

Facility Name & ID Number Alpine Fireside Health Ctr

# 0018275 Report Period Beginning: 10/1/12 Ending: 9/30/13

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	<u>32</u>	Skilled (SNF)	<u>32</u>	<u>11,680</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>34</u>	Intermediate (ICF)	<u>34</u>	<u>12,410</u>	3
4		Intermediate/DD			4
5	<u>33</u>	Sheltered Care (SC)	<u>33</u>	<u>12,045</u>	5
6		ICF/DD 16 or Less			6
7	<u>99</u>	TOTALS	<u>99</u>	<u>36,135</u>	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	<u>698</u>	<u>2,381</u>	<u>5,430</u>	<u>8,509</u>	8
9	SNF/PED					9
10	ICF	<u>7,518</u>	<u>3,089</u>		<u>10,607</u>	10
11	ICF/DD					11
12	SC			<u>7,776</u>	<u>7,776</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>8,216</u>	<u>5,470</u>	<u>13,206</u>	<u>26,892</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.42%

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 3,996

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: 9/30/13 Fiscal Year: 9/30/13

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

Facility Name &amp; ID Number

Alpine Fireside Health Ctr

# 0018275

Report Period Beginning:

10/1/12

Ending:

9/30/13

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	275,159	23,184	12,826	311,169		311,169		311,169		1
2	Food Purchase		254,304		254,304		254,304	(18,109)	236,195		2
3	Housekeeping	71,672	16,292		87,964		87,964		87,964		3
4	Laundry	44,926	10,118	18,752	73,796		73,796		73,796		4
5	Heat and Other Utilities			97,567	97,567		97,567		97,567		5
6	Maintenance	88,324	91,264	48,052	227,640		227,640	2,482	230,122		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>480,081</b>	<b>395,162</b>	<b>177,197</b>	<b>1,052,440</b>		<b>1,052,440</b>	<b>(15,627)</b>	<b>1,036,813</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	1,603,708	194,528	56,455	1,854,691		1,854,691		1,854,691		10
10a	Therapy	36,816			36,816		36,816		36,816		10a
11	Activities	63,376	30,151	2,960	96,487		96,487		96,487		11
12	Social Services	62,141		3,020	65,161		65,161		65,161		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>1,766,041</b>	<b>224,679</b>	<b>80,435</b>	<b>2,071,155</b>		<b>2,071,155</b>		<b>2,071,155</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	155,831			155,831		155,831		155,831		17
18	Directors Fees										18
19	Professional Services			223,032	223,032		223,032	(21,401)	201,631		19
20	Dues, Fees, Subscriptions & Promotions			15,055	15,055		15,055	(2,307)	12,748		20
21	Clerical & General Office Expenses	87,253	32,801	58,308	178,362		178,362	(1,469)	176,893		21
22	Employee Benefits & Payroll Taxes			537,786	537,786		537,786	8,736	546,522		22
23	Inservice Training & Education			3,745	3,745		3,745		3,745		23
24	Travel and Seminar			16,533	16,533		16,533	(1,468)	15,065		24
25	Other Admin. Staff Transportation			12,589	12,589		12,589		12,589		25
26	Insurance-Prop.Liab.Malpractice			82,035	82,035		82,035		82,035		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>243,084</b>	<b>32,801</b>	<b>949,083</b>	<b>1,224,968</b>		<b>1,224,968</b>	<b>(17,909)</b>	<b>1,207,059</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,489,206</b>	<b>652,642</b>	<b>1,206,715</b>	<b>4,348,563</b>		<b>4,348,563</b>	<b>(33,536)</b>	<b>4,315,027</b>		<b>29</b>

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

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

Facility Name & ID Number Alpine Fireside Health Ctr

#0018275

Report Period Beginning:

