

Facility Name & ID Number Alpine Fireside Health Center

0018275 Report Period Beginning: 10/1/08 Ending: 9/30/09

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	32	Skilled (SNF)	32	11,680	1
2		Skilled Pediatric (SNF/PED)			2
3	34	Intermediate (ICF)	34	12,410	3
4		Intermediate/DD			4
5	33	Sheltered Care (SC)	33	12,045	5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	1,882	1,218	3,629	6,729	8	
9	SNF/PED					9	
10	ICF	4,999	4,849		9,848	10	
11	ICF/DD					11	
12	SC			10,103	10,103	12	
13	DD 16 OR LESS					13	
14	TOTALS	6,881	6,067	13,732	26,680	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.83%

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

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 3,629

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: 9/30/09 Fiscal Year: 9/30/09

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

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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	217,845	7,807	10,847	236,499		236,499		236,499		1
2	Food Purchase		210,271		210,271		210,271	(17,760)	192,511		2
3	Housekeeping	72,316	34,918		107,234		107,234		107,234		3
4	Laundry	31,949	5,502	21,426	58,877		58,877	(9,706)	49,171		4
5	Heat and Other Utilities			130,396	130,396		130,396	3,484	133,880		5
6	Maintenance	82,339	56,986	54,546	193,871		193,871		193,871		6
7	Other (specify):*										7
8	TOTAL General Services	404,449	315,484	217,215	937,148		937,148	(23,982)	913,166		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	1,210,214	225,415	132,901	1,568,530		1,568,530		1,568,530		10
10a	Therapy			296,225	296,225		296,225		296,225		10a
11	Activities	61,496	17,883	4,212	83,591		83,591		83,591		11
12	Social Services	37,057		1,972	39,029		39,029		39,029		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,308,767	243,298	447,310	1,999,375		1,999,375		1,999,375		16
	C. General Administration										
17	Administrative	151,480			151,480		151,480	25,000	176,480		17
18	Directors Fees										18
19	Professional Services			191,628	191,628		191,628	(810)	190,818		19
20	Dues, Fees, Subscriptions & Promotions			27,785	27,785		27,785	(3,127)	24,658		20
21	Clerical & General Office Expenses	134,397	25,393	34,399	194,189		194,189	(13,441)	180,748		21
22	Employee Benefits & Payroll Taxes			397,320	397,320		397,320	6,645	403,965		22
23	Inservice Training & Education										23
24	Travel and Seminar			11,714	11,714		11,714		11,714		24
25	Other Admin. Staff Transportation			10,993	10,993		10,993	141	11,134		25
26	Insurance-Prop.Liab.Malpractice			83,796	83,796		83,796		83,796		26
27	Other (specify):*										27
28	TOTAL General Administration	285,877	25,393	757,635	1,068,905		1,068,905	14,408	1,083,313		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,999,093	584,175	1,422,160	4,005,428		4,005,428	(9,574)	3,995,854		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.

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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			106,572	106,572		106,572	46,145	152,717			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			38,832	38,832		38,832	21,487	60,319			32
33	Real Estate Taxes							67,238	67,238			33
34	Rent-Facility & Grounds			247,238	247,238		247,238	(247,238)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			392,642	392,642		392,642	(112,368)	280,274			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		96		96		96		96			39
40	Barber and Beauty Shops		1,157	19,648	20,805		20,805		20,805			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			36,135	36,135		36,135		36,135			42
43	Other (specify):* Non-allowable cost			42,584	42,584		42,584	(42,584)				43
44	TOTAL Special Cost Centers		1,253	98,367	99,620		99,620	(42,584)	57,036			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,999,093	585,428	1,913,169	4,497,690		4,497,690	(164,526)	4,333,164			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.

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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	(11,115)	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	(9,706)	4		8
9	Non-Straightline Depreciation	10,807	30		9
10	Interest and Other Investment Income	(37,896)	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	(1,488)	43		24
25	Fund Raising, Advertising and Promotional	(12,540)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(35)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG5A	(46,408)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (108,381)		\$	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)	(56,145)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (56,145)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (164,526)		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

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	X-Rays-Part A	\$ (3,306)	43	1
2	Ambulance	(2,555)	43	2
3	Labs-Part A	(11,606)	43	3
4	Sales Tax	(121)	43	4
5	Nonallowable Marketing	(10,375)	43	5
6	Contributions	(50)	43	6
7	Miscellaneous Expense	(508)	43	7
8	Miscellaneous Income	(13,950)	21	8
9	Chamber of Commerce Dues	(1,220)	20	9
10	Out of period legal	(810)	19	10
11	Lobbying	(1,907)	20	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	(46,408)		49

