FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0018275

Facility Name: Alpine Fireside Health Center

Address: 3650 North Alpine Road (Number) Rockford (City) 61114 (Zip Code)

County: Winnebago

Telephone Number: (815) 877-7408 **Fax #** (815) 877-9818

HFS ID Number:

Date of Initial License for Current Owners: 1973

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Michael W. Martin **Telephone Number:** (217) 258-8888
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/1/09 to 9/30/10 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed)
(Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT
(Date)
(Print Name and Title)
(Firm Name & Address) McGladrey & Pullen, LLP, 20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847) 517-7067

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001
Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,391	1,423	4,561	7,375	8
9	SNF/PED					9
10	ICF	6,149	3,736		9,885	10
11	ICF/DD					11
12	SC			10,218	10,218	12
13	DD 16 OR LESS					13
14	TOTALS	7,540	5,159	14,779	27,478	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.04%

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 [X] 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 [X]

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 [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 32 and days of care provided 4,561

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 9/30/10 Fiscal Year: 9/30/10

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	228,576	2,832	11,687	243,095		243,095		243,095			1
2	Food Purchase		219,084		219,084		219,084	(26,015)	193,069			2
3	Housekeeping	69,749	18,834		88,583		88,583		88,583			3
4	Laundry	32,725	21,795	18,298	72,818		72,818	(18,298)	54,520			4
5	Heat and Other Utilities			126,865	126,865		126,865	2,475	129,340			5
6	Maintenance	82,735	95,643	67,272	245,650		245,650	(34,092)	211,558			6
7	Other (specify):*											7
8	TOTAL General Services	413,785	358,188	224,122	996,095		996,095	(75,930)	920,165			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	1,343,079	141,166	11,630	1,495,875		1,495,875		1,495,875			10
10a	Therapy			417,414	417,414		417,414		417,414			10a
11	Activities	59,312	28,335	2,713	90,360		90,360		90,360			11
12	Social Services	35,846		2,713	38,559		38,559		38,559			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,438,237	169,501	452,470	2,060,208		2,060,208		2,060,208			16
	C. General Administration											
17	Administrative	177,366			177,366		177,366	25,000	202,366			17
18	Directors Fees											18
19	Professional Services			135,520	135,520		135,520	(1,462)	134,058			19
20	Dues, Fees, Subscriptions & Promotions			21,599	21,599		21,599	(1,987)	19,612			20
21	Clerical & General Office Expenses	130,999	22,435	68,177	221,611		221,611	4,181	225,792			21
22	Employee Benefits & Payroll Taxes			405,590	405,590		405,590	7,004	412,594			22
23	Inservice Training & Education											23
24	Travel and Seminar			23,595	23,595		23,595		23,595			24
25	Other Admin. Staff Transportation			13,176	13,176		13,176	214	13,390			25
26	Insurance-Prop.Liab.Malpractice			102,174	102,174		102,174		102,174			26
27	Other (specify):*											27
28	TOTAL General Administration	308,365	22,435	769,831	1,100,631		1,100,631	32,950	1,133,581			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,160,387	550,124	1,446,423	4,156,934		4,156,934	(42,980)	4,113,954			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			99,546	99,546		99,546	45,383	144,929			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			39,357	39,357		39,357	(31,617)	7,740			32
33	Real Estate Taxes							68,315	68,315			33
34	Rent-Facility & Grounds			249,302	249,302		249,302	(249,302)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			388,205	388,205		388,205	(167,221)	220,984			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		147,841		147,841		147,841		147,841			39
40	Barber and Beauty Shops		1,061	17,725	18,786		18,786		18,786			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			72,270	72,270		72,270		72,270			42
43	Other (specify):* Non-Allowable Cos			28,080	28,080		28,080	(28,080)				43
44	**TOTAL Special Cost Centers**		148,902	118,075	266,977		266,977	(28,080)	238,897			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,160,387	699,026	1,952,703	4,812,116		4,812,116	(238,281)	4,573,835			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(19,011)	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	(18,298)	4		8
9	Non-Straightline Depreciation	12,098	30		9
10	Interest and Other Investment Income	(86,451)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,432)	43		24
25	Fund Raising, Advertising and Promotional	(5,715)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,355)	43		28
29	Other-Attach Schedule See Pg 5A	(53,182)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (173,346)		$	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 Amount	2 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)	(64,935)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (64,935)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (238,281)		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 Yes	2 No	3 Amount	4 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

