

Facility Name & ID Number Alpine Fireside Health Center

0018275 Report Period Beginning: 10/01/07 Ending: 09/30/08

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	11,712	1
2		Skilled Pediatric (SNF/PED)			2
3	34	Intermediate (ICF)	34	12,444	3
4		Intermediate/DD			4
5	33	Sheltered Care (SC)	33	12,078	5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,234	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	2,883	2,319	4,086	9,288	8
9	SNF/PED					9
10	ICF	5,878	4,919		10,797	10
11	ICF/DD					11
12	SC			11,020	11,020	12
13	DD 16 OR LESS					13
14	TOTALS	8,761	7,238	15,106	31,105	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.84%

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 4,086

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 09/30/08 Fiscal Year: 09/30/08

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

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/01/07 Ending: 09/30/08

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	229,295	12,419	9,322	251,036		251,036		251,036		1
2	Food Purchase		222,544		222,544		222,544	(16,260)	206,284		2
3	Housekeeping	70,431	34,019		104,450		104,450		104,450		3
4	Laundry	34,692	6,010	30,187	70,889		70,889	(15,200)	55,689		4
5	Heat and Other Utilities			136,060	136,060		136,060	4,145	140,205		5
6	Maintenance	76,721	40,098	40,203	157,022		157,022		157,022		6
7	Other (specify):*										7
8	TOTAL General Services	411,139	315,090	215,772	942,001		942,001	(27,315)	914,686		8
	B. Health Care and Programs										
9	Medical Director			12,300	12,300		12,300		12,300		9
10	Nursing and Medical Records	1,130,658	188,006	265,149	1,583,813		1,583,813		1,583,813		10
10a	Therapy			305,691	305,691		305,691		305,691		10a
11	Activities	67,626	24,699	1,925	94,250		94,250		94,250		11
12	Social Services	35,659		2,768	38,427		38,427		38,427		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,233,943	212,705	587,833	2,034,481		2,034,481		2,034,481		16
	C. General Administration										
17	Administrative	112,845			112,845		112,845	25,000	137,845		17
18	Directors Fees										18
19	Professional Services			130,588	130,588		130,588		130,588		19
20	Dues, Fees, Subscriptions & Promotions			30,329	30,329		30,329	(2,754)	27,575		20
21	Clerical & General Office Expenses	128,199	15,157	39,366	182,722		182,722	550	183,272		21
22	Employee Benefits & Payroll Taxes			348,275	348,275		348,275	6,116	354,391		22
23	Inservice Training & Education										23
24	Travel and Seminar			8,558	8,558		8,558		8,558		24
25	Other Admin. Staff Transportation			10,882	10,882		10,882	141	11,023		25
26	Insurance-Prop.Liab.Malpractice			85,036	85,036		85,036		85,036		26
27	Other (specify):*										27
28	TOTAL General Administration	241,044	15,157	653,034	909,235		909,235	29,053	938,288		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,886,126	542,952	1,456,639	3,885,717		3,885,717	1,738	3,887,455		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:

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Ending:

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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	
	D. Ownership											
30	Depreciation			117,725	117,725		117,725	44,283	162,008			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			38,202	38,202		38,202	(13,499)	24,703			32
33	Real Estate Taxes							66,424	66,424			33
34	Rent-Facility & Grounds			117,797	117,797		117,797	(117,797)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			273,724	273,724		273,724	(20,589)	253,135			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		48,698		48,698		48,698		48,698			39
40	Barber and Beauty Shops		1,200	17,776	18,976		18,976		18,976			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			36,234	36,234		36,234		36,234			42
43	Other (specify):* Non-allowable cost			185,967	185,967		185,967	(185,967)				43
44	TOTAL Special Cost Centers		49,898	239,977	289,875		289,875	(185,967)	103,908			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,886,126	592,850	1,970,340	4,449,316		4,449,316	(204,818)	4,244,498			45

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Alpine Fireside Health Center

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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	(10,144)	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	(15,200)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(28,650)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(161,007)	43		24
25	Fund Raising, Advertising and Promotional	(11,577)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	2,018	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg. 5A	(18,155)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (242,715)		\$	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)	37,897		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 37,897		36
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (204,818)		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						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

