

Facility Name & ID Number Alpine Fireside Health Ctr

0018275 Report Period Beginning: 10/1/2014 Ending: 9/30/2015

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 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF		<u>344</u>	<u>5,709</u>	<u>6,053</u>	8
9	SNF/PED					9
10	ICF	<u>5,721</u>	<u>3,337</u>		<u>9,058</u>	10
11	ICF/DD					11
12	SC			<u>9,485</u>	<u>9,485</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>5,721</u>	<u>3,681</u>	<u>15,194</u>	<u>24,596</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.07%

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 5,085

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 09/30/15 Fiscal Year: 09/30/15

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

Facility Name & ID Number

Alpine Fireside Health Ctr

0018275

Report Period Beginning:

10/1/2014

Ending:

9/30/2015

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	290,950	26,335	12,198	329,483		329,483		329,483		1
2	Food Purchase		235,098		235,098		235,098	(18,521)	216,577		2
3	Housekeeping	73,378	22,646		96,024		96,024		96,024		3
4	Laundry	49,975	9,412	20,118	79,505		79,505		79,505		4
5	Heat and Other Utilities			90,691	90,691		90,691		90,691		5
6	Maintenance	89,905	73,678	62,190	225,773		225,773		225,773		6
7	Other (specify):*										7
8	TOTAL General Services	504,208	367,169	185,197	1,056,574		1,056,574	(18,521)	1,038,053		8
	B. Health Care and Programs										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	1,668,480	109,200	4,062	1,781,742		1,781,742	(51,148)	1,730,594		10
10a	Therapy	30,481			30,481		30,481		30,481		10a
11	Activities	68,281	21,365	3,181	92,827		92,827		92,827		11
12	Social Services	37,528		7,798	45,326		45,326		45,326		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,804,770	130,565	33,041	1,968,376		1,968,376	(51,148)	1,917,228		16
	C. General Administration										
17	Administrative	156,429			156,429		156,429	51,148	207,577		17
18	Directors Fees										18
19	Professional Services			169,459	169,459		169,459	(13,879)	155,580		19
20	Dues, Fees, Subscriptions & Promotions			19,112	19,112		19,112	(2,530)	16,582		20
21	Clerical & General Office Expenses	86,907	35,168	69,043	191,118		191,118	(4,374)	186,744		21
22	Employee Benefits & Payroll Taxes			434,104	434,104		434,104	8,765	442,869		22
23	Inservice Training & Education										23
24	Travel and Seminar			10,983	10,983		10,983	(615)	10,368		24
25	Other Admin. Staff Transportation			6,818	6,818		6,818		6,818		25
26	Insurance-Prop.Liab.Malpractice			96,781	96,781		96,781		96,781		26
27	Other (specify):*										27
28	TOTAL General Administration	243,336	35,168	806,300	1,084,804		1,084,804	38,515	1,123,319		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,552,314	532,902	1,024,538	4,109,754		4,109,754	(31,154)	4,078,600		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.

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			169,469	169,469		169,469	2,085	171,554			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			106,705	106,705		106,705	(19,763)	86,942			32
33	Real Estate Taxes			78,111	78,111		78,111		78,111			33
34	Rent-Facility & Grounds			3,000	3,000		3,000	(3,000)				34
35	Rent-Equipment & Vehicles			165	165		165		165			35
36	Other (specify):*											36
37	TOTAL Ownership			357,450	357,450		357,450	(20,678)	336,772			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		195,378	1,165,936	1,361,314		1,361,314		1,361,314			39
40	Barber and Beauty Shops		1,067	13,261	14,328		14,328		14,328			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			99,951	99,951		99,951		99,951			42
43	Other (specify):* Non-Allowable Co			358,822	358,822		358,822	(358,822)				43
44	TOTAL Special Cost Centers		196,445	1,637,970	1,834,415		1,834,415	(358,822)	1,475,593			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,552,314	729,347	3,019,958	6,301,619		6,301,619	(410,654)	5,890,965			45

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

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	(9,756)	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	441	30		9
10	Interest and Other Investment Income	(19,763)	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	(10,493)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(13,859)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(307,978)	43		24
25	Fund Raising, Advertising and Promotional	(310)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(11,027)	43		28
29	Other-Attach Schedule See Page 5A	(36,553)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (409,298)		\$	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)	(1,356)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,356)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (410,654)		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					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

