

Facility Name & ID Number Alpine Fireside Health Ctr

0018275 Report Period Beginning: 10/1/2013 Ending: 9/30/2014

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	92	1,220	4,820	6,132	8
9	SNF/PED					9
10	ICF	6,822	2,069		8,891	10
11	ICF/DD					11
12	SC			7,887	7,887	12
13	DD 16 OR LESS					13
14	TOTALS	6,914	3,289	12,707	22,910	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.40%

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

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 1973

J. Was the facility purchased or leased after January 1, 1978?

YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 32 and days of care provided 4,820

Medicare Intermediary

National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 9/30/14 Fiscal Year: 9/30/14

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

Facility Name & ID Number

Alpine Fireside Health Ctr

0018275

Report Period Beginning:

10/1/2013

Ending:

9/30/2014

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	281,766	17,692	15,101	314,559		314,559	314,559		1	
2	Food Purchase		253,019		253,019		253,019	(18,942)	234,077	2	
3	Housekeeping	75,175	21,176		96,351		96,351	96,351		3	
4	Laundry	46,872	12,009	23,026	81,907		81,907	81,907		4	
5	Heat and Other Utilities			107,615	107,615		107,615	107,615		5	
6	Maintenance	97,732	80,846	40,000	218,578		218,578	218,578		6	
7	Other (specify):*									7	
8	TOTAL General Services	501,545	384,742	185,742	1,072,029		1,072,029	(18,942)	1,053,087	8	
	B. Health Care and Programs										
9	Medical Director			18,000	18,000		18,000	18,000		9	
10	Nursing and Medical Records	1,664,139	141,200	4,740	1,810,079		1,810,079	1,810,079		10	
10a	Therapy	36,146			36,146		36,146	36,146		10a	
11	Activities	67,394	23,595	2,888	93,877		93,877	93,877		11	
12	Social Services	68,075		3,128	71,203		71,203	71,203		12	
13	CNA Training									13	
14	Program Transportation									14	
15	Other (specify):*									15	
16	TOTAL Health Care and Programs	1,835,754	164,795	28,756	2,029,305		2,029,305	2,029,305		16	
	C. General Administration										
17	Administrative	156,429			156,429		156,429	156,429		17	
18	Directors Fees									18	
19	Professional Services			239,572	239,572		239,572	(8,491)	231,081	19	
20	Dues, Fees, Subscriptions & Promotions			10,814	10,814		10,814	(2,613)	8,201	20	
21	Clerical & General Office Expenses	84,051	32,995	48,025	165,071		165,071	(1,425)	163,646	21	
22	Employee Benefits & Payroll Taxes			478,754	478,754		478,754	11,004	489,758	22	
23	Inservice Training & Education									23	
24	Travel and Seminar			16,165	16,165		16,165	(7,366)	8,799	24	
25	Other Admin. Staff Transportation			6,993	6,993		6,993	6,993		25	
26	Insurance-Prop.Liab.Malpractice			97,891	97,891		97,891	97,891		26	
27	Other (specify):*									27	
28	TOTAL General Administration	240,480	32,995	898,214	1,171,689		1,171,689	(8,891)	1,162,798	28	
29	TOTAL Operating Expense (sum of lines 8, 19 & 28)	2,577,779	582,532	1,112,712	4,273,023		4,273,023	(27,833)	4,245,190	29	

*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.

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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			164,895	164,895		164,895	882	165,777			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			102,211	102,211		102,211	(43,914)	58,297			32
33	Real Estate Taxes							85,486	85,486			33
34	Rent-Facility & Grounds			88,486	88,486		88,486	(88,486)				34
35	Rent-Equipment & Vehicles			135	135		135		135			35
36	Other (specify):*											36
37	TOTAL Ownership			355,727	355,727		355,727	(46,032)	309,695			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		176,940	1,024,496	1,201,436		1,201,436		1,201,436			39
40	Barber and Beauty Shops		1,064	13,806	14,870		14,870		14,870			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			101,272	101,272		101,272		101,272			42
43	Other (specify):* Non-Allowable Co			114,293	114,293		114,293	(114,293)				43
44	TOTAL Special Cost Centers		178,004	1,253,867	1,431,871		1,431,871	(114,293)	1,317,578			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,577,779	760,536	2,722,306	6,060,621		6,060,621	(188,158)	5,872,463			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	(7,938)	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	(13,429)	30		9
10	Interest and Other Investment Income	(43,914)	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	(8,491)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(72,225)	43		24
25	Fund Raising, Advertising and Promotional	(899)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(6,881)	43		28
29	Other-Attach Schedule See Page 5A	(45,692)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (199,469)		\$	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)	11,311		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 11,311		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (188,158)		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