10/1/12

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	
	<b>D. Ownership</b>											
30	Depreciation			172,891	172,891			25,724	198,615			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			100,543	100,543			(48,272)	52,271			32
33	Real Estate Taxes							67,782	67,782			33
34	Rent-Facility & Grounds			70,782	70,782			(70,782)				34
35	Rent-Equipment & Vehicles			793	793				793			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			345,009	345,009			(25,548)	319,461			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		181,715	760,224	941,939		941,939		941,939			39
40	Barber and Beauty Shops		1,242	17,504	18,746		18,746		18,746			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			147,644	147,644		147,644		147,644			42
43	Other (specify):* <b>Non-Allowable Co</b>			45,362	45,362		45,362	(45,362)				43
44	<b>TOTAL Special Cost Centers</b>		182,957	970,734	1,153,691		1,153,691	(45,362)	1,108,329			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,489,206	835,599	2,522,458	5,847,263		5,847,263	(104,446)	5,742,817			45

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

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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	(9,373)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(1,249)	30		9
10	Interest and Other Investment Income	(48,272)	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	(50)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(21,401)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(10,932)	43		24
25	Fund Raising, Advertising and Promotional	(280)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(7,747)	43		28
29	Other-Attach Schedule	(29,115)	Var.		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (128,419)		\$	30

BHF USE ONLY						
48		49		50		51
						52

**B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)**

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	23,973		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 23,973		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (104,446)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	X-Rays - Part A	\$ (9,704)	43	1
2	Labs-Part A	(16,734)	43	2
3	Income Tax/Other Taxes	(46)	43	3
4	Miscellaneous Exp/Suspense Acct.	131	43	4
5	Lobbying	(2,307)	20	5
6	Offset Miscellaneous Income	(1,469)	21	6
7	Out of state travel & seminar	(1,468)	24	7
8	Reclassified Fixed Asset Less than \$2500	2,482	6	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>		(29,115)	49

**VII. RELATED PARTIES**

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as 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:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	30 Depreciation	\$	Johs Oksnevad	100.00%	\$ 26,973	\$ 26,973	1
2	V	33 Real Estate Taxes		Johs Oksnevad	100.00%	67,782	67,782	2
3	V	34 Rent-facility and grounds	70,782	Johs Oksnevad	100.00%		(70,782)	3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 70,782			\$ 94,755	\$ * 23,973	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	Gordon Oksnevad	Administrator	Administrator	0.00	0	50	100.00	Salary	155,831	L17, C1	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 155,831		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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1			N/A		\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number

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Ending:

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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	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
<b>A. Directly Facility Related</b>																
<b>Long-Term</b>																
1	Durand State Bank		X	Working capital & impvmnts	Interest Only	06/12	\$ 997,396	\$ 1,619,985	05/05/16	0.0595	\$ 100,543					
2																
3																
4																
5																
<b>Working Capital</b>																
6																
7																
8																
9	<b>TOTAL Facility Related</b>						\$ 997,396	\$ 1,619,985			\$ 100,543					
<b>B. Non-Facility Related*</b>																
10							Offset interest against income			(48,272)						
11																
12																
13																
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (48,272)					
15	<b>TOTALS (line 9+line14)</b>						\$ 997,396	\$ 1,619,985			\$ 52,271					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A 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.)

\*\* 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**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
1. Real Estate Tax accrual used on 2012 report.			\$	<u>57,000</u>	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.)	2012		\$	<u>71,282</u>	2
3. Under or (over) accrual (line 2 minus line 1).			\$	<u>14,282</u>	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	<u>53,500</u>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	<u>67,782</u>	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2008	<u>66,238</u>	8	<b>FOR BHF USE ONLY</b>	
	2009	<u>67,815</u>	9	13	FROM R. E. TAX STATEMENT FOR 2012 \$
	2010	<u>70,985</u>	10	14	PLUS APPEAL COST FROM LINE 5 \$
	2011	<u>72,416</u>	11	15	LESS REFUND FROM LINE 6 \$
	2012	<u>71,282</u>	12	16	AMOUNT TO USE FOR RATE CALCULATION \$
<b>Accrual calculation</b>					
<b>2012 tax bill</b>	<u>71,282</u>				
<b>% Increase</b>	<u>x1.05</u>				
<b>Estimate of 2013 taxes</b>	<u>71,282 x 9/12=\$53,461. Use 53,500</u>				

**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.**

## 2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Alpine Fireside Health Ctr 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 2012 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 2012.