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ID# 0018275

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	X-Rays - Part A	\$ (8,609)	43	1
2	Labs-Part A	(20,355)	43	2
3	Out of state travel & seminar	(615)	24	3
4	Miscellaneous Exp/Suspense Acct.	(50)	43	4
5	Lobbying	(2,530)	20	5
6	Offset Miscellaneous Income	(4,394)	21	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(36,553)	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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	30 Depreciation	\$	Johs Oksnevad	100.00%	\$ 1,644	\$ 1,644	1
2	V	33 Real Estate Taxes	78,311	Johs Oksnevad	100.00%	78,311		2
3	V	34 Rent-facility and grounds	3,000	Johs Oksnevad	100.00%		(3,000)	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		\$ 81,311			\$ 79,955	\$ * (1,356)	14

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

Facility Name & ID Number Alpine Fireside Health Ctr # 0018275 Report Period Beginning: 10/1/2014 Ending: 9/30/2015

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	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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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	\$ 1,516,751	05/05/16	0.06	\$ 92,866						
2																	
3																	
4	Loan Amortization										1,468						
5																	
Working Capital																	
6	Durand State Bank		X	Working Capital	Interest Only	10/14	250,000	116,687	7/23/16	0.06	12,371						
7																	
8																	
9	TOTAL Facility Related						\$ 1,247,396	\$ 1,633,438			\$ 106,705						
B. Non-Facility Related*																	
10																	
11																	
12											Interest Income						
13											(19,763)						
14	TOTAL Non-Facility Related						\$	\$			\$ (19,763)						
15	TOTALS (line 9+line14)						\$ 1,247,396	\$ 1,633,438			\$ 86,942						

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 2014 report.			\$	<u>61,200</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.)	2014		\$	<u>77,911</u>	2										
3. Under or (over) accrual (line 2 minus line 1).			\$	<u>16,711</u>	3										
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	<u>61,400</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										
Allocated from Management Co.															
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>78,111</u>	7										
Real Estate Tax History:															
Real Estate Tax Bill for Calendar Year:	2010	<u>70,985</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 2014 \$ _____</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$ _____</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$ _____</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$ _____</td> </tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2014 \$ _____	14	PLUS APPEAL COST FROM LINE 5 \$ _____	15	LESS REFUND FROM LINE 6 \$ _____	16	AMOUNT TO USE FOR RATE CALCULATION \$ _____
FOR BHF USE ONLY															
13	FROM R. E. TAX STATEMENT FOR 2014 \$ _____														
14	PLUS APPEAL COST FROM LINE 5 \$ _____														
15	LESS REFUND FROM LINE 6 \$ _____														
16	AMOUNT TO USE FOR RATE CALCULATION \$ _____														
	2011	<u>72,416</u>	9												
	2012	<u>71,282</u>	10												
	2013	<u>77,786</u>	11												
	2014	<u>77,911</u>	12												
Accrual calculation															
2014 tax bill	<u>77,911</u>														
% Increase	<u>x1.05</u>														
Estimate of 2015 taxes	<u>81,806 x 9/12=\$61,355. Use 61,400</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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Alpine Fireside Health Center, Ltd. 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 2014 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 2014.

(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>77,910.82</u>	\$ <u>77,910.82</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>77,910.82</u></u>	\$ <u><u>77,910.82</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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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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10/1/2014 Ending:

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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:

	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	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			280,820	33
34		Carpeting / flooring / wallcovering	1999		81,812		15			81,812	34
35		Parking lot lights	1999		16,900		15			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:

10/1/2014

Ending:

9/30/2015

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	
37	Air conditioning	2000	\$ 24,655	\$	15	\$ 1,644	\$ 1,644	\$ 23,837	37
38	Parking lot	2002	42,683	1,764	15	2,846	1,082	38,421	38
39	Boiler electrical improvements	2002	11,560		20	578	578	7,803	39
40	Gazebo pad	2002	12,657	70	20	633	563	8,545	40
41	Painting and wallpapering hallways	2003	27,403	996	20	1,370	374	17,125	41
42	Gazebo	2003	35,825	1,303	20	1,792	489	22,400	42
43	Fence	2003	3,400	214	20	170	(44)	2,125	43
44	Sign	2003	1,675	82	20	84	2	1,050	44
45	Garage	2003	3,077	152	20	154	2	1,924	45
46	Fire alarm	2003	30,208		20	1,510	1,510	18,875	46
47	Boiler	2004	31,880	1,054	20	1,594	540	18,334	47
48	Sign	2004	3,487	127	20	174	47	2,001	48
49	Smoke detectors	2004	2,153		20	108	108	1,242	49
50	Boiler	2005	7,060	257	20	352	95	3,696	50
51	Commercial disposal	2005	826		20	42	42	441	51
52	Fire supression system	2005	1,866	68	20	94	26	987	52
53	Pond	2006	11,930	796	20	596	(200)	5,662	53
54	Fire alarm system	2006	2,738	99	20	137	38	1,301	54
55	Floor tile, baseboards	2006	5,759	209	20	288	79	2,736	55
56	Air conditioning	2006	13,634	496	20	682	186	6,479	56
57	Sidewalk	2006	1,196	80	20	60	(20)	570	57
58	Remodel grieving room	2006	2,198	80	20	110	30	1,045	58
59	Fire sprinkler system	2007	169,761	6,173	20	8,487	2,314	72,140	59
60	Nurse call system	2007	69,282	954	20	3,464	2,510	29,444	60
61	Remodel fireplace	2007	39,855	1,449	20	1,993	544	16,940	61
62	Ceiling tiles	2007	12,820	466	20	641	175	5,449	62
63	Drywall stairways	2007	8,000	291	20	400	109	3,400	63
64	20 ton rooftop unit	2007	34,100	1,240	20	1,705	465	14,492	64
65	Ductless heat pump	2007	7,760	282	20	388	106	3,298	65
66	Remodel fireplace	2007	6,631	241	20	332	91	2,822	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,386,638	\$ 18,943		\$ 32,428	\$ 13,485	\$ 2,095,143	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:

10/1/2014

Ending:

9/30/2015

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	Totals from Page 12A, Carried Forward		\$ 2,386,638	\$ 18,943		\$ 32,428	\$ 13,485	\$ 2,095,143	1
2	Circuit panel in kitchen	2007	4,045	147	20	202	55	1,515	2
3	Replace ceiling tiles	2008	11,366	413	20	568	155	4,260	3
4	New boiler and expansion tank	2008	10,635	387	20	532	145	3,458	4
5	Nurses station	2009	12,283	447	20	614	167	3,991	5
6	Carpeting	2009	12,306		20	615	615	3,998	6
7	Zone controls for main rooftop unit	2009	14,640	532	20	732	200	4,758	7
8	3 garage doors	2009	3,670	133	20	184	51	1,196	8
9									9
10	Basement A/C	2010	13,395	1,527	20	670	(857)	3,685	10
11	200 AMP Breaker/Conduit	2010	12,426	452	20	621	169	3,416	11
12	Drywall/Ceiling Tile/Metal Grid for Pt Rooms & Hallway	2010	10,563	384	20	528	144	2,904	12
13	Repl Hot Water Holding Tank	2010	5,269	192	20	263	71	1,447	13
14	Roofer Sealer Paint	2010	9,085	927	20	454	(473)	2,497	14
15	Driveway Sealer Coat	2010	10,608	471	20	530	59	2,915	15
16	Transfer Switch in Kohler Cabinet	2010	3,669	286	20	183	(103)	1,007	16
17	New Addition - Activity Room	2010	2,953	107	20	148	41	814	17
18									18
19									19
20	Windows	2011	42,307	1,538	20	2,115	577	9,519	20
21	Wanderguard	2011	113,678	4,134	20	5,684	1,550	25,578	21
22	Stove Hood	2011	40,750	1,482	20	2,038	556	9,169	22
23	Kitchen Air Conditioning	2011	36,470	1,326	20	1,824	498	8,206	23
24	Rooftop A/C Unit	2011	5,995	218	20	300	82	1,349	24
25	Water Cooler Coil on Heat Pump	2011	9,675	352	20	484	132	2,177	25
26	New Interior Paint front door	2011	4,104	149	20	205	56	923	26
27									27
28	Therapy Room Addition : framing, drywall, electrical, HVAC,	2011	619,228	26,102	20	30,961	4,859	108,365	28
29	flooring, paint, architect services, etc.								29
30	Generator	2011	168,336	4,336	20	8,417	4,081	29,459	30
31	New Front Door	2012	4,385	86	20	219	133	767	31
32	2 Pressure Tanks & 2 Ductless Heat Pumps for new Laundry Area	2012	14,160	94	20	708	614	2,478	32
33	Replace Glass in Windows in Offices, Dining Room & Lobby	2012	7,236	11	20	362	351	1,266	33
34	TOTAL (lines 1 thru 33)		\$ 3,589,875	\$ 65,176		\$ 92,588	\$ 27,412	\$ 2,336,260	34