SEE ACCOUNTANTS' COMPILATION REPORT

Alpine Fireside Health Center

ID# 0018275

Report Period Beginning: 10/1/09

Ending: 9/30/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	X-Rays-Part A	$ (4,703)	43	1
2	Ambulance	(3,202)	43	2
3	Labs-Part A	(1,421)	43	3
4	Sales Tax	(790)	43	4
5	Nonallowable Marketing	(5,526)	43	5
6	Contributions	(4,050)	43	6
7	Miscellaneous Expense	114	43	7
8	Miscellaneous Income	3,937	21	8
9	Nonallowable Legal	(1,462)	19	9
10	Lobbying	(1,987)	20	10
11	Employee Meal Reclass	7,004	22	11
12	Employee Meal Reclass	(7,004)	2	12
13	Maintenance Supplies - Capitalized	(35,525)	6	13
14	Bldg Maintenance Supplies - Capitalized	(6,622)	6	14
15	Bldg Maintenance Supplies - Expensed	8,055	6	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**	(53,182)		49

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

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Johs Oksnevad	100			Johs Oksnevad	Rockford, IL	

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Heat and other utilities	$	Johs Oksnevad	100.00%	$ 2,475	$ 2,475	1
2	V	21	Office		Johs Oksnevad	100.00%	244	244	2
3	V	24	Travel and seminar		Johs Oksnevad	100.00%	214	214	3
4	V	30	Depreciation		Johs Oksnevad	100.00%	33,285	33,285	4
5	V	32	Interest		Johs Oksnevad	100.00%	54,834	54,834	5
6	V	33	Reat Estate taxes		Johs Oksnevad	100.00%	68,315	68,315	6
7	V	34	Rent-facility and grounds	249,302	Johs Oksnevad	100.00%		(249,302)	7
8	V	17	Assistant Administrator Salary		Johs Oksnevad	100.00%	25,000	25,000	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 249,302			$ 184,367	$ * (64,935)	14

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

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

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Johs Oksnevad	President	Asst Administrator	100.00	0	20	50.00	Salary	$ 25,000	L17,C8	1
2	Gordon Oksnevad	Administrator	Administrator	0.00	0	50	100.00	Salary	177,366	L17, C1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 202,366		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

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

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 [X]

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

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

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

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

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Durand State Bank		X	Working capital & impvmnts	$10,000.00	12/01	$ 915,387	$ 745,018	6/4/12	0.0695	$ 54,834	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Johs Oksnevad	X		Working Capital	None	9/30/99	169,000	655,507	Demand	0.0600	39,357	6
7												7
8												8
9	TOTAL Facility Related				$10,000.00		$ 1,084,387	$ 1,400,525			$ 94,191	9
	B. Non-Facility Related*											
10												10
11								Less Interest Income offset			(47,094)	11
12								Eliminate related party interest			(39,357)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (86,451)	14
15	TOTALS (line 9+line14)						$ 1,084,387	$ 1,400,525			$ 7,740	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.)**

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 52,000	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.)	2009	$ 67,815	2
3. Under or (over) accrual (line 2 minus line 1).		$ 15,815	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 52,500	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.		$ 68,315	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005	58,304	8
2006	59,701	9
2007	62,424	10
2008	66,238	11
2009	67,815	12

Accrual calculation

2009 tax bill	67,814.92
% Increase	x1.0238
Estimate of 2010 taxes	$69,847 x 9/12=$52,500

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Alpine Fireside Health Center 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 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	12-05-376-003	Nursing Home	$ 67,814.92	$ 67,814.92
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 67,814.92	$ 67,814.92

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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

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

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 [X] (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? [X] (a) Own the Equipment [X] (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 [X] NO
If so, please complete the following:

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	99		1973	1973	$ 717,727	$	30	$	$	$ 717,727	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9				1973	1,277		10			1,277	9
10				1973	3,172		20			3,172	10
11				1973	694		40	17	17	646	11
12				1973	201		25			201	12
13				1973	93,791		11			93,791	13
14				1973	96,886		34	2,850	2,850	93,622	14
15				1974	8,366		11			8,366	15
16				1975	3,593		10			3,593	16
17				1977	10,055		10			10,055	17
18				1981	2,656		15			2,656	18
19				1982	5,132		11			5,132	19
20				1982	1,063		15			1,063	20
21				1984	21,939		15			21,939	21
22	Smoke detectors			1984	1,145		10			1,145	22
23				1985	3,300		15			3,300	23
24	Roof			1986	19,094		15			19,094	24
25	Kitchen addition and storm sewers			1988	235,818		20			235,818	25
26	Kitchen improvements			1989	9,541		20			9,541	26
27	Black top			1990	5,000		10			5,000	27
28	Broiler			1991	29,033		20	1,452	1,452	28,314	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	1,168	1,168	34,924	32
33	Air conditioning system			1999	280,820		15	18,721	18,721	215,292	33
34	Carpeting / flooring / wallcovering			1999	81,812		15	5,454	5,454	62,721	34
35	Parking lot lights			1999	16,900		15	1,126	1,126	12,949	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 Center # 0018275 Report Period Beginning: 10/1/09 Ending: 9/30/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	
37	Air conditioning	2000	$ 24,655	$	15	$ 1,644	$ 1,644	$ 15,617	37
38	Parking lot	2002	42,683	2,846	15	2,846		24,191	38
39	Boiler electrical improvements	2002	11,560	578	20	578		4,913	39
40	Gazebo pad	2002	12,657	633	20	633		5,380	40
41	Painting and wallpapering hallways	2003	27,403	1,370	20	1,370		10,275	41
42	Gazebo	2003	35,825	1,792	20	1,792		13,440	42
43	Fence	2003	3,400	170	20	170		1,275	43
44	Sign	2003	1,675	84	20	84		630	44
45	Garage	2003	3,077	154	20	154		1,154	45
46	Fire alarm	2003	30,208	1,510	20	1,510		11,325	46
47	Boiler	2004	31,880	1,594	20	1,594		10,364	47
48	Sign	2004	3,487	174	20	174		1,131	48
49	Smoke detectors	2004	2,153	108	20	108		702	49
50	Boiler	2005	7,060	352	20	352		1,936	50
51	Commercial disposal	2005	826	42	20	42		231	51
52	Fire supression system	2005	1,866	94	20	94		517	52
53	Pond	2006	11,930	596	20	596		2,682	53
54	Fire alarm system	2006	2,738	137	20	137		616	54
55	Floor tile, baseboards	2006	5,759	288	20	288		1,296	55
56	Air conditioning	2006	13,634	682	20	682		3,069	56
57	Sidewalk	2006	1,196	60	20	60		270	57
58	Remodel grieving room	2006	2,198	110	20	110		495	58
59	Fire sprinkler system	2007	169,761	8,487	20	8,487		29,705	59
60	Nurse call system	2007	69,282	3,464	20	3,464		12,124	60
61	Remodel fireplace	2007	39,855	1,993	20	1,993		6,975	61
62	Ceiling tiles	2007	12,820	641	20	641		2,244	62
63	Drywall stairways	2007	8,000	400	20	400		1,400	63
64	20 ton rooftop unit	2007	34,100	1,705	20	1,705		5,967	64
65	Ductless heat pump	2007	7,760	388	20	388		1,358	65
66	Remodel fireplace	2007	6,631	332	20	332		1,162	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,386,638	$ 30,784		$ 63,216	$ 32,432	$ 1,840,402	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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 12A, Carried Forward		$ 2,386,638	$ 30,784		$ 63,216	$ 32,432	$ 1,840,402	1
2	Circuit panel in kitchen	2007	4,045	202	20	202		505	2
3	Replace ceiling tiles	2008	11,366	568	20	568		1,420	3
4	New boiler and expanstion tank	2008	10,635	532	20	532		798	4
5	Nurses station	2009	12,283	614	20	614		921	5
6	Carpeting	2009	12,306	615	20	615		923	6
7	Zone controls for main rooftop unit	2009	14,640	732	20	732		1,098	7
8	3 garage doors	2009	3,670	184	20	184		276	8
9									9
10	Basement A/C	2010	13,395	847	20	335	(512)	335	10
11	200 AMP Breaker/Conduit	2010	12,426		20	311	311	311	11
12	Drywall/Ceiling Tile/Metal Grid for Pt Rooms & Hallway	2010	10,563		20	264	264	264	12
13	Repl Hot Water Holding Tank	2010	5,269		20	132	132	132	13
14	Roofer Sealer Paint	2010	9,085		20	227	227	227	14
15	Driveway Sealer Coat	2010	10,608		20	265	265	265	15
16	Transfer Switch in Kohler Cabinet	2010	3,669		20	92	92	92	16
17	New Addition - Activity Room	2010	2,953		20	74	74	74	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,523,551	$ 35,078		$ 68,363	$ 33,285	$ 1,848,043	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 541,109	$ 60,492	$ 72,590	$ 12,098	3-10	$ 571,177	71
72	Current Year Purchases	36,943	3,694	3,694		5	3,694	72
73	Fully Depreciated Assets	318,391					318,391	73
74								74
75	TOTALS	$ 896,443	$ 64,186	$ 76,284	$ 12,098		$ 893,262	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Totals from Sch 13A	Various		$ 178,414	$ 282	$ 282	$	5	$ 167,411	76
77										77
78										78
79										79
80	TOTALS			$ 178,414	$ 282	$ 282	$		$ 167,411	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,608,408	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 99,546	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 144,929	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 45,383	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,908,716	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	Construction in Progress	$ 142,049	92
93			93
94			94
95		$ 142,049	95