(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>71,281.78</u>	\$ <u>71,281.78</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>71,281.78</u></u>	\$ <u><u>71,281.78</u></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 and 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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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

Facility Name & ID Number Alpine Fireside Health Ctr

# 0018275 Report Period Beginning:

10/1/12 Ending:

9/30/13

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 40,000 B. General Construction Type: Exterior Brick Frame Concrete/Steel Number of Stories One

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)  
 List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
 If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A  
 3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs: \_\_\_\_\_  
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

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

**XI. OWNERSHIP COSTS (continued)**

**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	99	1973	1973	\$ 717,727	\$	30	\$	\$	\$ 717,727	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9		1973		1,277		10			1,277	9
10		1973		3,172		20			3,172	10
11		1973		694		40	14	14	694	11
12		1973		201		25			201	12
13		1973		93,791		11			93,791	13
14		1973		96,886		34			96,886	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	Boiler	1991		29,033		20			29,033	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			57,648	31
32	Generator	1995		34,924		15			34,924	32
33	Air conditioning system	1999		280,820		15	18,721	18,721	271,455	33
34	Carpeting / flooring / wallcovering	1999		81,812		15	5,454	5,454	79,083	34
35	Parking lot lights	1999		16,900		15	1,126	1,126	16,327	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

Facility Name &amp; ID Number Alpine Fireside Health Ctr

# 0018275

Report Period Beginning:

10/1/12

Ending:

9/30/13

## XI. OWNERSHIP COSTS (continued)

## B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	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	\$ 20,549	37
38	Parking lot	2002	42,683	1,764	15	2,846	1,082	32,729	38
39	Boiler electrical improvements	2002	11,560		20	578	578	6,647	39
40	Gazebo pad	2002	12,657	70	20	633	563	7,279	40
41	Painting and wallpapering hallways	2003	27,403	996	20	1,370	374	14,385	41
42	Gazebo	2003	35,825	1,303	20	1,792	489	18,816	42
43	Fence	2003	3,400	214	20	170	(44)	1,785	43
44	Sign	2003	1,675	82	20	84	2	882	44
45	Garage	2003	3,077	152	20	154	2	1,616	45
46	Fire alarm	2003	30,208		20	1,510	1,510	15,855	46
47	Boiler	2004	31,880	1,054	20	1,594	540	15,146	47
48	Sign	2004	3,487	127	20	174	47	1,653	48
49	Smoke detectors	2004	2,153		20	108	108	1,026	49
50	Boiler	2005	7,060	257	20	352	95	2,992	50
51	Commercial disposal	2005	826		20	42	42	357	51
52	Fire supression system	2005	1,866	68	20	94	26	799	52
53	Pond	2006	11,930	796	20	596	(200)	4,470	53
54	Fire alarm system	2006	2,738	99	20	137	38	1,027	54
55	Floor tile, baseboards	2006	5,759	209	20	288	79	2,160	55
56	Air conditioning	2006	13,634	496	20	682	186	5,115	56
57	Sidewalk	2006	1,196	80	20	60	(20)	450	57
58	Remodel grieving room	2006	2,198	80	20	110	30	825	58
59	Fire sprinkler system	2007	169,761	6,173	20	8,487	2,314	55,166	59
60	Nurse call system	2007	69,282	954	20	3,464	2,510	22,516	60
61	Remodel fireplace	2007	39,855	1,449	20	1,993	544	12,954	61
62	Ceiling tiles	2007	12,820	466	20	641	175	4,167	62
63	Drywall stairways	2007	8,000	291	20	400	109	2,600	63
64	20 ton rooftop unit	2007	34,100	1,240	20	1,705	465	11,082	64
65	Ductless heat pump	2007	7,760	282	20	388	106	2,522	65
66	Remodel fireplace	2007	6,631	241	20	332	91	2,158	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,386,638	\$ 18,943		\$ 57,743	\$ 38,800	\$ 2,017,620	70