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

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 12B, Carried Forward		\$ 3,589,875	\$ 65,176		\$ 92,588	\$ 27,412	\$ 2,336,260	1
2	Countertop in Therapy Room	2013	5,645	282	20	282	0	705	2
3									3
4	Carpet - Hall 4	2014	4,724	118	20	236	118	236	4
5	Northeast Sidewalk Replacement	2015	36,300	908	20	908		908	5
6	Stonewall - Northeast side of building	2015	3,407	85	20	85		85	6
7	Blacktop work - Parking Lot	2015	5,750	144	20	144		144	7
8	Sealing - Roof	2015	5,458		20	136	136	136	8
9	Sealing - Roof	2015	3,137		20	78	78	78	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	To tie book depreciation to financials			25,659			(25,659)		27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,654,296	\$ 92,372		\$ 94,458	\$ 2,086	\$ 2,338,552	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	\$ 797,249	\$ 43,620	\$ 43,620	\$	5	\$ 813,271	71
72	Current Year Purchases	24,401	2,440	2,440		5	2,440	72
73	Fully Depreciated Assets	132,853					132,853	73
74								74
75	TOTALS	\$ 954,503	\$ 46,060	\$ 46,060	\$		\$ 948,564	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	\$ 31,037	\$ 31,036	\$ (1)	5	\$ 254,656	76
77										77
78										78
79										79
80	TOTALS			\$ 307,298	\$ 31,037	\$ 31,036	\$ (1)		\$ 254,656	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)	\$ 4,926,097	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 169,469	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 171,554	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,085	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,541,772	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: 9/30/2015

Schedule 13A

XI. Ownership Costs
Line 79 - Vehicle Depreciation

Use	Model, Make & Year	Year Acquired	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustments	Life in Years	Accumulated Depreciation
Administrative	2004 Yukon	2004	53,115	-	-	-	5	53,115
Maintenance Truck	2006 GMC Sierra	2005	48,333	-	-	-	5	48,333
Resident Transportation	1998 Ford Supreme Bus	1999	49,247	-	-	-	5	49,247
Dump Truck for Tractor	2010	2010	2,817	279	279	-	5	2,817
Administrative	2011 Dodge Challenger	2011	55,605	11,122	11,121	(1)	5	50,046
Administrative	2011 Toyota Rav 4	2011	34,200	6,840	6,840	-	5	23,940
Administrative	GMC Denali	2013	63,981	12,796	12,796	-	5	31,990
						-		
						-		
						-		
						-		
						-		
TOTAL			307,298	31,037	31,036	(1)		259,488