ID# 0018275

Report Period Beginning: 10/01/07

Ending: 09/30/08

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	X-Rays - Part A	\$ (1,773)	43	1
2	Ambulance	(1,485)	43	2
3	Labs - Part A	(4,103)	43	3
4	Sales Tax	(156)	43	4
5	Nonallowable Marketing	(1,933)	43	5
6	Yellow Page Advertising	(5,951)	43	6
7	Nonallowable Chamber Dues	(835)	19	7
8	Nonallowable PAC Dues	(1,919)	19	8
9	Reclass paid employee meals to benefits	(6,116)	2	9
10	Reclass paid employee meals to benefits	6,116	22	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(18,155)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alpine Fireside Health Center# 0018275

Report Period Beginning:

10/01/07

Ending:

09/30/08

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	(16,260)	0	0	0	0	0	0	0	0	0	0	(16,260)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(15,200)	0	0	0	0	0	0	0	0	0	0	(15,200)	4
5	Heat and Other Utilities	0	4,145	0	0	0	0	0	0	0	0	0	4,145	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	(31,460)	4,145	0	(27,315)	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	(2,754)	0	0	0	0	0	0	0	0	0	0	(2,754)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	550	0	0	0	0	0	0	0	0	0	550	21
22	Employee Benefits & Payroll Taxes	6,116	0	0	0	0	0	0	0	0	0	0	6,116	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	141	0	0	0	0	0	0	0	0	0	141	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	3,362	25,691	0	29,053	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(28,098)	29,836	0	1,738	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Alpine Fireside Health Center# 0018275

Report Period Beginning:

10/01/07

Ending:

09/30/08

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	44,283	0	0	0	0	0	0	0	0	0	44,283	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(28,650)	15,151	0	0	0	0	0	0	0	0	0	(13,499)	32
33	Real Estate Taxes	0	66,424	0	0	0	0	0	0	0	0	0	66,424	33
34	Rent-Facility & Grounds	0	(117,797)	0	0	0	0	0	0	0	0	0	(117,797)	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	(28,650)	8,061	0	(20,589)	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):*	(185,967)	0	0	0	0	0	0	0	0	0	0	(185,967)	43
44	TOTAL Special Cost Centers	(185,967)	0	0	0	0	0	0	0	0	0	0	(185,967)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(242,715)	37,897	0	(204,818)	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%	\$ 4,145	\$ 4,145	1
2	V	21 Office		Johs Oksnevad	100.00%	550	550	2
3	V	24 Travel and seminar		Johs Oksnevad	100.00%	141	141	3
4	V	30 Depreciation		Johs Oksnevad	100.00%	44,283	44,283	4
5	V	32 Interest		Johs Oksnevad	100.00%	15,151	15,151	5
6	V	33 Real estate taxes		Johs Oksnevad	100.00%	66,424	66,424	6
7	V	34 Rent - facility and grounds	117,797	Johs Oksnevad	100.00%		(117,797)	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		\$ 117,797			\$ 155,694	\$ * 37,897	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:

10/01/07

Ending:

09/30/08

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	112,845	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	\$ 137,845		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

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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 N/A

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			N/A						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:

10/01/07

Ending:

09/30/08

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	Name of Lender	2		3	4	5	6		7	8	9	10						
		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 State Bank		X	Working capital & impvmnts	\$10,000.00	12/01	\$ 915,387	\$ 870,801	6/4/12	Prime	\$ 15,151	1						
2	Avaya Financial		X	Telephone Equipment	\$1,708.31	10/06	55,765	21,786	10/09	0.1289	4,117	2						
3												3						
4												4						
5												5						
Working Capital																		
6	Johs Oksnevad	X		Working Capital	None	9/30/99	169,000	464,902	Demand	0.0600	28,650	6						
7	Durand State Bank		X	Working Capital	None	5/23/07			5/23/08	0.0775	5,435	7						
8												8						
9	TOTAL Facility Related				\$11,708.31		\$ 1,140,152	\$ 1,357,489			\$ 53,353	9						
B. Non-Facility Related*																		
10												10						
11									Eliminate related party interest		(28,650)	11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ (28,650)	14						
15	TOTALS (line 9+line14)						\$ 1,140,152	\$ 1,357,489			\$ 24,703	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.)

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 2007 report.		\$	47,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2007	\$	62,424	2
3. Under or (over) accrual (line 2 minus line 1).		\$	15,424	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	51,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	66,424	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	52,043	8
	2004	55,725	9
	2005	58,304	10
	2006	59,701	11
	2007	62,424	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2007	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

Accrual calculation

2007 tax bill	63,424
% increase	x 1.07
Estimate of 2008 taxes	67,863 x 9/12 = \$51,000

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 2007 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 2007.