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	X-Rays - Part A	\$ (9,765)	43	1
2	Labs-Part A	(23,805)	43	2
3	Income Tax/Other Taxes	(787)	43	3
4	Miscellaneous Exp/Suspense Acct.	69	43	4
5	Lobbying	(2,613)	20	5
6	Offset Miscellaneous Income	(1,425)	21	6
7	Out of state travel & seminar	(7,366)	24	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(45,692)	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	Real estate lessor

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
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%	\$ 14,311	\$ 14,311	1
2	V	33 Real Estate Taxes		Johs Oksnevad	100.00%	85,486	85,486	2
3	V	34 Rent-facility and grounds	88,486	Johs Oksnevad	100.00%		(88,486)	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		\$ 88,486			\$ 99,797	\$ * 11,311	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	\$ 156,429	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	\$ 156,429		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					\$	\$		\$	1
2									2
3		N/A							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

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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**					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	Interest Only	06/12	\$ 997,396	\$ 1,819,783	05/05/16	0.0595	\$ 102,211	1					
2												2					
3												3					
4												4					
5												5					
Working Capital																	
6												6					
7												7					
8												8					
9	TOTAL Facility Related						\$ 997,396	\$ 1,819,783			\$ 102,211	9					
B. Non-Facility Related*																	
10							Offset Interest Income Against Expense				(43,914)	10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$ (43,914)	14					
15	TOTALS (line 9+line14)						\$ 997,396	\$ 1,819,783			\$ 58,297	15					

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

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																	
1. Real Estate Tax accrual used on 2013 report.			\$	<u>53,500</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.)	2013		\$	<u>77,786</u>	2														
3. Under or (over) accrual (line 2 minus line 1).			\$	<u>24,286</u>	3														
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	<u>61,200</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. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5														
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6														
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	<u>85,486</u>	7														
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2009	<u>67,815</u>	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2013 \$ _____</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$ _____</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$ _____</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$ _____</td> <td style="text-align: center;">16</td> </tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2013 \$ _____	13	14	PLUS APPEAL COST FROM LINE 5 \$ _____	14	15	LESS REFUND FROM LINE 6 \$ _____	15	16	AMOUNT TO USE FOR RATE CALCULATION \$ _____	16
FOR BHF USE ONLY																			
13	FROM R. E. TAX STATEMENT FOR 2013 \$ _____	13																	
14	PLUS APPEAL COST FROM LINE 5 \$ _____	14																	
15	LESS REFUND FROM LINE 6 \$ _____	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$ _____	16																	
	2010	<u>70,985</u>	9																
	2011	<u>72,416</u>	10																
	2012	<u>71,282</u>	11																
	2013	<u>77,786</u>	12																
Accrual calculation																			
2013 tax bill	<u>77,786</u>																		
% Increase	<u>x1.05</u>																		
Estimate of 2014 taxes	<u>81,675 x 9/12=\$61,256. Use 61,200</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.

