

Facility Name & ID Number Alpine Fireside Health Ctr

0018275 Report Period Beginning: 10/01/2015 Ending: 09/30/2016

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>11,712</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>34</u>	Intermediate (ICF)	<u>34</u>	<u>12,444</u>	3
4		Intermediate/DD			4
5	<u>33</u>	Sheltered Care (SC)	<u>33</u>	<u>12,078</u>	5
6		ICF/DD 16 or Less			6
7	<u>99</u>	TOTALS	<u>99</u>	<u>36,234</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF		<u>262</u>	<u>5,101</u>	<u>5,363</u>	8
9	SNF/PED					9
10	ICF	<u>5,652</u>	<u>3,410</u>		<u>9,062</u>	10
11	ICF/DD					11
12	SC			<u>9,990</u>	<u>9,990</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>5,652</u>	<u>3,672</u>	<u>15,091</u>	<u>24,415</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.38%

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 4,799

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: 9/30/2016 Fiscal Year: 9/30/2016

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	267,349	36,423	14,014	317,786		317,786		317,786		1
2	Food Purchase		261,239		261,239		261,239	(19,999)	241,240		2
3	Housekeeping	82,156	24,316		106,472		106,472		106,472		3
4	Laundry	47,119	14,586	5,095	66,800		66,800		66,800		4
5	Heat and Other Utilities			98,649	98,649		98,649		98,649		5
6	Maintenance	88,260	53,007	56,875	198,142		198,142		198,142		6
7	Other (specify):*										7
8	TOTAL General Services	484,884	389,571	174,633	1,049,088		1,049,088	(19,999)	1,029,089		8
	B. Health Care and Programs										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	1,636,886	114,545	3,805	1,755,236		1,755,236	(93,548)	1,661,688		10
10a	Therapy	13,726	325		14,051		14,051		14,051		10a
11	Activities	68,816	27,322	3,339	99,477		99,477		99,477		11
12	Social Services	35,621		3,169	38,790		38,790		38,790		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,755,049	142,192	28,313	1,925,554		1,925,554	(93,548)	1,832,006		16
	C. General Administration										
17	Administrative	184,848			184,848		184,848	93,548	278,396		17
18	Directors Fees										18
19	Professional Services			209,163	209,163		209,163	(4,280)	204,883		19
20	Dues, Fees, Subscriptions & Promotions			16,212	16,212		16,212	(3,412)	12,800		20
21	Clerical & General Office Expenses	106,800	41,620	66,192	214,612		214,612	(18,784)	195,828		21
22	Employee Benefits & Payroll Taxes			487,148	487,148		487,148	9,442	496,590		22
23	Inservice Training & Education										23
24	Travel and Seminar			8,360	8,360		8,360		8,360		24
25	Other Admin. Staff Transportation			5,923	5,923		5,923		5,923		25
26	Insurance-Prop.Liab.Malpractice			104,362	104,362		104,362		104,362		26
27	Other (specify):*										27
28	TOTAL General Administration	291,648	41,620	897,360	1,230,628		1,230,628	76,514	1,307,142		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,531,581	573,383	1,100,306	4,205,270		4,205,270	(37,033)	4,168,237		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			162,238	162,238		162,238	1,547	163,785			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			93,775	93,775		93,775	(39,913)	53,862			32
33	Real Estate Taxes			79,981	79,981		79,981	(153)	79,828			33
34	Rent-Facility & Grounds			3,000	3,000		3,000	(3,000)				34
35	Rent-Equipment & Vehicles			207	207		207		207			35
36	Other (specify):*											36
37	TOTAL Ownership			339,201	339,201		339,201	(41,519)	297,682			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		159,171	1,451,768	1,610,939		1,610,939		1,610,939			39
40	Barber and Beauty Shops		1,299	13,734	15,033		15,033		15,033			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			94,334	94,334		94,334		94,334			42
43	Other (specify):* Non-Allowable Cos			68,213	68,213		68,213	(68,213)				43
44	TOTAL Special Cost Centers		160,470	1,628,049	1,788,519		1,788,519	(68,213)	1,720,306			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,531,581	733,853	3,067,556	6,332,990		6,332,990	(146,765)	6,186,225			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	(10,557)	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	729	30		9
10	Interest and Other Investment Income	(39,913)	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	(5,765)	43		19
20	Contributions	(6,330)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(4,280)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(19,515)	43		24
25	Fund Raising, Advertising and Promotional	(65)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(18,106)	43		28
29	Other-Attach Schedule See Page 5A	(40,781)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (144,583)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(2,182)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (2,182)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (146,765)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	52