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

Facility Name &amp; ID Number Alpine Fireside Health Ctr

# 0018275

Report Period Beginning:

10/1/12

Ending:

9/30/13

**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 2,386,638	\$ 18,943		\$ 57,743	\$ 38,800	\$ 2,017,620	1
2	Circuit panel in kitchen	2007	4,045	147	20	202	55	1,111	2
3	Replace ceiling tiles	2008	11,366	413	20	568	155	3,124	3
4	New boiler and expansion tank	2008	10,635	387	20	532	145	2,394	4
5	Nurses station	2009	12,283	447	20	614	167	2,763	5
6	Carpeting	2009	12,306		20	615	615	2,768	6
7	Zone controls for main rooftop unit	2009	14,640	532	20	732	200	3,294	7
8	3 garage doors	2009	3,670	133	20	184	51	828	8
9									9
10	Basement A/C	2010	13,395	1,527	20	670	(857)	2,345	10
11	200 AMP Breaker/Conduit	2010	12,426	452	20	621	169	2,174	11
12	Drywall/Ceiling Tile/Metal Grid for Pt Rooms & Hallway	2010	10,563	384	20	528	144	1,848	12
13	Repl Hot Water Holding Tank	2010	5,269	192	20	263	71	921	13
14	Roofer Sealer Paint	2010	9,085	927	20	454	(473)	1,589	14
15	Driveway Sealer Coat	2010	10,608	471	20	530	59	1,855	15
16	Transfer Switch in Kohler Cabinet	2010	3,669	286	20	183	(103)	641	16
17	New Addition - Activity Room	2010	2,953	107	20	148	41	518	17
18									18
19									19
20	Windows	2011	42,307	1,538	20	2,115	577	5,288	20
21	Wanderguard	2011	113,678	4,134	20	5,684	1,550	14,210	21
22	Stove Hood	2011	40,750	1,482	20	2,038	556	5,094	22
23	Kitchen Air Conditioning	2011	36,470	1,326	20	1,824	498	4,559	23
24	Rooftop A/C Unit	2011	5,995	218	20	300	82	749	24
25	Water Cooler Coil on Heat Pump	2011	9,675	352	20	484	132	1,209	25
26	New Interior Paint front door	2011	4,104	149	20	205	56	513	26
27									27
28	Therapy Room Addition : framing, drywall, electrical, HVAC,	2011	619,228	26,102	20	30,961	4,859	46,442	28
29	flooring, paint, architect services, etc.								29
30	Generator	2011	168,336	4,336	20	8,417	4,081	12,625	30
31	New Front Door	2012	4,385	86	20	219	133	329	31
32	2 Pressure Tanks & 2 Ductless Heat Pumps for new Laundry Area	2012	14,160	94	20	708	614	1,062	32
33	Replace Glass in Windows in Offices, Dining Room & Lobby	2012	7,236	11	20	362	351	543	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,589,875	\$ 65,176		\$ 117,903	\$ 52,727	\$ 2,138,416	34

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

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

# **0018275**

Report Period Beginning:

10/1/12

Ending:

9/30/13

**XI. OWNERSHIP COSTS (continued)**

**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 3,589,875	\$ 65,176		\$ 117,903	\$ 52,727	\$ 2,138,416	1
2	<b>Countertop in Therapy Room</b>	2013	5,645	60	20	141	81	141	2
3									3
4									4
5									5
6	<b>To tie book depreciation to financials</b>			29,729			(29,729)		6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,595,520	\$ 94,965		\$ 118,044	\$ 23,079	\$ 2,138,557	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 1,116,646	\$ 13,623	\$ 53,024	\$ 39,401		\$ 1,088,081	71
72	Current Year Purchases	25,619	25,619	2,562	(23,057)		2,562	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,142,265	\$ 39,242	\$ 55,586	\$ 16,344		\$ 1,090,643	75

D. Vehicle Costs. (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	Totals from Sch 13A	Various		\$ 307,298	\$ 38,684	\$ 24,923	\$ (13,761)	5	\$ 192,299	76
77										77
78										78
79										79
80	TOTALS			\$ 307,298	\$ 38,684	\$ 24,923	\$ (13,761)		\$ 192,299	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)	\$ 5,055,083	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 172,891	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 198,553	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 25,662	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,421,499	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	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	92
93			93
94			94
95		\$	95

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

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

## STATE OF ILLINOIS

Sch 13A

Facility Name &amp; ID Number

Alpine Fireside Health Center, Ltd.