(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>62,423.78</u>	\$ <u>62,423.78</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>62,423.78</u>	\$ <u>62,423.78</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Alpine Fireside Health Center

0018275 Report Period Beginning:

10/01/07 Ending:

09/30/08

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: N/A
 (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	TOTALS	#VALUE!		\$ 10,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Alpine Fireside Health Center# 0018275

Report Period Beginning:

10/01/07

Ending:

09/30/08**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	612	11
12		1973		201		25			201	12
13		1973		93,791		11			93,791	13
14		1973		96,886		34	2,850	2,850	87,922	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	5,894	5,894	235,818	25
26	Kitchen improvements	1989		9,541		20	478	478	9,541	26
27	Black top	1990		5,000		10			5,000	27
28	Broiler	1991		29,033		20	1,452	1,452	25,410	28
29	Lawn sprinkler	1992		5,000		15	4	4	5,000	29
30	Leasehold improvements	1993		13,972		15	472	472	13,972	30
31	Roof improvements	1994		57,648		15	3,843	3,843	55,902	31
32	Generator	1995		34,924		15	2,328	2,328	31,428	32
33	Air conditioning system	1999		280,820		15	18,721	18,721	177,850	33
34	Carpeting / flooring / wallcovering	1999		81,812		15	5,454	5,454	51,813	34
35	Parking lot lights	1999		16,900		15	1,126	1,126	10,697	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:

10/01/07

Ending:

09/30/08**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	\$ 12,329	37
38	Parking lot	2002	42,683	2,846	15	2,846		18,499	38
39	Boiler electrical improvements	2002	11,560	578	20	578		3,757	39
40	Gazebo pad	2002	12,657	633	20	633		4,114	40
41	Painting and wallpapering hallways	2003	27,403	1,370	20	1,370		7,535	41
42	Gazebo	2003	35,825	1,792	20	1,792		9,856	42
43	Fence	2003	3,400	170	20	170		935	43
44	Sign	2003	1,675	84	20	84		462	44
45	Garage	2003	3,077	154	20	154		846	45
46	Fire alarm	2003	30,208	1,510	20	1,510		8,305	46
47	Boiler	2004	31,880	1,594	20	1,594		7,176	47
48	Sign	2004	3,487	174	20	174		783	48
49	Smoke detectors	2004	2,153	108	20	108		486	49
50	Boiler	2005	7,060	352	20	352		1,232	50
51	Commercial disposal	2005	826	42	20	42		147	51
52	Fire supression system	2005	1,866	94	20	94		329	52
53	Pond	2006	11,930	596	20	596		1,490	53
54	Fire alarm system	2006	2,738	137	20	137		342	54
55	Floor tile, baseboards	2006	5,759	288	20	288		720	55
56	Air conditioning	2006	13,634	682	20	682		1,705	56
57	Sidewalk	2006	1,196	60	20	60		150	57
58	Remodel grieving room	2006	2,198	110	20	110		275	58
59	Fire sprinkler system	2007	169,761	8,487	20	8,487		12,731	59
60	Nurse call system	2007	69,282	3,464	20	3,464		5,196	60
61	Remodel fireplace	2007	39,855	1,993	20	1,993		2,989	61
62	Ceiling tiles	2007	12,820	641	20	641		962	62
63	Drywall stairways	2007	8,000	400	20	400		600	63
64	20 ton rooftop unit	2007	34,100	1,705	20	1,705		2,557	64
65	Ductless heat pump	2007	7,760	388	20	388		582	65
66	Remodel fireplace	2007	6,631	332	20	332		498	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,386,638	\$ 30,784		\$ 75,067	\$ 44,283	\$ 1,711,064	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1		\$ 2,386,638	\$ 30,784		\$ 75,067	\$ 44,283	\$ 1,711,064
2	2007	4,045	101		101		101
3	2008	11,366	284		284		284
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (lines 1 thru 33)	\$ 2,402,049	\$ 31,169		\$ 75,452	\$ 44,283	\$ 1,711,449