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	

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%	\$ 3,484	\$ 3,484	1
2	V	21 Office		Johs Oksnevad	100.00%	509	509	2
3	V	24 Travel and seminar		Johs Oksnevad	100.00%	141	141	3
4	V	30 Depreciation		Johs Oksnevad	100.00%	35,338	35,338	4
5	V	32 Interest		Johs Oksnevad	100.00%	59,383	59,383	5
6	V	33 Reat Estate taxes		Johs Oksnevad	100.00%	67,238	67,238	6
7	V	34 Rent-facility and grounds	247,238	Johs Oksnevad	100.00%		(247,238)	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		\$ 247,238			\$ 191,093	\$ * (56,145)	14

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

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VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Johs Oksnevad	President	Asst Administrator	100.00	0	20	50.00	Salary	\$ 25,000	L17,C8	1
2	Gordon Oksnevad	Administrator	Administrator	0.00	0	50	100.00	Salary	151,480	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	\$ 176,480		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

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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

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IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10										
										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	\$ 810,184	6/4/12	0.0695	\$ 59,383	1							
2	Avaya Financial		X	Telephone Equipment	\$1,708.31	10/06	55,765		10/09	0.1289	1,607	2							
3												3							
4												4							
5												5							
Working Capital																			
6	Johs Oksnevad	X		Working Capital	None	9/30/99	169,000	655,507	Demand	0.0600	37,225	6							
7												7							
8												8							
9	TOTAL Facility Related				\$11,708.31		\$ 1,140,152	\$ 1,465,691			\$ 98,215	9							
B. Non-Facility Related*																			
10												10							
11											(671)	11							
12											(37,225)	12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$ (37,896)	14							
15	TOTALS (line 9+line14)						\$ 1,140,152	\$ 1,465,691			\$ 60,319	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.)

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** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

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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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Resident Care</u>	<u>119,840</u>	<u>1961</u>	<u>\$ 10,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	119,840		\$ 10,000	3

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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	629	11
12		1973		201		25			201	12
13		1973		93,791		11			93,791	13
14		1973		96,886		34	2,850	2,850	90,772	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			235,818	25
26	Kitchen improvements	1989		9,541		20			9,541	26
27	Black top	1990		5,000		10			5,000	27
28	Broiler	1991		29,033		20	1,452	1,452	26,862	28
29	Lawn sprinkler	1992		5,000		15			5,000	29
30	Leasehold improvements	1993		13,972		15			13,972	30
31	Roof improvements	1994		57,648		15	1,746	1,746	57,648	31
32	Generator	1995		34,924		15	2,328	2,328	33,756	32
33	Air conditioning system	1999		280,820		15	18,721	18,721	196,571	33
34	Carpeting / flooring / wallcovering	1999		81,812		15	5,454	5,454	57,267	34
35	Parking lot lights	1999		16,900		15	1,126	1,126	11,823	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

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9/30/09**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	\$ 13,973	37
38	Parking lot	2002	42,683	2,846	15	2,846		21,345	38
39	Boiler electrical improvements	2002	11,560	578	20	578		4,335	39
40	Gazebo pad	2002	12,657	633	20	633		4,747	40
41	Painting and wallpapering hallways	2003	27,403	1,370	20	1,370		8,905	41
42	Gazebo	2003	35,825	1,792	20	1,792		11,648	42
43	Fence	2003	3,400	170	20	170		1,105	43
44	Sign	2003	1,675	84	20	84		546	44
45	Garage	2003	3,077	154	20	154		1,000	45
46	Fire alarm	2003	30,208	1,510	20	1,510		9,815	46
47	Boiler	2004	31,880	1,594	20	1,594		8,770	47
48	Sign	2004	3,487	174	20	174		957	48
49	Smoke detectors	2004	2,153	108	20	108		594	49
50	Boiler	2005	7,060	352	20	352		1,584	50
51	Commercial disposal	2005	826	42	20	42		189	51
52	Fire supression system	2005	1,866	94	20	94		423	52
53	Pond	2006	11,930	596	20	596		2,086	53
54	Fire alarm system	2006	2,738	137	20	137		479	54
55	Floor tile, baseboards	2006	5,759	288	20	288		1,008	55
56	Air conditioning	2006	13,634	682	20	682		2,387	56
57	Sidewalk	2006	1,196	60	20	60		210	57
58	Remodel grieving room	2006	2,198	110	20	110		385	58
59	Fire sprinkler system	2007	169,761	8,487	20	8,487		21,218	59
60	Nurse call system	2007	69,282	3,464	20	3,464		8,660	60
61	Remodel fireplace	2007	39,855	1,993	20	1,993		4,982	61
62	Ceiling tiles	2007	12,820	641	20	641		1,603	62
63	Drywall stairways	2007	8,000	400	20	400		1,000	63
64	20 ton rooftop unit	2007	34,100	1,705	20	1,705		4,262	64
65	Ductless heat pump	2007	7,760	388	20	388		970	65
66	Remodel fireplace	2007	6,631	332	20	332		830	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,386,638	\$ 30,784		\$ 66,122	\$ 35,338	\$ 1,777,186	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	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	
1	Totals from Page 12A, Carried Forward		\$ 2,386,638	\$ 30,784		\$ 66,122	\$ 35,338	\$ 1,777,186	1
2	Circuit panel in kitchen	2007	4,045	202	20	202		303	2
3	Replace ceiling tiles	2008	11,366	568	20	568		852	3
4	New boiler and expansion tank	2008	10,635	266	20	266		266	4
5	Nurses station	2009	12,283	307	20	307		307	5
6	Carpeting	2009	12,306	308	20	308		308	6
7	Zone controls for main rooftop unit	2009	14,640	366	20	366		366	7
8	3 garage doors	2009	3,670	92	20	92		92	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	TOTAL (lines 1 thru 33)		\$ 2,455,583	\$ 32,893		\$ 68,231	\$ 35,338	\$ 1,779,680	34