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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.**

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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 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:

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>	1
2					2
3	TOTALS	119,840		\$ 10,000	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
Improvement Type**										
9		1973		1,277		10			1,277	9
10		1973		3,172		20			3,172	10
11		1973		694		40			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	9,365	9,365	280,820	33
34	Carpeting / flooring / wallcovering	1999		81,812		15	2,729	2,729	81,812	34
35	Parking lot lights	1999		16,900		15	573	573	16,900	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 & ID Number Alpine Fireside Health Ctr

0018275

Report Period Beginning:

10/1/2013

Ending:

9/30/2014

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	\$ 22,193	37
38	Parking lot	2002	42,683	1,764	15	2,846	1,082	35,575	38
39	Boiler electrical improvements	2002	11,560		20	578	578	7,225	39
40	Gazebo pad	2002	12,657	70	20	633	563	7,912	40
41	Painting and wallpapering hallways	2003	27,403	996	20	1,370	374	15,755	41
42	Gazebo	2003	35,825	1,303	20	1,792	489	20,608	42
43	Fence	2003	3,400	214	20	170	(44)	1,955	43
44	Sign	2003	1,675	82	20	84	2	966	44
45	Garage	2003	3,077	152	20	154	2	1,770	45
46	Fire alarm	2003	30,208		20	1,510	1,510	17,365	46
47	Boiler	2004	31,880	1,054	20	1,594	540	16,740	47
48	Sign	2004	3,487	127	20	174	47	1,827	48
49	Smoke detectors	2004	2,153		20	108	108	1,134	49
50	Boiler	2005	7,060	257	20	352	95	3,344	50
51	Commercial disposal	2005	826		20	42	42	399	51
52	Fire supression system	2005	1,866	68	20	94	26	893	52
53	Pond	2006	11,930	796	20	596	(200)	5,066	53
54	Fire alarm system	2006	2,738	99	20	137	38	1,164	54
55	Floor tile, baseboards	2006	5,759	209	20	288	79	2,448	55
56	Air conditioning	2006	13,634	496	20	682	186	5,797	56
57	Sidewalk	2006	1,196	80	20	60	(20)	510	57
58	Remodel grieving room	2006	2,198	80	20	110	30	935	58
59	Fire sprinkler system	2007	169,761	6,173	20	8,487	2,314	63,653	59
60	Nurse call system	2007	69,282	954	20	3,464	2,510	25,980	60
61	Remodel fireplace	2007	39,855	1,449	20	1,993	544	14,947	61
62	Ceiling tiles	2007	12,820	466	20	641	175	4,808	62
63	Drywall stairways	2007	8,000	291	20	400	109	3,000	63
64	20 ton rooftop unit	2007	34,100	1,240	20	1,705	465	12,787	64
65	Ductless heat pump	2007	7,760	282	20	388	106	2,910	65
66	Remodel fireplace	2007	6,631	241	20	332	91	2,490	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,386,638	\$ 18,943		\$ 45,095	\$ 26,152	\$ 2,062,715	70

**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:

10/1/2013

Ending:

9/30/2014

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	
	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	\$ 18,943		\$ 45,095	\$ 26,152	\$ 2,062,715	1
2	Circuit panel in kitchen	2007	4,045	147	20	202	55	1,313	2
3	Replace ceiling tiles	2008	11,366	413	20	568	155	3,692	3
4	New boiler and expansion tank	2008	10,635	387	20	532	145	2,926	4
5	Nurses station	2009	12,283	447	20	614	167	3,377	5
6	Carpeting	2009	12,306		20	615	615	3,383	6
7	Zone controls for main rooftop unit	2009	14,640	532	20	732	200	4,026	7
8	3 garage doors	2009	3,670	133	20	184	51	1,012	8
9									9
10	Basement A/C	2010	13,395	1,527	20	670	(857)	3,015	10
11	200 AMP Breaker/Conduit	2010	12,426	452	20	621	169	2,795	11
12	Drywall/Ceiling Tile/Metal Grid for Pt Rooms & Hallway	2010	10,563	384	20	528	144	2,376	12
13	Repl Hot Water Holding Tank	2010	5,269	192	20	263	71	1,184	13
14	Roofer Sealer Paint	2010	9,085	927	20	454	(473)	2,043	14
15	Driveway Sealer Coat	2010	10,608	471	20	530	59	2,385	15
16	Transfer Switch in Kohler Cabinet	2010	3,669	286	20	183	(103)	824	16
17	New Addition - Activity Room	2010	2,953	107	20	148	41	666	17
18									18
19									19
20	Windows	2011	42,307	1,538	20	2,115	577	7,404	20
21	Wanderguard	2011	113,678	4,134	20	5,684	1,550	19,894	21
22	Stove Hood	2011	40,750	1,482	20	2,038	556	7,131	22
23	Kitchen Air Conditioning	2011	36,470	1,326	20	1,824	498	6,382	23
24	Rooftop A/C Unit	2011	5,995	218	20	300	82	1,049	24
25	Water Cooler Coil on Heat Pump	2011	9,675	352	20	484	132	1,693	25
26	New Interior Paint front door	2011	4,104	149	20	205	56	718	26
27									27
28	Therapy Room Addition : framing, drywall, electrical, HVAC,	2011	619,228	26,102	20	30,961	4,859	77,404	28
29	flooring, paint, architect services, etc.								29
30	Generator	2011	168,336	4,336	20	8,417	4,081	21,042	30
31	New Front Door	2012	4,385	86	20	219	133	548	31
32	2 Pressure Tanks & 2 Ductless Heat Pumps for new Laundry Area	2012	14,160	94	20	708	614	1,770	32
33	Replace Glass in Windows in Offices, Dining Room & Lobby	2012	7,236	11	20	362	351	905	33
34	TOTAL (lines 1 thru 33)		\$ 3,589,875	\$ 65,176		\$ 105,255	\$ 40,079	\$ 2,243,671	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:

10/1/2013

Ending:

9/30/2014

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	Totals from Page 12B, Carried Forward		\$ 3,589,875	\$ 65,176		\$ 105,255	\$ 40,079	\$ 2,243,671	1
2	Countertop in Therapy Room	2013	5,645	282	20	282	0	422	2
3									3
4									4
5									5
6	To tie book depreciation to financials			27,127			(27,127)		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	TOTAL (lines 1 thru 33)		\$ 3,595,520	\$ 92,585		\$ 105,537	\$ 12,952	\$ 2,244,094	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	\$ 792,354	\$ 40,399	\$ 28,430	\$ (11,969)	5	\$ 769,162	71
72	Current Year Purchases	4,895	589	489	(100)	5	489	72
73	Fully Depreciated Assets	349,911					349,911	73
74								74
75	TOTALS	\$ 1,147,160	\$ 40,988	\$ 28,919	\$ (12,069)		\$ 1,119,562	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	\$ 31,322	\$ 31,321	\$ (1)	5	\$ 223,620	76
77										77
78										78
79										79
80	TOTALS			\$ 307,298	\$ 31,322	\$ 31,321	\$ (1)		\$ 223,620	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)	\$ 5,059,978	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 164,895	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 165,777	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 882	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,587,276	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.

Facility Name: Alpine Fireside Health Ctr
IDPH License ID Number: 0018275
Fiscal Year End: 9/30/2014

Schedule 13A

XI. Ownership Costs
Line 79 - Vehicle Depreciation

Use	Model, Make & Year	Year Acquired	Cost	Current Book	Straight Line	Adjustments	Life in	Accumulated
				Depreciation	Depreciation		Years	Depreciation
Administrative	2004 Yukon	2004	53,115	0	0	-	5	53,115
Maintenance Truck	2006 GMC Sierra	2005	48,333	0	0	-	5	43,501
Resident Transportation	1998 Ford Supreme Bus	1999	49,247	0	0	-	5	49,247
Dump Trailer for Tractor	2010	2010	2,817	564	564	-	5	2,538
Administrative	2011 Dodge Challenger	2011	55,605	11,122	11,121	(1)	5	38,925
Administrative	2011 Toyota Rav 4	2011	34,200	6,840	6,840	-	5	17,100
Administrative	GMC Denali	2013	63,981	12,796	12,796	-	5	19,194
						-		
						-		
						-		
						-		
						-		
TOTAL			307,298	31,322	31,321	(1)		223,620

Facility Name & ID Number Alpine Fireside Health Ctr

0018275

Report Period Beginning: 10/1/2013

Ending: 9/30/2014

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	TOTAL				\$			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. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

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: \$ 135 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	TOTAL		\$	\$	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: 10/1/2013 Ending: 9/30/2014
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.

