		8,064	42
43	Fence	2003	3,400	170	20	170		765	43
44	Sign	2003	1,675	84	20	84		378	44
45	Garage	2003	3,077	154	20	154		692	45
46	Fire alarm	2003	30,208	1,510	20	1,510		6,795	46
47	Boiler	2004	31,880	1,594	20	1,594		5,582	47
48	Sign	2004	3,487	174	20	174		609	48
49	Smoke detectors	2004	2,153	108	20	108		378	49
50	Boiler	2005	7,060	352	20	352		880	50
51	Commercial disposal	2005	826	42	20	42		105	51
52	Fire supression system	2005	1,866	94	20	94		235	52
53	Pond	2006	11,930	596	20	596		894	53
54	Fire alarm system	2006	2,738	137	20	137	(0)	205	54
55	Floor tile, baseboards	2006	5,759	288	20	288	(0)	432	55
56	Air conditioning	2006	13,634	682	20	682	(0)	1,023	56
57	Sidewalk	2006	1,196	60	20	60	(0)	90	57
58	Remodel grieving room	2006	2,198	110	20	110	(0)	165	58
59	Fire sprinkler system	2007	169,761	4,244	20	4,244		4,244	59
60	Nurse call system	2007	69,282	1,732	20	1,732		1,732	60
61	Remodel fireplace	2007	39,855	996	20	996		996	61
62	Ceiling tiles	2007	12,820	321	20	321		321	62
63	Drywall stairways	2007	8,000	200	20	200		200	63
64	20 ton rooftop unit	2007	34,100	852	20	852		852	64
65	Ductless heat pump	2007	7,760	194	20	194		194	65
66	Remodel fireplace	2007	6,631	166	20	166		166	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,386,638	\$ 22,079		\$ 73,044	\$ 50,965	\$ 1,635,997	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Alpine Fireside Health Center

# 0018275

Report Period Beginning:

10/01/06

Ending:

09/30/07

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	\$ 424,228	\$ 47,617	\$ 47,617	\$	3-10 yrs	\$ 376,121	71
72	Current Year Purchases	99,372	11,567	11,567		5 yrs	11,567	72
73	Fully Depreciated Assets	303,476					303,476	73
74								74
75	TOTALS	\$ 827,076	\$ 59,184	\$ 59,184	\$		\$ 691,164	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	\$ 37,181	76
77	Maintenace truck	2006 GMC Sierra	2005	48,333	9,667	9,667		5	24,167	77
78	Administrative	2006 Chrysler 300	2006	24,902	4,980	4,980		5	11,306	78
79	Resident transportation	1998 Ford Supreme Bus	1999	49,247					49,247	79
80	TOTALS			\$ 175,597	\$ 25,270	\$ 25,270	\$		\$ 121,901	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)	\$ 3,399,311	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 106,533	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 157,498	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 50,965	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,449,062	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	Construction in progress	\$ 14,631	92
93			93
94			94
95		\$ 14,631	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.	<u>/2008</u>	\$ _____
13.	<u>/2009</u>	\$ _____
14.	<u>/2010</u>	\$ _____

\* 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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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	\$	998	\$ 86,506	\$	998	\$ 86,506	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		165	15,975		165	15,975	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		867	68,332		867	68,332	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				59,081		59,081	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	<b>TOTAL</b>			\$	2,030	\$ 170,813	\$ 59,081	2,030	\$ 229,894	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: **10/01/06**

Ending:

**09/30/07**

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **09/30/07**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (78,101)	\$ (78,101)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>30,000</u> )	572,991	572,991	3
4	Supply Inventory (priced at _____ )			4
5	Short-Term Investments			5
6	Prepaid Insurance	45,515	45,515	6
7	Other Prepaid Expenses	16,500	16,500	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Deposits</u>	17,918	17,918	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 574,823	\$ 574,823	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		10,000	13
14	Buildings, at Historical Cost	601,423	2,386,638	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	585,911	1,002,673	16
17	Accumulated Depreciation (book methods)	(415,108)	(2,449,062)	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 progres</u> )	14,631	14,631	22
23	Other(specify): _____			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 786,857	\$ 964,880	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,361,680	\$ 1,539,703	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 101,825	\$ 101,825	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	539,084	278,702	29
30	Accrued Salaries Payable	46,845	46,845	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,802	10,802	31
32	Accrued Real Estate Taxes(Sch.IX-B)	47,000	47,000	32
33	Accrued Interest Payable	60,198	60,198	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	1,635	1,635	35
	<b>Other Current Liabilities(specify):</b>			
36	_____			36
37	_____			37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 807,389	\$ 547,007	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable		747,037	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	_____			43
44	_____			44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 747,037	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 807,389	\$ 1,294,044	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 554,291	\$ 245,659	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,361,680	\$ 1,539,703	48

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>705,621</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>	<b>Prior period adjustments</b>	<b>141,830</b>	<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>847,451</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(293,160)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(293,160)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>554,291</b>	<b>24</b> *

\* 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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,942,850	1
2	Discounts and Allowances for all Levels	(706,221)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,236,629	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	212,843	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 212,843	8
<b>C. Other Operating Revenue</b>			
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	27,396	13
14	Non-Patient Meals	9,204	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	201,349	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	23,429	19
20	Radiology and X-Ray	3,590	20
21	Other Medical Services	4,376	21
22	Laundry	16,900	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 286,244	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	560	24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 560	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a	Miscellaneous store sales	15,988	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 15,988	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,752,264	30