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	\$ 525,927	\$ 52,203	\$ 63,010	\$ 10,807	3-10	\$ 497,069	71
72	Current Year Purchases	15,182	1,518	1,518		5	1,518	72
73	Fully Depreciated Assets	318,391					318,391	73
74								74
75	TOTALS	\$ 859,500	\$ 53,721	\$ 64,528	\$ 10,807		\$ 816,978	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	\$ 5,311	\$ 5,311		5	\$ 53,115	76
77	Maintenance Truck	2006 GMC Sierra	2005	48,333	9,667	9,667		5	43,501	77
78	Administrative	2006 Chrysler 300	2006	24,902	4,980	4,980		5	21,266	78
79	Resident Transportation	1998 Ford Supreme Bus	1999	49,247					49,247	79
80	TOTALS			\$ 175,597	\$ 19,958	\$ 19,958			\$ 167,129	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)	\$ 3,500,680	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 106,572	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 152,717	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 46,145	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,763,787	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	N/A				88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in progress	\$ 142,049	92
93			93
94			94
95		\$ 142,049	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: 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				<u>N/A</u>			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			<u>N/A</u>		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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* 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.

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/1/08 Ending: 9/30/09
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	\$	2,019	\$ 199,959	\$	2,019	\$ 199,959	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		189	18,758		189	18,758	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		775	77,508		775	77,508	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				96		96	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			\$	2,983	\$ 296,225	\$ 96	2,983	\$ 296,321	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: 10/1/08

Ending: 9/30/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/30/09 (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	\$ (1,082)	\$ (1,082)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>30,000</u>)	900,420	900,420	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	49,478	49,478	6
7	Other Prepaid Expenses	19,542	19,542	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Cafeteria Plan</u>	37	37	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 968,395	\$ 968,395	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	670,369	2,455,583	15
16	Equipment, at Historical Cost	603,420	1,035,097	16
17	Accumulated Depreciation (book methods)	(624,490)	(2,763,787)	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 (spe (CIP))	142,049	142,049	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 791,348	\$ 878,942	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,759,743	\$ 1,847,337	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 123,878	\$ 123,878	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	81,951	81,951	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	262,181	262,181	32
33	Accrued Interest Payable	126,070	126,070	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Unemployment tax</u>	6,333	6,333	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 600,413	\$ 600,413	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	655,507	1,465,691	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)	\$ 655,507	\$ 1,465,691	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,255,920	\$ 2,066,104	46
47	TOTAL EQUITY(page 18, line 24)	\$ 503,823	\$ (218,767)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,759,743	\$ 1,847,337	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,026,480	1
2	Restatements (describe):		2
3			3
4	Prior Period adjustment	(292,644)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 733,836	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(230,013)	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)	\$ (230,013)	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)	\$ 503,823	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Alpine Fireside Health Center# 0018275Report Period Beginning: 10/1/08Ending: 9/30/09

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	\$ 4,100,557	1
2	Discounts and Allowances for all Levels	(736,005)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,364,552	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	495,638	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 495,638	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	37,394	13
14	Non-Patient Meals	11,115	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	274,987	17
18	Sale of Supplies to Non-Patients	7,112	18
19	Laboratory	14,211	19
20	Radiology and X-Ray	4,989	20
21	Other Medical Services	19,387	21
22	Laundry	9,706	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 378,901	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>	28,586	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 28,586	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,267,677	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	937,148	31
32	Health Care	1,999,375	32
33	General Administration	1,068,905	33
B. Capital Expense			
34	Ownership	392,642	34
C. Ancillary Expense			
35	Special Cost Centers	63,485	35
36	Provider Participation Fee	36,135	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,497,690	40
41	Income before Income Taxes (line 30 minus line 40)**	(230,013)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (230,013)	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
9/30/2009