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	Sch. V Line
1	X-Rays - Part A	\$ (6,164)	43	1
2	Labs-Part A	(9,356)	43	2
3	Income Tax/ Other Taxes	(2,967)	43	3
4	Miscellaneous Exp/Suspense Acct.	55	43	4
5	Lobbying	(3,412)	20	5
6	Offset Miscellaneous Income	(18,784)	21	6
7	Adjust real estate taxes	(153)	33	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
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26				26
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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	(40,781)		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	1	\$ 818	\$ 818	1
2	V	33 Real Estate Taxes	79,828	Johs Oksnevad	1	79,828		2
3	V	34 Rent-facility and grounds	3,000	Johs Oksnevad	1		(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		\$ 82,828			\$ 80,646	\$ * (2,182)	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	Asst Administrator	Administrative	0.00		50	100.00	Salary	\$ 197,317	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	\$ 197,317		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

Name of Related Organization N/A

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

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

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IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	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	\$ 1,460,676	11/30/2021	0.0595	\$ 90,719	1								
2												2								
3												3								
4	Loan Amortization											979	4							
5												5								
Working Capital																				
6	Durand State Bank		X	Working Capital	Interest Only	10/14	250,000	25,000	11/30/2017	0.0500	2,077	6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 1,247,396	\$ 1,485,676			\$ 93,775	9								
B. Non-Facility Related*																				
10												10								
11												11								
12								Interest Income			(39,913)	12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ (39,913)	14								
15	TOTALS (line 9+line14)						\$ 1,247,396	\$ 1,485,676			\$ 53,862	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 2015 report.			\$	61,400	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.)	2015		\$	79,028	2
3. Under or (over) accrual (line 2 minus line 1).			\$	17,628	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	62,200	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.			\$	79,828	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2011	<u>72,416</u>	<u>8</u>	FOR BHF USE ONLY	
	2012	<u>71,282</u>	<u>9</u>	13	FROM R. E. TAX STATEMENT FOR 2015 \$
	2013	<u>77,786</u>	<u>10</u>	14	PLUS APPEAL COST FROM LINE 5 \$
	2014	<u>77,911</u>	<u>11</u>	15	LESS REFUND FROM LINE 6 \$
	2015	<u>79,028</u>	<u>12</u>	16	AMOUNT TO USE FOR RATE CALCULATION \$
Accrual calculation					
2015 tax bill	79,028				
% Increase	x1.05				
Estimate of 2016 taxes	82,979 x 9/12=\$62,235. Use 62,200				

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.

2015 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 2015 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 2015.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>12-05-376-003</u>	<u>Nursing Home</u>	\$ <u>79,028.00</u>	\$ <u>79,028.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>79,028.00</u></u>	\$ <u><u>79,028.00</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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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	2	3	4	
	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
5										
6										
7										
8										
	Improvement Type**									
9			1973		1,277		10			1,277
10			1973		3,172		20			3,172
11			1973		694		40			694
12			1973		201		25			201
13			1973		93,791		11			93,791
14			1973		96,886		34			96,886
15			1974		8,366		11			8,366
16			1975		3,593		10			3,593
17			1977		10,055		10			10,055
18			1981		2,656		15			2,656
19			1982		5,132		11			5,132
20			1982		1,063		15			1,063
21			1984		21,939		15			21,939
22		Smoke detectors	1984		1,145		10			1,145
23			1985		3,300		15			3,300
24		Roof	1986		19,094		15			19,094
25		Kitchen addition and storm sewers	1988		235,818		20			235,818
26		Kitchen improvements	1989		9,541		20			9,541
27		Black top	1990		5,000		10			5,000
28		Broiler	1991		29,033		20			29,033
29		Lawn sprinkler	1992		5,000		15			5,000
30		Leasehold improvements	1993		13,972		15			13,972
31		Roof improvements	1994		57,648		15			57,648
32		Generator	1995		34,924		15			34,924
33		Air conditioning system	1999		280,820		15			280,820
34		Carpeting / flooring / wallcovering	1999		81,812		15			81,812
35		Parking lot lights	1999		16,900		15			16,900
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:

10/01/2015 Ending: 09/30/2016**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	\$ 818	\$ 818	\$ 24,655	37
38	Parking lot	2002	42,683	1,763	15	2,846	1,083	41,267	38
39	Boiler electrical improvements	2002	11,560		20	578	578	8,381	39
40	Gazebo pad	2002	12,657	7	20	633	626	9,178	40
41	Painting and wallpapering hallways	2003	27,403		20	1,370	1,370	18,495	41
42	Gazebo	2003	35,825		20	1,792	1,792	24,192	42
43	Fence	2003	3,400		20	170	170	2,295	43
44	Sign	2003	1,675		20	84	84	1,134	44
45	Garage	2003	3,077		20	154	154	2,078	45
46	Fire alarm	2003	30,208		20	1,510	1,510	20,385	46
47	Boiler	2004	31,880		20	1,594	1,594	19,928	47
48	Sign	2004	3,487		20	174	174	2,175	48
49	Smoke detectors	2004	2,153		20	108	108	1,350	49
50	Boiler	2005	7,060	257	20	352	95	4,048	50
51	Commercial disposal	2005	826	30	20	42	12	483	51
52	Fire supression system	2005	1,866	68	20	94	26	1,081	52
53	Pond	2006	11,930	448	20	596	148	6,258	53
54	Fire alarm system	2006	2,738	99	20	137	38	1,438	54
55	Floor tile, baseboards	2006	5,759	209	20	288	79	3,024	55
56	Air conditioning	2006	13,634	496	20	682	186	7,161	56
57	Sidewalk	2006	1,196	80	20	60	(20)	630	57
58	Remodel grieving room	2006	2,198	80	20	110	30	1,155	58
59	Fire sprinkler system	2007	169,761	6,173	20	8,487	2,314	80,627	59
60	Nurse call system	2007	69,282		20	3,464	3,464	32,908	60
61	Remodel fireplace	2007	39,855	1,690	20	1,993	303	18,933	61
62	Ceiling tiles	2007	12,820	466	20	641	175	6,090	62
63	Drywall stairways	2007	8,000	291	20	400	109	3,800	63
64	20 ton rooftop unit	2007	34,100	1,240	20	1,705	465	16,197	64
65	Ductless heat pump	2007	7,760	282	20	388	106	3,686	65
66	Remodel fireplace	2007	6,631		20	332	332	3,154	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,386,638	\$ 13,679		\$ 31,602	\$ 17,923	\$ 2,126,745	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:

10/01/2015 Ending: 09/30/2016

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	\$ 13,679		\$ 31,602	\$ 17,923	\$ 2,126,745	1
2	Circuit panel in kitchen	2007	4,045	147	20	202	55	1,717	2
3	Replace ceiling tiles	2008	11,366	413	20	568	155	4,828	3
4	New boiler and expansion tank	2008	10,635	387	20	532	145	3,990	4
5	Nurses station	2009	12,283	447	20	614	167	4,605	5
6	Carpeting	2009	12,306		20	615	615	4,613	6
7	Zone controls for main rooftop unit	2009	14,640	532	20	732	200	5,490	7
8	3 garage doors	2009	3,670	133	20	184	51	1,380	8
9									9
10	Basement A/C	2010	13,395		20	670	670	4,355	10
11	200 AMP Breaker/Conduit	2010	12,426	452	20	621	169	4,037	11
12	Drywall/Ceiling Tile/Metal Grid for Pt Rooms & Hallway	2010	10,563	384	20	528	144	3,432	12
13	Repl Hot Water Holding Tank	2010	5,269	192	20	263	71	1,710	13
14	Roofer Sealer Paint	2010	9,085		20	454	454	2,951	14
15	Driveway Sealer Coat	2010	10,608	313	20	530	217	3,445	15
16	Transfer Switch in Kohler Cabinet	2010	3,669		20	183	183	1,190	16
17	New Addition - Activity Room	2010	2,953	107	20	148	41	962	17
18									18
19									19
20	Windows	2011	42,307	1,538	20	2,115	577	11,634	20
21	Wanderguard	2011	113,678	4,134	20	5,684	1,550	31,261	21
22	Stove Hood	2011	40,750	1,482	20	2,038	556	11,206	22
23	Kitchen Air Conditioning	2011	36,470	1,326	20	1,824	498	10,029	23
24	Rooftop A/C Unit	2011	5,995	218	20	300	82	1,649	24
25	Water Cooler Coil on Heat Pump	2011	9,675	352	20	484	132	2,661	25
26	New Interior Paint front door	2011	4,104	149	20	205	56	1,129	26
27									27
28	Therapy Room Addition : framing, drywall, electrical, HVAC,	2011	619,228	22,347	20	30,961	8,614	139,326	28
29	flooring, paint, architect services, etc.								29
30	Generator	2011	168,336	6,121	20	8,417	2,296	37,876	30
31	New Front Door	2012	4,385	159	20	219	60	987	31
32	2 Pressure Tanks & 2 Ductless Heat Pumps for new Laundry Area	2012	14,160	515	20	708	193	3,186	32
33	Replace Glass in Windows in Offices, Dining Room & Lobby	2012	7,236	263	20	362	99	1,628	33
34	TOTAL (lines 1 thru 33)		\$ 3,589,875	\$ 55,790		\$ 91,762	\$ 35,972	\$ 2,428,022	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	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	\$ 55,790		\$ 91,762	\$ 35,972	\$ 2,428,022	1
2	Countertop in Therapy Room	2013	5,645	205	20	282	77	987	2
3									3
4	Carpet - Hall 4	2014	4,724		20	236	236	472	4
5	Northeast Sidewalk Replacement	2015	36,300	1,961	20	1,815	(146)	2,723	5
6	Stonewall - Northeast side of building	2015	3,407		20	170	170	256	6
7	Blacktop work - Parking Lot	2015	5,750	284	20	288	4	431	7
8	Sealing - Roof	2015	5,458	90	20	273	183	409	8
9	Sealing - Roof	2015	3,137		20	157	157	235	9
10									10
11	Carpet/Tile - Lobby	2016	28,437	28,437	20	711	(27,726)	711	11
12	Water Softener - Garage	2016	7,295	7,295	20	182	(7,113)	182	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			46573			(46,573)		27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,690,028	\$ 140,635		\$ 95,876	\$ (44,759)	\$ 2,434,428	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	\$ 223,273	\$ 4,555	\$ 34,992	\$ 30,437		\$ 188,980	71
72	Current Year Purchases	7,406	7,406	741	(6,665)	5	741	72
73	Fully Depreciated Assets	329,838					329,838	73
74								74
75	TOTALS	\$ 560,517	\$ 11,961	\$ 35,733	\$ 23,772		\$ 519,559	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		\$ 226,410	\$ 9,642	\$ 32,176	\$ 22,534	5	\$ 140,969	76
77										77
78										78
79										79
80	TOTALS			\$ 226,410	\$ 9,642	\$ 32,176	\$ 22,534		\$ 140,969	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)	\$ 4,486,955	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 162,238	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 163,785	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,547	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,094,956	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: 09/30/2016

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
Dump Truck for	2010	2010	2,817			-	5	2,817
Administrative	2011 Dodge Ch	2011	55,605		5,559	5,559	5	55,605
Administrative	2011 Toyota Ra	2011	34,200	1,775	6,840	5,065	5	30,780
Administrative	GMC Denali	2013	63,981	4,376	12,796	8,420	5	44,786
Administrative	2013 Chevy Tal	2016	43,171	2,159	4,317	2,158	5	4,317
Maintenance Tru	2014 Dodge Ra	2016	26,635	1,332	2,664	1,332	5	2,664
						-		
						-		
						-		
TOTAL			226,410	9,642	32,176	22,534		140,969

Facility Name & ID Number Alpine Fireside Health Ctr

0018275

Report Period Beginning: 10/01/2015

Ending: 09/30/2016

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.	<u>/2017</u>	\$ _____
13.	<u>/2018</u>	\$ _____
14.	<u>/2019</u>	\$ _____

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: \$ 207 Description: Equipment Rental - \$207

(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.