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	\$	6,815	\$	490,679	\$	6,815	\$	490,679	1	
2	Licensed Speech and Language Development Therapist	39(3)	hrs		549		39,532		549		39,532	2	
3	Licensed Recreational Therapist		hrs									3	
4	Licensed Physical Therapist	39(3)	hrs		6,865		494,285		6,865		494,285	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					176,940			176,940	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			\$	14,229	\$	1,024,496	\$	176,940	14,229	\$	1,201,436	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: 10/1/2013 Ending: 9/30/2014
 XV. BALANCE SHEET - Unrestricted Operating Fund. As of 9/30/2014 (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>176,185</u>)	2,275,796	2,275,796	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	67,641	67,641	6
7	Other Prepaid Expenses	43,531	43,531	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,386,968	\$ 2,386,968	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	1,808,102	3,595,520	15
16	Equipment, at Historical Cost	733,646	1,454,458	16
17	Accumulated Depreciation (book methods)	(1,024,801)	(3,587,276)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs	2,447	2,447	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,519,394	\$ 1,475,149	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,906,362	\$ 3,862,117	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 471,548	\$ 471,548	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	136,260	136,260	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,986	6,986	31
32	Accrued Real Estate Taxes(Sch.IX-B)	61,200	61,200	32
33	Accrued Interest Payable	4,570	4,570	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Schedule 17A</u>	231,369	231,369	36
37				37
38	TOTAL Current Liabilities (sum of lines 29 thru 37)	\$ 911,933	\$ 911,933	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	1,819,783	1,819,783	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)	\$ 1,819,783	\$ 1,819,783	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,731,716	\$ 2,731,716	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,174,646	\$ 1,130,401	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,906,362	\$ 3,862,117	48

*(See instructions.)

Facility Name: Alpine Fireside Health Ctr
IDPH License ID Number: 0018275
Fiscal Year End: 9/30/2014

Schedule 17A

XV. Balance Sheet

Line 36 Other Current Liabilities (specify):

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
Accrued Rent	217,026	217,026
Illinois Bed Tax	14,343	14,343
Total - Line 36	<u>231,369</u>	<u>231,369</u>

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,436,259	1
2	Restatements (describe):		2
3	Post Period Adjustment	(160,094)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,276,165	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(101,519)	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)	\$ (101,519)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,174,646	24 *

* 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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,302,277	1
2	Discounts and Allowances for all Levels	(438,403)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,863,874	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,768,965	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,768,965	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	27,205	13
14	Non-Patient Meals	7,938	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	168,833	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	25,438	19
20	Radiology and X-Ray	9,650	20
21	Other Medical Services	24,917	21
22	Laundry	7,240	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 271,221	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	43,914	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 43,914	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Schedule 19A</u>	11,128	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 11,128	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 29 and 29)	\$ 5,959,102	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,072,029	31
32	Health Care	2,029,305	32
33	General Administration	1,171,689	33
B. Capital Expense			
34	Ownership	355,727	34
C. Ancillary Expense			
35	Special Cost Centers	1,330,599	35
36	Provider Participation Fee	101,272	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,060,621	40
41	Income before Income Taxes (line 30 minus line 40)**	(101,519)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (101,519)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,062,050	44
45	Private Pay - Net Inpatient Revenue	594,300	45
46	Medicare - Net Inpatient Revenue	985,517	46
47	Other-(specify) <u>Shelter Care</u>	1,222,007	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,863,874	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.

^-This entity is a cash basis taxpayer

Facility Name: Alpine Fireside Health Ctr
IDPH License ID Number: 0018275
Fiscal Year End: 9/30/2014

Schedule 19A

XVII. Income Statement

Line 28 Other Revenue (specify):

<u>Description</u>	<u>Amount</u>
Store & Misc Sales	10,448
Misc Income	1,425
Petty Cash Adjustment	(745)
Total - Line 28	<u><u>11,128</u></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: 10/1/2013