#

0018275

Report Period Beginning:

10/1/2012 to 9/30/2013

## 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
Administrative	2004 Yukon	2004	\$ 53,115	\$ 0	\$ 0	\$ 0	5	\$ 53,115
Maintenance Truck	2006 GMC Sierra	2005	48,333	0	0	0	5	43,501
Resident Transportation	1998 Ford Supreme Bus	1999	49,247	0	0	0	5	49,247
Dump Trailer for Tractor	2010	2010	2,817	193	564	371	5	1,974
Administrative	2011 Dodge Challenger	2011	55,605		11,121	11,121	5	27,804
Administrative	2011 Toyota Rav 4	2011	34,200	4,900	6,840	1,940	5	10,260
Administrative	GMC Denely	2013	63,981	33,591	6,398	(27,193)	5	6,398
<b>TOTALS</b>			\$ 307,298	\$ 38,684	\$ 24,923	\$ (13,761)		\$ 192,299

Facility Name & ID Number Alpine Fireside Health Ctr

# 0018275

Report Period Beginning: 10/1/12

Ending: 9/30/13

**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:				\$ <u>N/A</u>			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending	Annual Rent
--------------------	-------------

12. \_\_\_\_\_ /2014 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2015 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2016 \$ \_\_\_\_\_

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: \$ 793 Description: Equipment Rental

(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			\$ <u>N/A</u>	\$	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	21

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

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

Facility Name & ID Number Alpine Fireside Health Ctr # 0018275 Report Period Beginning: 10/1/12 Ending: 9/30/13  
**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS** (See instructions.)

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
10	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**

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	39(3)	hrs	\$	5,944	\$	427,962	\$	5,944	\$	427,962	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		388		27,918		388		27,918	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39(3)	hrs		4,227		304,344		4,227		304,344	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 prescrpts					181,715			181,715	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	<b>TOTAL</b>			\$	10,559	\$	760,224	\$	181,715	\$	941,939	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.

Facility Name & ID Number Alpine Fireside Health Ctr # 0018275 Report Period Beginning: 10/1/12 Ending: 9/30/13  
 XV. BALANCE SHEET - Unrestricted Operating Fund. As of 9/30/13 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 52,403	\$ 52,403	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>115,543</u> )	1,865,612	1,865,612	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	77,263	77,263	6
7	Other Prepaid Expenses	32,268	32,268	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Cafeteria Plan</u>	1,111	1,111	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,028,657	\$ 2,028,657	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		10,000	13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,808,102	3,595,520	15
16	Equipment, at Historical Cost	728,752	1,449,563	16
17	Accumulated Depreciation (book methods)	(861,373)	(3,421,500)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs	3,915	3,915	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,679,396	\$ 1,637,498	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,708,053	\$ 3,666,155	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 188,337	\$ 188,337	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	129,753	129,753	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	53,500	53,500	32
33	Accrued Interest Payable	4,300	4,300	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>See Schedule 17A</u>	275,919	275,919	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 651,809	\$ 651,809	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	1,619,985	1,619,985	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 1,619,985	\$ 1,619,985	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,271,794	\$ 2,271,794	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,436,259	\$ 1,394,361	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,708,053	\$ 3,666,155	48

\*(See instructions.)

Alpine Fireside Health Center, Ltd.  
Provider # 0018275  
9/30/2013

Schedule 17A

E. Other Current Liability (specify)  
Line 36

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
State Unemployment	10,615	10,615
Federal Unemployment	392	392
Accrued Rent	217,026	217,026
Illinois Bed Tax	47,886	47,886
	<u>275,919</u>	<u>275,919</u>

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,034,852</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>1,034,852</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	401,407	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>401,407</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,436,259</b>	<b>24</b> *

\* This must agree with page 17, line 47.