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			
		1	2	3	4
		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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	\$	9,750	\$ 701,987	\$	9,750	\$ 701,987	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		2,265	163,090		2,265	163,090	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		8,148	586,691	325	8,148	587,016	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				152,127		152,127	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Oxygen</u>	39(2)					7,044		7,044	12
13	Other (specify): _____									13
14	TOTAL			\$	20,163	\$ 1,451,768	\$ 159,496	20,163	\$ 1,611,264	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.

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	\$ 5,453	\$ 5,453	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>265,551</u>)	2,675,755	2,675,755	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	59,808	59,808	6
7	Other Prepaid Expenses	76,984	76,984	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Cafeteria Plan Account Cash</u>	66,052	66,052	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,884,052	\$ 2,884,052	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	1,894,015	3,690,028	15
16	Equipment, at Historical Cost	786,927	786,927	16
17	Accumulated Depreciation (book methods)	(1,308,174)	(3,094,956)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,372,768	\$ 1,391,999	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,256,820	\$ 4,276,051	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 178,363	\$ 178,363	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	44,719	44,719	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,158	3,158	31
32	Accrued Real Estate Taxes(Sch.IX-B)	62,200	62,200	32
33	Accrued Interest Payable	3,883	3,883	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Schedule 17A</u>	255,155	255,155	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 547,478	\$ 547,478	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,485,676	1,485,676	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)	\$ 1,485,676	\$ 1,485,676	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,033,154	\$ 2,033,154	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,223,666	\$ 2,242,897	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,256,820	\$ 4,276,051	48

*(See instructions.)

Facility Name: Alpine Fireside Health Ctr
IDPH License ID Number: 0018275
Fiscal Year End: 09/30/2016

Schedule 17A

XV. Balance Sheet

Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
2240 Fed Income Tax Withheld	9,215	9,215
2250 FICA Taxes Withheld	13,977	13,977
2260 Illinois State Income Tax Withheld	2,755	2,755
2265 Wisconsin State Income Tax Withheld	451	451
2375 401 K	2,403	2,403
2380 ROTH 401 K	319	319
2420 Illinois Bed Tax	9,009	9,009
2640 Rent Accrued	217,026	217,026
Total - Line 36	255,155	255,155

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,415,509	1
2	Restatements (describe):		2
3	Prior Period Adjustment	(998)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,414,511	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	808,155	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)	\$ 809,155	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)	\$ 2,223,666	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Alpine Fireside Health Ctr# 0018275Report Period Beginning: 10/01/2015Ending: 09/30/2016**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**

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,716,244	1
2	Discounts and Allowances for all Levels	(2,288,363)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,427,881	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,402,514	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,402,514	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	27,188	13
14	Non-Patient Meals	10,557	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	142,834	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	26,137	19
20	Radiology and X-Ray	5,831	20
21	Other Medical Services	28,256	21
22	Laundry	11,250	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 252,053	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	39,913	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 39,913	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Schedule 19A</u>	18,784	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 18,784	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,141,145	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,049,088	31
32	Health Care	1,925,554	32
33	General Administration	1,230,628	33
B. Capital Expense			
34	Ownership	339,201	34
C. Ancillary Expense			
35	Special Cost Centers	1,694,185	35
36	Provider Participation Fee	94,334	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,332,990	40
41	Income before Income Taxes (line 30 minus line 40)**	808,155	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 808,155	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 1,087,740	44
45	Private Pay - Net Inpatient Revenue	773,053	45
46	Medicare - Net Inpatient Revenue	(85,043)	46
47	Other-(specify) <u>Shelter Care</u>	1,652,131	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,427,881	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: 09/30/2016

Schedule 19A

XVII. Income Statement

Line 28 Other Revenue (specify):

<u>Description</u>	<u>Amount</u>
4870 Store & Misc Sales	15,506
4880 Uniform Sales	(100)
4990 Miscellaneous Income	2,728
4991 Petty Cash Adjustment Account	650
Total - Line 28	<u>18,784</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: 10/01/2015