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. _____ /2016 \$ _____

13. _____ /2017 \$ _____

14. _____ /2018 \$ _____

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: \$ 165.00 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: 10/1/2014 Ending: 9/30/2015
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	\$	6,596	\$	474,876	\$	6,596	\$	474,876	1	
2	Licensed Speech and Language Development Therapist	39(3)	hrs		2,921		210,298		2,921		210,298	2	
3	Licensed Recreational Therapist		hrs									3	
4	Licensed Physical Therapist	39(3)	hrs		6,677		480,762		6,677		480,762	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					187,724			187,724	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10	
11	Academic Education		hrs									11	
12	Other (specify): <u>Oxygen</u>							7,654			7,654	12	
13	Other (specify):											13	
14	TOTAL			\$	16,194	\$	1,165,936	\$	195,378	16,194	\$	1,361,314	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: 10/1/2014 Ending: 9/30/2015
 XV. BALANCE SHEET - Unrestricted Operating Fund. As of 9/30/2015 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 148	\$ 148	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>325,000</u>)	2,055,287	2,055,287	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	66,364	66,364	6
7	Other Prepaid Expenses	49,389	49,389	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Cafeteria Plan Account Cash</u>	738	738	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,171,926	\$ 2,171,926	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	1,858,283	3,654,296	15
16	Equipment, at Historical Cost	758,048	1,261,801	16
17	Accumulated Depreciation (book methods)	(1,194,270)	(3,541,772)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs	979	979	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)	\$ 1,423,040	\$ 1,385,304	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,594,966	\$ 3,557,230	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 118,916	\$ 118,916	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	135,095	135,095	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,024	5,024	31
32	Accrued Real Estate Taxes(Sch.IX-B)	61,400	61,400	32
33	Accrued Interest Payable	3,890	3,890	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Schedule 17A</u>	221,694	221,694	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 546,019	\$ 546,019	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	1,633,438	1,633,438	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)	\$ 1,633,438	\$ 1,633,438	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,179,457	\$ 2,179,457	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,415,509	\$ 1,377,773	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,594,966	\$ 3,557,230	48

*(See instructions.)

Facility Name: Alpine Fireside Health Ctr
IDPH License ID Number: 0018275
Fiscal Year End: 9/30/2015

Schedule 17A

XV. Balance Sheet

Line 36 Other Current Liabilities (specify):

<u>Description</u>	<u>After</u>	
	<u>Operating</u>	<u>Consolidation</u>
Illinois Bed Tax	4,668	4,668
Rent Accrued	217,026	217,026
Total - Line 36	<u>221,694</u>	<u>221,694</u>

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,174,646	1
2	Restatements (describe):		2
3	Prior Period Adjustment	(115,058)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,059,588	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	354,921	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	1,000	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)	\$ 355,921	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)	\$ 1,415,509	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Alpine Fireside Health Ctr# 0018275Report Period Beginning: 10/1/2014Ending: 9/30/2015

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	\$ 4,905,699	1
2	Discounts and Allowances for all Levels	(1,455,487)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,450,212	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,871,054	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,871,054	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	25,872	13
14	Non-Patient Meals	9,756	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	174,286	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	29,217	19
20	Radiology and X-Ray	8,693	20
21	Other Medical Services	41,018	21
22	Laundry	8,200	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 297,042	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	19,763	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 19,763	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Schedule 19A</u>	18,469	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 18,469	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,656,540	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,056,574	31
32	Health Care	1,968,376	32
33	General Administration	1,084,804	33
B. Capital Expense			
34	Ownership	357,450	34
C. Ancillary Expense			
35	Special Cost Centers	1,734,464	35
36	Provider Participation Fee	99,951	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,301,619	40
41	Income before Income Taxes (line 30 minus line 40)**	354,921	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 354,921	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,204,371	44
45	Private Pay - Net Inpatient Revenue	633,575	45
46	Medicare - Net Inpatient Revenue	116,130	46
47	Other-(specify) <u>Shelter Care</u>	1,496,136	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,450,212	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.

^ - This entity is a cash basis taxpayer

Facility Name: Alpine Fireside Health Ctr
IDPH License ID Number: 0018275
Fiscal Year End: 9/30/2015

Schedule 19A

XVII. Income Statement

Line 28 Other Revenue (specify):

<u>Description</u>	<u>Amount</u>
Store & Misc Sales	14,005
Miscellaneous Income	4,394
Petty Cash Adjustment Account	70
Total - Line 28	<u><u>18,469</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: 10/1/2014