**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		
I. Revenue		Amount		
<b>A. Inpatient Care</b>				
1	Gross Revenue -- All Levels of Care	\$ 4,976,932	1	
2	Discounts and Allowances for all Levels	(456,855)	2	
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 4,520,077</b>	3	
<b>B. Ancillary Revenue</b>				
4	Day Care		4	
5	Other Care for Outpatients		5	
6	Therapy	1,403,179	6	
7	Oxygen		7	
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 1,403,179</b>	8	
<b>C. Other Operating Revenue</b>				
9	Payments for Education		9	
10	Other Government Grants		10	
11	CNA Training Reimbursements		11	
12	Gift and Coffee Shop		12	
13	Barber and Beauty Care	35,543	13	
14	Non-Patient Meals	9,373	14	
15	Telephone, Television and Radio		15	
16	Rental of Facility Space		16	
17	Sale of Drugs	173,262	17	
18	Sale of Supplies to Non-Patients		18	
19	Laboratory	8,639	19	
20	Radiology and X-Ray	6,996	20	
21	Other Medical Services	21,820	21	
22	Laundry	11,663	22	
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 267,296</b>	23	
<b>D. Non-Operating Revenue</b>				
24	Contributions		24	
25	Interest and Other Investment Income***	48,272	25	
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 48,272</b>	26	
<b>E. Other Revenue (specify):****</b>				
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27	
28	<u>See Schedule 19A</u>	9,846	28	
28a			28a	
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 9,846</b>	29	
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 6,248,670</b>	30	

		2		
II. Expenses		Amount		
<b>A. Operating Expenses</b>				
31	General Services	1,052,440	31	
32	Health Care	2,071,155	32	
33	General Administration	1,224,968	33	
<b>B. Capital Expense</b>				
34	Ownership	345,009	34	
<b>C. Ancillary Expense</b>				
35	Special Cost Centers	1,006,047	35	
36	Provider Participation Fee	147,644	36	
<b>D. Other Expenses (specify):</b>				
37			37	
38			38	
39			39	
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 5,847,263</b>	40	
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>401,407</b>	41	
42	<b>Income Taxes</b>		42	
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 401,407</b>	43	

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,430,711	44
45	Private Pay - Net Inpatient Revenue	605,867	45
46	Medicare - Net Inpatient Revenue	1,306,608	46
47	Other-(specify) <u>Shelter Care</u>	1,176,891	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$ 4,520,077</b>	49

\* 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.

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

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

\*\*\*\*\* - Tax return is prepared on cash basis of accounting.

Alpine Fireside Health Center, Ltd.  
Provider # 0018275  
9/30/2013

Schedule 19A

E. Other Revenue (specify)  
Line 28

<u>Description</u>	<u>Amount</u>
Store & Misc Sales	8,404
Misc Income	1,469
Petty Cash Adjustment	<u>(27)</u>
	<u><b>9,846</b></u>

Facility Name & ID Number Alpine Fireside Health Ctr  
 XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)  
 (This schedule must cover the entire reporting period.)

# 0018275

Report Period Beginning:

10/1/12

Ending:

9/30/13

	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	\$ 77,563	\$ 37.29	1
2	Assistant Director of Nursing	2,715	2,851	94,124	33.01	2
3	Registered Nurses	12,725	13,242	366,107	27.65	3
4	Licensed Practical Nurses	10,955	11,584	261,863	22.61	4
5	CNAs & Orderlies	59,436	62,009	690,039	11.13	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,165	2,365	36,816	15.57	8
9	Activity Director	1,916	1,996	24,205	12.13	9
10	Activity Assistants	4,409	4,561	39,171	8.59	10
11	Social Service Workers	3,669	3,837	62,141	16.20	11
12	Dietician					12
13	Food Service Supervisor	2,407	2,567	33,895	13.20	13
14	Head Cook	4,394	7,733	74,164	9.59	14
15	Cook Helpers/Assistants	18,847	19,467	167,100	8.58	15
16	Dishwashers					16
17	Maintenance Workers	4,934	5,334	88,324	16.56	17
18	Housekeepers	8,091	8,467	71,672	8.46	18
19	Laundry	3,127	3,295	44,926	13.63	19
20	Administrator	2,080	2,080	155,831	74.92	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,247	2,439	48,847	20.03	23
24	Clerical	2,517	2,621	38,406	14.65	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,879	3,111	66,454	21.36	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care: <u>Care Plan Coordin</u>	1,479	1,615	47,558	29.45	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	153,072	163,254	\$ 2,489,206 *	\$ 15.25	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	267	\$ 12,826	L1,C3	35
36	Medical Director	Monthly	18,000	L9,C3	36
37	Medical Records Consultant	24	2,827	L10,C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,415	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	49	2,960	L11,C3	44
45	Social Service Consultant	50	3,020	L12,C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	390	\$ 44,048		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$		50
51	Licensed Practical Nurses		N/A		51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Gordon Oksnevad	Administrator	0	\$ 155,831	Workers' Compensation Insurance	\$ 109,073	IDPH License Fee	\$	
				Unemployment Compensation Insurance	70,937	Advertising: Employee Recruitment	2,707	
				FICA Taxes	178,612	Health Care Worker Background Check	205	
				Employee Health Insurance	143,560	(Indicate # of checks performed _____)		
				Employee Meals	8,736	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Illinois Health Care Association	5,940	
				401 K	26,851	Rockford Register & City of Rockford	812	
				Uniforms	1,402	Miscellaneous Dues & Subscriptions		
				Pre-Employment Physicals	7,351	Miscellaneous License	5,391	
						Lobbying Expense	(2,307)	
						Less: Public Relations Expense	( )	
						Non-allowable advertising	( )	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
\$ 155,831				\$ 546,522			\$ 12,748	
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	
\$				\$			15,065	
C. Professional Services							Entertainment Expense	
Vendor/Payee	Type	Amount					( )	
See Schedule 21C		\$ 201,631					TOTAL (agree to Sch. V, line 24, col. 8)	
							\$ 15,065	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				TOTAL				
\$ 201,631				\$				

\* Attach copy of IMRF notifications

\*\*See instructions.

Alpine Fireside Health Center, Ltd.  
PROVIDER # 0018275  
9/30/13

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
Duane Morris LLP	Legal	89,030
Reno & Zahm	Legal	8,992
McGladrey LLP	Accounting	44,687
3 Cubed, Inc.	Computer Services	48,326
NTT Data Long Term Care Solutions	Computer Services	23,708
E Health Data	Computer Services	3,357
Cerner Corp	Computer Services	4,373
Cristensen Comp	Computer Services	379
Nebo System	Computer Services	<u>180</u>
<b>TOTAL (agree to Schedule V, line 19, column 3)</b>		<b><u>223,032</u></b>
Out of period legal		21,401
<b>TOTAL (agree to Schedule V, line 19, column 8)</b>		<b><u>201,631</u></b>