Ending: 09/30/2016

	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	3,122	3,310	\$ 105,403	\$ 31.84	1
2	Assistant Director of Nursing	1,693	1,797	54,379	30.26	2
3	Registered Nurses	10,813	11,401	357,704	31.37	3
4	Licensed Practical Nurses	12,496	13,068	331,483	25.37	4
5	CNAs & Orderlies	51,780	53,353	639,855	11.99	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	825	897	13,726	15.30	8
9	Activity Director	1,919	2,010	20,440	10.17	9
10	Activity Assistants	5,373	5,616	48,376	8.61	10
11	Social Service Workers	2,572	2,730	35,621	13.05	11
12	Dietician					12
13	Food Service Supervisor	1,874	1,977	37,089	18.76	13
14	Head Cook	6,425	6,936	61,664	8.89	14
15	Cook Helpers/Assistants	18,682	19,413	168,596	8.68	15
16	Dishwashers					16
17	Maintenance Workers	4,540	4,807	88,260	18.36	17
18	Housekeepers	8,652	9,151	82,156	8.98	18
19	Laundry	3,919	4,129	47,119	11.41	19
20	Administrator	2,160	2,080	81,079	38.98	20
21	Assistant Administrator	2,160	2,080	197,317	94.86	21
22	Other Administrative					22
23	Office Manager	3,848	4,171	84,798	20.33	23
24	Clerical	1,504	1,550	22,002	14.19	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,178	1,178	20,404	17.32	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care Care Plan Coordin	949	969	34,110	35.20	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	146,484	152,623	\$ 2,531,581 *	\$ 16.59	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	280	\$ 14,014	L1,C3	35
36	Medical Director	Monthly	18,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	76	3,805	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	67	3,339	L11,C3	44
45	Social Service Consultant	63	3,169	L12,C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	486	\$ 42,327		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	Asst Administrator	0	\$ 184,848	Workers' Compensation Insurance	\$ 60,825	IDPH License Fee	\$	
See Schedule 21A				Unemployment Compensation Insurance	22,180	Advertising: Employee Recruitment		
				FICA Taxes	211,486	Health Care Worker Background Check		
				Employee Health Insurance	137,053	(Indicate # of checks performed <u>12</u>)	349	
				Employee Meals	9,442	Patient Background Checks	1,780	
				Illinois Municipal Retirement Fund (IMRF)*		Illinois Health Care Association	7,931	
				401 K	41,694	Ability Network	1,920	
				Uniforms	1,030	Miscellaneous Dues & Subscriptions	2,862	
				Pre-Employment Physicals	12,880	Miscellaneous License	1,370	
						Lobbying Expense	(3,412)	
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 184,848	TOTAL (agree to Schedule V, line 22, col.8)	\$ 496,590	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 12,800	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
N/A			\$	N/A		\$	Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	8,360
							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)	\$ 8,360
C. Professional Services								
Vendor/Payee	Type		Amount					
See Schedule 21C			\$ 209,163					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 209,163					

* Attach copy of IMRF notifications

**See instructions.

Facility Name: Alpine Fireside Health Ctr
IDPH License ID Number: 0018275
Fiscal Year End: 09/30/2016

Schedule 21A

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Position	Amount
Gordon Oksnevad	Assistant Administrator	184,848
Total (agree to Schedule V, line 17, column 1)		<u>184,848</u>
Reclass Administrator Gordon Oksnevad	Assistant Administrator	12,469
Reclass Assistant Administrator Michelle Cruden	Administrator	81,079
Total (agree to Schedule V, line 17, column 8)		<u>278,396</u>

Facility Name: Alpine Fireside Health Ctr
IDPH License ID Number: 0018275
Fiscal Year End: 09/30/2016

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
Duane Morris	Legal	12,336
Reno & Zahm	Legal	5,561
RSM US LLP	Accounting	41,617
Verisight	Accounting	785
Williams-Manny, Inc.	Accounting	385
Bank of America	Computer Services	1,856
Brian W. Law	Computer Services	91,715
Chase Card	Computer Services	923
E-Health Data Solutions	Computer Services	5,228
Nebo Systems	Computer Services	60
NTT Long Term Care	Computer Services	48,697
Total (agree to Schedule V, line 19, column 3)		<u><u>209,163</u></u>
Less: Non-Allowable Legal Fees Legal Fees		(4,280)
Total (agree to Schedule V, line 19, column 8)		<u><u>204,883</u></u>

Facility Name & ID Number Alpine Fireside Health Ctr# 0018275Report Period Beginning: 10/01/2015Ending: 09/30/2016**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-\$7,931
- (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. \$ 27,454 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. \$ 94,334
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. \$ 9,442 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 10,557
- (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