Ending: 9/30/2015

	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	2,064	2,080	\$ 75,204	\$ 36.16	1
2	Assistant Director of Nursing	2,201	2,401	75,585	31.48	2
3	Registered Nurses	13,494	14,461	399,827	27.65	3
4	Licensed Practical Nurses	10,928	11,512	284,345	24.70	4
5	CNAs & Orderlies	56,924	60,327	676,073	11.21	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,770	2,046	30,481	14.90	8
9	Activity Director	1,901	2,084	24,404	11.71	9
10	Activity Assistants	5,159	5,290	43,877	8.29	10
11	Social Service Workers	2,719	3,042	37,528	12.34	11
12	Dietician					12
13	Food Service Supervisor	2,688	2,806	35,628	12.70	13
14	Head Cook	2,699	4,078	66,092	16.21	14
15	Cook Helpers/Assistants	20,391	21,878	189,230	8.65	15
16	Dishwashers					16
17	Maintenance Workers	4,659	5,085	89,905	17.68	17
18	Housekeepers	7,755	8,391	73,378	8.74	18
19	Laundry	3,687	3,889	49,975	12.85	19
20	Administrator	2,080	2,600	156,429	60.17	20
21	Assistant Administrator	1,520	1,520	51,148	33.65	21
22	Other Administrative					22
23	Office Manager	2,508	2,644	49,717	18.80	23
24	Clerical	3,090	3,178	37,190	11.70	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,608	2,640	49,287	18.67	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care Care Plan Coordin	1,564	1,756	57,011	32.47	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	152,409	163,708	\$ 2,552,314 *	\$ 15.59	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	249	\$ 12,198	L1,C3	35
36	Medical Director	Monthly	18,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,561	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	47	3,181	L11,C3	44
45	Social Service Consultant	116	7,798	L12,C3	45
46	Other(specify) Rehab	Monthly	501	L10,C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	412	\$ 45,239		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$ N/A		50
51	Licensed Practical Nurses				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	\$ 69,371	IDPH License Fee	\$ 3,980	
See Schedule 21A				Unemployment Compensation Insurance	35,594	Advertising: Employee Recruitment	506	
				FICA Taxes	190,012	Health Care Worker Background Check		
				Employee Health Insurance	95,951	(Indicate # of checks performed <u>48</u>)	484	
				Employee Meals	8,765	Patient Background Checks	47	
				Illinois Municipal Retirement Fund (IMRF)*		Illinois Health Care Association	6,589	
				401 K	31,813	Rockford Register & City of Rockford	1,713	
				Uniforms	371	Miscellaneous Dues & Subscriptions	3,801	
				Pre-Employment Physicals	10,992	Miscellaneous License	1,569	
						Lobbying Expense	(2,530)	
						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)	\$ 442,869	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 16,582	
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	\$ (615)
							In-State Travel	
							Seminar Expense	10,983
							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)	\$ 10,368
C. Professional Services								
Vendor/Payee	Type		Amount					
See Schedule 21C			\$ 169,459					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 169,459					

* Attach copy of IMRF notifications

**See instructions.

Facility Name: Alpine Fireside Health Ctr
IDPH License ID Number: 0018275
Fiscal Year End: 9/30/2015

Schedule 21A

XIX. SUPPORT SCHEDULES

A. Administrative - Salary/Wage

<u>Name</u>	<u>Position</u>	<u>Amount</u>
Gordon Oksnevad	Administrator	156,429
Total (agree to Schedule V, line 17, column 3)		<u>156,429</u>
Reclass Assistant Administrator		
Michelle Cruden	Assistant Administrator	51,148
Total (agree to Schedule V, line 17, column 8)		<u>207,577</u>

Facility Name: Alpine Fireside Health Ctr
IDPH License ID Number: 0018275
Fiscal Year End: 9/30/2015

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
Duane Morris	Legal	29,988
Reno & Zahm	Legal	6,621
Raw Imports	Medical Records	20
McGladrey LLP	Accounting	41,680
Verisight	Accounting	1,655
3 Cubed	Computer Services	3,039
AAA Financial Services	Computer Services	850
Alpha Controls	Computer Services	248
Bank of America	Computer Services	159
Brian W Law	Computer Services	52,911
Cerner Corporation	Computer Services	4,451
E-Health Data Systems	Computer Services	5,228
Nebo Systems, Inc.	Computer Services	240
NTT Data Long Term Care	Computer Services	22,370
Total (agree to Schedule V, line 19, column 3)		<u>169,459</u>
Less: Non-Allowable Legal Fees Out of Period		(3,136)
Less: Non-Allowable Legal Fees Non Allowable		(10,723)
Less: Reclass to Account 4990 Correction for Medical Records Reimbursement		(20)
Total (agree to Schedule V, line 19, column 8)		<u>155,580</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: 10/1/2014Ending: 9/30/2015**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Health Care Assn-\$6,589
- (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. \$ 25,839 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 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. \$ 99,951
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. \$ 8,765 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 9,756
- (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.