Schedule 19A

E. Other Revenue (specify)
Line 28

Description	Amount
Store & Misc Sales	13,245
Interest Income	671
Petty Cash Adjustment	720
Misc. Income	<u>13,950</u>
	<u><u>28,586</u></u>

See Accountants' Compilation Report

Facility Name & ID Number Alpine Fireside Health Center

0018275

Report Period Beginning:

10/1/08

Ending:

9/30/09

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	\$ 75,397	\$ 36.25	1
2	Assistant Director of Nursing	2,553	2,657	65,496	24.65	2
3	Registered Nurses	7,369	7,521	153,843	20.46	3
4	Licensed Practical Nurses	9,386	9,735	207,279	21.29	4
5	CNAs & Orderlies	55,244	57,665	620,724	10.76	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,784	1,812	23,541	12.99	9
10	Activity Assistants	4,465	4,641	37,955	8.18	10
11	Social Service Workers	2,225	2,329	37,057	15.91	11
12	Dietician					12
13	Food Service Supervisor	2,517	2,605	26,542	10.19	13
14	Head Cook	1,929	2,161	25,739	11.91	14
15	Cook Helpers/Assistants	19,627	20,744	165,564	7.98	15
16	Dishwashers					16
17	Maintenance Workers	5,536	5,980	82,339	13.77	17
18	Housekeepers	8,213	8,781	72,316	8.24	18
19	Laundry	2,713	2,929	31,949	10.91	19
20	Administrator	2,080	2,080	151,480	72.83	20
21	Assistant Administrator	1,040	1,040	25,000	24.04	21
22	Other Administrative					22
23	Office Manager	1,495	1,717	33,639	19.59	23
24	Clerical	2,789	2,929	38,208	13.04	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,974	3,182	62,550	19.66	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care: Care Plan Coordi	1,967	2,143	50,353	23.50	32
33	Other(specify) <u>Habilitation Aide</u>	2,355	2,603	37,122	14.26	33
34	TOTAL (lines 1 - 33)	140,341	147,334	\$ 2,024,093 *	\$ 13.74	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	85	\$ 10,847	L1,C3	35
36	Medical Director	36	12,000	L9,C3	36
37	Medical Records Consultant	48	1,800	L10,C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	28	944	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	48	4,212	L11,C3	44
45	Social Service Consultant	36	1,972	L12,C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	281	\$ 31,775		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,432	\$ 57,269	L10,C3	50
51	Licensed Practical Nurses	2,430	72,888	L10,C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	3,862	\$ 130,157		53

SEE ACCOUNTANTS' COMPILATION REPORT

Alpine Fireside Health Center, Ltd.
PROVIDER # 0018275
September 30, 2009

Schedule 21A

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

<u>Name</u>	<u>Funtion</u>	<u>Ownership %</u>	<u>Amount</u>
Gordon Oksnevad	Administrator	0%	<u>151,480</u>
TOTAL (agree to Schedule V, line 17, col. 1)			
Johs Oksnevad	Assistant Administrator	100%	<u>25,000</u>
TOTAL (agree to Schedule V, line 17, col. 8)			<u>176,480</u>

Note: Assistant Administrator is brought on thru realted party transaction on page 6 of the cost report.

See Accountants' Compilation Report

Alpine Fireside Health Center, Ltd.
PROVIDER # 0018275
September 30, 2009

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
Duane Morris LLP	Legal	77,762
Williams & McCarthy	Legal	235
Reno & Zahm	Legal	2,106
RSM McGladrey	Accounting	16,358
McGladrey & Pullen	Accounting	21,645
Business Management Services	Computer Services	23,023
AAA	Computer Services	2,267
Keane Care	Computer Services	40,117
E Health Data	Computer Services	4,153
Resource Systems	Computer Services	3,560
Stanley Security Solutions	Computer Services	403
		<u>191,628</u>
TOTAL (agree to Schedule V, line 19, column 3)		<u>191,628</u>
		<u>(810)</u>
Less Out of Period Legal		<u>(810)</u>
TOTAL (agree to Schedule V, line 19, column 8)		<u>190,818</u>

See Accountants' Compilation Report

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

1	2	3	4	5	6	7	8	9	10	11	12	13								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2006	FY2007	FY2008	FY2009
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								
2																				
3							N/A													
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Alpine Fireside Health Center# 0018275Report Period Beginning: 10/1/08Ending: 9/30/09**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Health Care Assn- \$6,356
- (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. \$ 10,006 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.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 36,135
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 6,645 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 11,115
- (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
- (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.

SEE ACCOUNTANTS' COMPILATION REPORT