Ending: 9/30/2014

	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	1,984	2,043	\$ 73,474	\$ 35.96	1
2	Assistant Director of Nursing	2,659	2,713	89,590	33.02	2
3	Registered Nurses	13,445	13,604	375,308	27.59	3
4	Licensed Practical Nurses	11,989	12,184	281,810	23.13	4
5	CNAs & Orderlies	63,751	64,469	722,971	11.21	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,014	2,014	25,912	12.87	9
10	Activity Assistants	4,666	4,666	41,482	8.89	10
11	Social Service Workers	4,194	4,371	68,075	15.57	11
12	Dietician					12
13	Food Service Supervisor	1,908	2,041	35,580	17.43	13
14	Head Cook	7,430	7,430	63,892	8.60	14
15	Cook Helpers/Assistants	20,860	20,969	182,294	8.69	15
16	Dishwashers					16
17	Maintenance Workers	5,367	5,537	97,732	17.65	17
18	Housekeepers	8,592	8,681	75,175	8.66	18
19	Laundry	3,140	3,376	46,872	13.88	19
20	Administrator	2,019	2,019	156,429	77.48	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,428	2,500	51,011	20.40	23
24	Clerical	2,393	2,423	33,040	13.64	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	3,191	3,264	73,902	22.64	29
30	Habilitation Aides (DD Homes)	2,192	2,280	36,146	15.85	30
31	Medical Records					31
32	Other Health Care Care Plan Coordin	1,533	1,549	47,084	30.40	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	165,755	168,133	\$ 2,577,779 *	\$ 15.33	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	315	\$ 15,101	L1,C3	35
36	Medical Director	656	18,000	L9,C3	36
37	Medical Records Consultant	24	900	L10,C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	31	3,840	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	54	2,888	L11,C3	44
45	Social Service Consultant	57	3,128	L12,C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,137	\$ 43,857		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	\$ 156,429	Workers' Compensation Insurance	\$ 103,785	IDPH License Fee	\$	
				Unemployment Compensation Insurance	35,421	Advertising: Employee Recruitment	2,033	
				FICA Taxes	198,713	Health Care Worker Background Check		
				Employee Health Insurance	104,816	(Indicate # of checks performed <u>122</u>)	1,220	
				Employee Meals	11,004	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Illinois Health Care Association	5,980	
				401 K	28,973	Rockford Register & City of Rockford		
				Uniforms	447	Miscellaneous Dues & Subscriptions	60	
				Pre-Employment Physicals	6,599	Miscellaneous License	1,521	
						Lobbying Expense	(2,613)	
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 156,429	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 489,758		\$ 8,201		
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	\$ (7,366)
							In-State Travel	
							Seminar Expense	16,165
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	
							\$ 8,799	
C. Professional Services								
Vendor/Payee	Type		Amount					
See Schedule 21C			\$ 239,572					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 239,572					

* Attach copy of IMRF notifications

**See instructions.

Facility Name: Alpine Fireside Health Ctr
IDPH License ID Number: 0018275
Fiscal Year End: 9/30/2014

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
Reno & Zahn, LLP	Legal	11,516
Duane Morris	Legal	61,716
McGladrey LLP	Accounting	43,468
FR&R	Accounting	10,500
Brian W. Law	Computer Services	78,207
Cerner Corporation	Computer Services	4,455
Christensen Computer Company, Inc.	Computer Services	236
E-Health Data Solutions	Computer Services	5,228
Mediprocity, Inc.	Computer Services	50
Nebo Systems, Inc.	Computer Services	220
NTT DATA Long Term Care Solutions, Inc.	Computer Services	20,872
Olav Oksnevad	Computer Services	3,104
Total (agree to Schedule V, line 19, column 3)		<u><u>239,572</u></u>
Less: Non-Allowable Legal Fees		(8,491)
Total (agree to Schedule V, line 19, column 8)		<u><u>231,081</u></u>

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

1	2	3	4	5	6	7	8	9	10	11	12	13
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	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Alpine Fireside Health Ctr# 0018275Report Period Beginning: 10/1/2013Ending: 9/30/2014**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-\$5,980
- (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. \$ 7,535 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. \$ 101,272
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. \$ 11,004 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 7,938
- (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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.