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

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

STATE OF ILLINOIS

Sch 13A

Facility Name & ID Number Alpine Fireside Health Center # 18275 Report Period Beginning: 10/1/09 Ending: 9/30/10

D. Vehicle Depreciation (See instructions.)*

1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
Administrative	2004 Yukon	2004	$ 53,115	$ 0	$ 0	$ 0	5	$ 53,115
Maintenance Truck	2006 GMC Sierra	2005	48,333	0	0	0	5	43,501
Administrative	2006 Chrysler 300	2006	24,902	0	0	0	5	21,266
Resident Transportation	1998 Ford Supreme Bus	1999	49,247	0	0	0	5	49,247
Dump Trailer for Tractor	2010	2010	2,817	282	282	0	5	282
TOTALS			$ 178,414	$ 282	$ 282	$ 0		$ 167,411

SEE ACCOUNTANTS' COMPILATION REPORT

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions				N/A			4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

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.	/2011	$
13.	/2012	$
14.	/2013	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ ____ Description: N/A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18			N/A		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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

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.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	CNA Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

		1	2	3	4	5	6	7	8	
	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	L10A, C3	hrs	$	1,908	$ 188,980	$	1,908	$ 188,980	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		361	35,840		361	35,840	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		1,926	192,594		1,926	192,594	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				147,841		147,841	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$	4,195	$ 417,414	$ 147,841	4,195	$ 565,255	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

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

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 9/30/10 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 30,000)	1,182,083	1,182,083	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	54,532	54,532	6
7	Other Prepaid Expenses	37,390	37,390	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Cafeteria Plan	887	887	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,274,892	$ 1,274,892	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	704,244	2,523,551	15
16	Equipment, at Historical Cost	643,179	1,074,857	16
17	Accumulated Depreciation (book methods)	(724,036)	(2,908,716)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe CIP	142,049	142,049	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 765,436	$ 841,741	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,040,328	$ 2,116,633	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 106,967	$ 106,967	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	89,063	89,063	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	269,526	269,526	32
33	Accrued Interest Payable	165,170	165,170	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Unemployment Tax	4,861	4,861	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 635,587	$ 635,587	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	655,507	1,400,525	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 655,507	$ 1,400,525	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,291,094	$ 2,036,112	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 749,234	$ 80,521	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,040,328	$ 2,116,633	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