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	\$ 523,600	\$ 59,562	\$ 59,562	\$	3-10	\$ 447,250	71
72	Current Year Purchases	17,242	1,724	1,724		5	1,724	72
73	Fully Depreciated Assets	303,476					303,476	73
74								74
75	TOTALS	\$ 844,318	\$ 61,286	\$ 61,286	\$		\$ 752,450	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	\$ 47,804	76
77	Maintenance truck	2006 GMC Sierra	2005	48,333	9,667	9,667		5	33,834	77
78	Administrative	2006 Chrysler 300	2006	24,902	4,980	4,980		5	16,286	78
79	Resident transportation	1998 Ford Supreme Bus	1999	49,247					49,247	79
80	TOTALS			\$ 175,597	\$ 25,270	\$ 25,270	\$		\$ 147,171	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)	\$ 3,431,964	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 117,725	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 162,008	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 44,283	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,611,070	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	\$ 132,631	92
93			93
94			94
95		\$ 132,631	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				N/A			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: N/A

(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			N/A		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. _____ /2009 \$ _____

13. _____ /2010 \$ _____

14. _____ /2011 \$ _____

* 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?</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>2. CLASSROOM PORTION:</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. CLINICAL PORTION:</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	10A(3)	hrs	\$	1,380	\$ 136,700	\$	1,380	\$ 136,700	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		485	48,106		485	48,106	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		1,209	120,885		1,209	120,885	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				48,698		48,698	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	TOTAL			\$	3,074	\$ 305,691	\$ 48,698	3,074	\$ 354,389	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: **10/01/07**

Ending:

09/30/08

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **09/30/08**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>30,000</u>)	1,333,836	1,333,836	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	52,015	52,015	6
7	Other Prepaid Expenses	31,434	31,434	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Deposits</u>	3,320	3,320	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,420,605	\$ 1,420,605	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			14
15	Leasehold Improvements, at Historical Cost	616,834	2,402,049	15
16	Equipment, at Historical Cost	603,153	1,019,915	16
17	Accumulated Depreciation (book methods)	(532,833)	(2,611,070)	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 Process</u>)	132,631	132,631	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 819,785	\$ 953,525	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,240,390	\$ 2,374,130	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 320,648	\$ 320,648	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	72,467	72,467	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	51,000	51,000	32
33	Accrued Interest Payable	88,846	88,846	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	1,635	1,635	35
	Other Current Liabilities(specify):			
36	<u>Payroll Liabilities</u>	2,021	2,021	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 536,617	\$ 536,617	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	677,293	1,357,489	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 677,293	\$ 1,357,489	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,213,910	\$ 1,894,106	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,026,480	\$ 480,024	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,240,390	\$ 2,374,130	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 554,291	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 554,291	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	472,189	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)	\$ 472,189	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,026,480	24 *

* 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	\$ 4,450,790	1
2	Discounts and Allowances for all Levels	(562,791)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,887,999	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	471,853	6
7	Oxygen	900	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 472,753	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	36,560	13
14	Non-Patient Meals	10,144	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	436,118	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	21,554	19
20	Radiology and X-Ray	3,284	20
21	Other Medical Services	31,858	21
22	Laundry	15,200	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 554,718	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Schedule 19A</u>	6,035	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 6,035	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,921,505	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	942,001	31
32	Health Care	2,034,481	32
33	General Administration	909,235	33
	B. Capital Expense		
34	Ownership	273,724	34
	C. Ancillary Expense		
35	Special Cost Centers	253,641	35
36	Provider Participation Fee	36,234	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,449,316	40
41	Income before Income Taxes (line 30 minus line 40)**	472,189	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 472,189	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.

Alpine Fireside Health Center, Ltd.

PROVIDER # 0018275

September 30, 2008

Schedule 19A

E. Other Revenue (specify):****

Line 28

Description	Amount
Store & Miscellaneous Sales	6,102
Interest Income	(111)
Petty Cash Adjustment AC	44
	<u>6,035</u>

Facility Name & ID Number Alpine Fireside Health Center

0018275

Report Period Beginning:

10/01/07

Ending:

09/30/08

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	\$ 73,415	\$ 35.30	1
2	Assistant Director of Nursing	1,994	2,002	33,421	16.69	2
3	Registered Nurses	3,771	3,803	80,195	21.09	3
4	Licensed Practical Nurses	11,406	11,481	242,638	21.13	4
5	CNAs & Orderlies	54,512	55,180	613,034	11.11	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,260	2,420	34,957	14.45	8
9	Activity Director	1,678	1,708	21,069	12.34	9
10	Activity Assistants	5,624	5,672	46,557	8.21	10
11	Social Service Workers	1,617	1,647	35,659	21.65	11
12	Dietician					12
13	Food Service Supervisor	3,053	3,063	40,564	13.24	13
14	Head Cook	4,257	4,385	34,489	7.87	14
15	Cook Helpers/Assistants	19,391	19,711	154,242	7.83	15
16	Dishwashers					16
17	Maintenance Workers	5,360	5,624	76,721	13.64	17
18	Housekeepers	8,459	8,869	70,431	7.94	18
19	Laundry	2,960	3,088	34,692	11.23	19
20	Administrator	2,080	2,080	112,845	54.25	20
21	Assistant Administrator	1,040	1,040	25,000	24.04	21
22	Other Administrative					22
23	Office Manager	2,277	2,377	49,151	20.68	23
24	Clerical	1,671	1,728	17,973	10.40	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: MDS Coord.	2,107	2,195	52,998	24.14	32
33	Other(specify) <u>Admissions</u>	3,050	3,186	61,075	19.17	33
34	TOTAL (lines 1 - 33)	140,647	143,339	\$ 1,911,126 *	\$ 13.33	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	176	\$ 8,840	1(3)	35
36	Medical Director	36	12,300	9(3)	36
37	Medical Records Consultant	45	1,800	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	30	2,106	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	38	1,925	11(3)	44
45	Social Service Consultant	55	2,768	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	380	\$ 29,739		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	2,870	\$ 114,818	10(3)	50
51	Licensed Practical Nurses	4,871	146,131	10(3)	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	7,741	\$ 260,949		53

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	Administrato	0	\$ 112,845	Workers' Compensation Insurance	\$ 45,963	IDPH License Fee	\$		
Johs Oksnevad	Asst Administrator	100	25,000	Unemployment Compensation Insurance	28,805	Advertising: Employee Recruitment	12,612		
				FICA Taxes	143,269	Health Care Worker Background Check (Indicate # of checks performed <u>207</u>)	2,070		
				Employee Health Insurance	74,047	Patient Background Checks	85		
				Employee Meals	6,116	Illinois Health Care Association	5,940		
				Illinois Municipal Retirement Fund (IMRF)*		Rockford Register	5,338		
				Pre-Employment physicals	18,324	Miscellaneous Dues & Subscriptions	1,481		
				401(k)	35,712	Miscellaneous Licenses	2,038		
				Uniforms	2,155				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 137,845	TOTAL (agree to Schedule V, line 22, col.8)		\$ 27,575			
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			\$	N/A		\$	Out-of-State Travel	\$	
							In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	Seminar Expense		
C. Professional Services							See Attached		8,558
Vendor/Payee	Type		Amount						
See Schedule 21A			\$ 130,588						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 130,588	TOTAL		\$	Entertainment Expense (agree to Sch. V, line 24, col. 8)		
							TOTAL		

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Alpine Fireside Health Center, Ltd.
PROVIDER # 0018275
September 30, 2008

Schedule 21A

XIX. SUPPORT SCHEDULES

C. Professional Services

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
Duane Morris LLP	Legal	47,264
Williams & McCarthy	Legal	168
Reno & Zahm	Legal	3,404
RSM McGladrey	Accounting	14,386
McGladrey & Pullen	Accounting	18,560
Business Management Services	Computer Services	8,997
AAA	Computer Services	1,177
Keane Care	Computer Services	25,991
E Health Data	Computer Services	4,153
Ingenix	Computer Services	290
IVANS	Computer Services	22
Rock River	Computer Services	325
Bank of America	Computer Services	796
Resource Systems	Computer Services	2,560
Silverchair Learning	Computer Services	1,800
Nursing Resources Inc	Employment Fees	695
TOTAL (agree to Schedule V, line 19, column 3)		<u><u>130,588</u></u>

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	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$										
2																						
3																						
4	N/A																					
5																						
6																						
7																						
8																						
9																						
10																						
11																						
12																						
13																						
14																						
15																						
16																						
17																						
18																						
19																						
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$										

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Alpine Fireside Health Center# 0018275Report Period Beginning: 10/01/07Ending: 09/30/08**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? _____
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 11,108 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. \$ 36,234
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. \$ 6,116 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 10,144
- (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. N/A
- (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