2

Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	828,800	31
32	Health Care	1,795,954	32
33	General Administration	885,669	33
<b>B. Capital Expense</b>			
34	Ownership	386,316	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	112,550	35
36	Provider Participation Fee	36,135	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,045,424	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(293,160)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (293,160)	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:

10/01/06

Ending:

09/30/07

**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	2,080	\$ 70,926	\$ 34.10	1
2	Assistant Director of Nursing	1,259	1,279	38,904	30.42	2
3	Registered Nurses	4,569	4,741	112,425	23.71	3
4	Licensed Practical Nurses	11,765	12,207	251,844	20.63	4
5	CNAs & Orderlies	50,388	52,150	566,282	10.86	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,706	2,882	43,094	14.95	8
9	Activity Director	1,550	1,614	22,061	13.67	9
10	Activity Assistants	6,542	6,714	47,352	7.05	10
11	Social Service Workers	2,310	2,422	39,011	16.11	11
12	Dietician					12
13	Food Service Supervisor	2,892	2,956	34,479	11.66	13
14	Head Cook	5,166	5,418	41,477	7.66	14
15	Cook Helpers/Assistants	16,059	16,755	119,253	7.12	15
16	Dishwashers					16
17	Maintenance Workers	3,619	3,899	62,512	16.03	17
18	Housekeepers	9,059	9,579	66,827	6.98	18
19	Laundry	2,757	2,925	41,899	14.32	19
20	Administrator	2,080	2,080	101,557	48.83	20
21	Assistant Administrator	1,040	1,040	25,000	24.04	21
22	Other Administrative					22
23	Office Manager	1,954	2,078	41,643	20.04	23
24	Clerical	1,591	1,679	15,315	9.12	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: <a href="#">See Sch 20a</a>	3,570	3,851	81,935	21.28	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	132,956	138,349	\$ 1,823,796 *	\$ 13.18	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	90	\$ 8,001	L1, C3	35
36	Medical Director	Monthly	20,604	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,870	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	59	3,502	L11, C3	44
45	Social Service Consultant	51	3,090	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	200	\$ 37,067		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,806	\$ 72,229	L10, C3	50
51	Licensed Practical Nurses	3,605	91,928	L10, C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	5,411	\$ 164,157		53

SEE ACCOUNTANTS' COMPILATION REPORT

Alpine Fireside Health Center, Ltd.  
PROVIDER # 0018275  
September 30, 2007

Schedule 20A

XVIII. STAFFING AND SALARY COSTS

LINE 32 - Other (specify)

	<u>Hours Worked</u>	<u>Hours Paid</u>	<u>Salary</u>	<u>Avg Hr Wage</u>
MDS Plan Coordinator	1,943	2,103	50,633	24.08
Admissions	1,627	1,748	31,302	17.91
<b>Total Line 32 - Other</b>	<b><u>3,570</u></b>	<b><u>3,851</u></b>	<b><u>\$ 81,935</u></b>	<b><u>\$ 21.28</u></b>

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		
Gordon Oksnevad	Administrator	0	\$ 101,557	Workers' Compensation Insurance	\$ 67,014	IDPH License Fee	\$ 1,990		
Johs Oksnevad	Asst Administrator	100	25,000	Unemployment Compensation Insurance	52,358	Advertising: Employee Recruitment	12,159		
				FICA Taxes	131,215	Health Care Worker Background Check	1,440		
				Employee Health Insurance	151,424	(Indicate # of checks performed <u>100</u> )			
				Employee Meals	5,376	Patient Background Checks	40		
				Illinois Municipal Retirement Fund (IMRF)*					
				Pre-employment physicals	16,016	Miscellaneous licenses	1,587		
				401(k)	25,735	Miscellaneous subscriptions	1,358		
				Uniforms	3,298	Illinois Health Care Association dues	5,940		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 126,557			Less: Public Relations Expense	( )		
B. Administrative - Other						Non-allowable advertising	( )		
Description			Amount			Yellow page advertising	( )		
N/A			\$						
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$						
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	
Duane Morris LLP	Legal		\$ 16,768				Out-of-State Travel	\$	
Williams & McCarthy	Legal		3,684						
Altschuler Melvoin & Glasser	Accounting		36,901						
RSM McGladrey, Inc.	Accounting		230				In-State Travel	8,257	
TALX Corp	Accounting		600						
Business Management Services	Computer consulting		16,031						
Keane Care Inc	Computer consulting		9,516						
E-Health Data	Computer consulting		5,740				Seminar Expense	21,946	
Resource Systems	Computer consulting		6,115						
Silverchair Learning	Computer consulting		1,800						
Ingenix	Computer consulting		541						
Nursing Resources Inc	Employment fees		1,236				Entertainment Expense	( )	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 99,162	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$ 30,203

\* 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								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2004	FY2005	FY2006	FY2007
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								
2																				
3																				
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Alpine Fireside Health Center# 0018275Report Period Beginning: 10/01/06Ending: 09/30/07**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 - \$ 5,940
- (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. \$ 5,870 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.

**SEE ACCOUNTANTS' COMPILATION REPORT**

- (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. \$ 5,376 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 9,204
- (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 \$5,000, 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