Alpine Fireside Health Center, Ltd.  
 PROVIDER # 0018275  
 9/30/13

Alpine Fireside Health Center					
Travel & Seminars	Provider I.D.	18275 Year End	9/30/2013		
Person Attending	Title	Dates	Location	Title / Sponsor	Cost
Gordon Oksnevad	Adm	9/9-9/12/13	Peoria	IHCA Annual Convention	607.02
Audra Johnson	DON	9/9-9/12/13	Peoria	IHCA Annual Convention	607.02
Krissy Frank	S.S.	9/9-9/12/13	Peoria	IHCA Annual Convention	607.02
Connie Reinert	CPC	9/9-9/12/13	Peoria	IHCA Annual Convention	607.02
Fiona Okoroti	Medicare	9/9-9/12/13	Peoria	IHCA Annual Convention	607.02
Michelle Cruden	Admission	9/9-9/12/13	Peoria	IHCA Annual Convention	607.02
Kim Klinger	Activity	9/9-9/12/13	Peoria	IHCA Annual Convention	607.02
Darija Kostovki	Office	9/9-9/12/13	Peoria	IHCA Annual Convention	607.02
Peter Daughty	Dietary	9/9-9/12/13	Peoria	IHCA Annual Convention	607.02
Ketut Setiawan	Maint	9/9-9/12/13	Peoria	IHCA Annual Convention	607.02
Star McClintock	ADON	9/9-9/12/13	Peoria	IHCA Annual Convention	607.02
Lori Thurman	CNA	9/9-9/12/13	Peoria	IHCA Annual Convention	607.02
Dennis Miller	Activity	9/9-9/12/13	Peoria	IHCA Annual Convention	607.02
Amber Dietery	Dietary	9/9-9/12/13	Peoria	IHCA Annual Convention	607.02
Pattie Bishop	S.S.	9/9-9/12/13	Peoria	IHCA Annual Convention	607.02
Gordon Oksnevad	Administrator	10/10-12/12	Springfield	IDPH	311.36
Audra Johnson	DON	11/14/2012	Alsip	ICLTC - New OBRA Feeding Tubes	165.00
Gordon Oksnevad	Administrator	11/20/2012	Webinar	IHCA - Managed Care	75.00
Gordon Oksnevad	Administrator	2/6/2013	Springfield	IHCA - Compliance Plans	95.00
Star McClintock	ADON	2/28/2013	Skokie	ICLTC - New OBRA Guidelines	645.00
Audra Johnson	DON	2/28/2013	Skokie	ICLTC - New OBRA Guidelines	645.00
Star McClintock	ADON	3/20/2013	Missouri	Cerner	454.40
Audra Johnson	DON	3/20/2013	Missouri	Cerner	454.40
Audra Johnson	DON	4/18/13	Springfield	IHCA	295.66
Star McClintock	ADON	4/18/13	Springfield	IHCA	295.66
Connie Reinert	MDS	4/18/13	Springfield	IHCA	295.66
Fiona Okoroti	Medicare	4/18/13	Springfield	IHCA	295.66
Gordon Oksnevad	Administrator	6/27/13	Springfield	IDPH	654.20
Gordon Oksnevad	Administrator	7/9/13	Cleveland	EHealthDataSolution	559.02
Alex Flodin	CPC	7/16/13	Skokie	IHCA - HIPPA Update	271.25
Audra Johnson	DON	7/16/13	Skokie	IHCA - HIPPA Update	271.25

FALSE  
 FALSE

FALSE

Star McClintock	ADON	7/16/13	Skokie	IHCA - HIPPA Update	271.25
Connie Reinert	CPC	7/16/13	Skokie	IHCA - HIPPA Update	271.25
Fiona Okoroti	Medicare	7/23/13	Skokie	IHCA - Wound Care Nurses	195.00
Alex Flodin	CPC	7/23/13	Skokie	IHCA - Wound Care Nurses	195.00
Gordon Oksnevad	Administrator	7/31/13	Skokie	IHCA - RUG 48	105.00
Alex Flodin	CPC	7/31/13	Skokie	IHCA - RUG 48	105.00
Gordon Oksnevad	Administrator	8/12/13	Lisle	IDPH	109.89
Gordon Oksnevad	Administrator	8/21/13	Lisle	IHCA	130.60
Krissy Frank	S.S.	8/21/13	Lisle	IHCA	130.60
Peter Daughy	Dietary	8/21/13	Lisle	IHCA	130.59

Run the AP and GL for 8676 Seminars

16,533

1,468

Balance per gl - 9/30/13

15,065

**To Pg 21 Sec G**

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3										N/A		
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Alpine Fireside Health Ctr# 0018275

Report Period Beginning:

10/1/12

Ending:

9/30/13**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. Illinois Health Care Assn-\$5,940
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 5 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 10,472 Line 10(2)
- (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. \$ 147,644  
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. \$ 8,736 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 9,373
- (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.