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

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 503,823	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 503,823	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	245,411	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 245,411	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)**	$ 749,234	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,440,534	1
2	Discounts and Allowances for all Levels	(73,833)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,366,701	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	340,198	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 340,198	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	34,698	13
14	Non-Patient Meals	19,011	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	176,904	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,694	19
20	Radiology and X-Ray	4,628	20
21	Other Medical Services	34,635	21
22	Laundry	21,702	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 296,272	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	47,094	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 47,094	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Schedule 19A	7,890	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 7,890	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,058,155	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	996,095	31
32	Health Care	2,060,208	32
33	General Administration	1,100,631	33
	B. Capital Expense		
34	Ownership	388,205	34
	C. Ancillary Expense		
35	Special Cost Centers	194,707	35
36	Provider Participation Fee	72,270	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,812,116	40
41	**Income before Income Taxes (line 30 minus line 40)****	246,039	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 246,039	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. Tax return is prepared on the cash basis of accounting.**

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

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

Alpine Fireside Health Center, Ltd.
Provider # 0018275
9/30/2010

Schedule 19A

E. Other Revenue (specify)
Line 28

Description	Amount
Store & Misc Sales	12,718
Petty Cash Adjustment	(891)
Misc. Income	(3,937)
	7,890

See Accountants' Compilation Report

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

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,080	$ 78,934	$ 37.95	1
2	Assistant Director of Nursing	2,289	2,407	63,329	26.31	2
3	Registered Nurses	7,690	8,014	187,117	23.35	3
4	Licensed Practical Nurses	13,645	13,993	304,732	21.78	4
5	CNAs & Orderlies	57,452	59,362	621,798	10.47	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,367	2,551	37,195	14.58	8
9	Activity Director	1,860	1,900	24,166	12.72	9
10	Activity Assistants	3,728	3,808	35,146	9.23	10
11	Social Service Workers	2,138	2,226	35,846	16.10	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	4,502	4,766	55,513	11.65	14
15	Cook Helpers/Assistants	19,991	20,987	173,063	8.25	15
16	Dishwashers					16
17	Maintenance Workers	5,324	5,676	82,735	14.58	17
18	Housekeepers	8,182	8,518	69,749	8.19	18
19	Laundry	2,670	2,854	32,725	11.47	19
20	Administrator	2,080	2,080	177,366	85.27	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,841	1,977	32,762	16.57	23
24	Clerical	2,836	2,932	41,917	14.30	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)	4,530	4,922	106,294	21.60	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	145,205	151,053	$ 2,160,387 *	$ 14.30	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	85	$ 11,687	L1,C3	35
36	Medical Director	36	18,000	L9,C3	36
37	Medical Records Consultant	48	900	L10,C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	28	2,203	L10,C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	48	2,713	L11,C3	44
45	Social Service Consultant	36	2,713	L12,C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	281	$ 38,216		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	94	$ 3,752	L10,C3	50
51	Licensed Practical Nurses	159	4,775	L10,C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	253	$ 8,527		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Alpine Fireside Health Center, Ltd.
PROVIDER # 0018275
September 30, 2010

Breakdown of PG20, Line #32 - Other Health Care

Description	# of Hours Acrtually Worked	# of Hours Paid and Accrued	Reporting Period Total Salaries, Wages
Rehab Services Coordinator	2,648	2,864	56,320
Care Plan Cordinator	1,882	2,058	49,974
Totals	4,530	4,922	106,294

SEE ACCOUNTANTS' COMPILATION REPORT

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
See Schedule 21A			$ 177,366
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 177,366

B. Administrative - Other

Description	Amount
N/A	$ 0
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Schedule 21C		$ 135,520
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 135,520

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 91,356
Unemployment Compensation Insurance	25,154
FICA Taxes	156,363
Employee Health Insurance	95,412
Employee Meals	7,004
Illinois Municipal Retirement Fund (IMRF)*	
401 K	21,425
Uniforms	407
Pre-Employement Physicals	15,473
TOTAL (agree to Schedule V, line 22, col.8)	$ 412,594

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	33
Health Care Worker Background Check	
(Indicate # of checks performed 585)	10,590
Patient Background Checks	
Illinois Health Care Association	5,619
Rockford Register	2,779
Miscellaneous Dues & Subscriptions	638
Miscellaneous License	1,940
Less: Public Relations Expense	( )
Non-allowable advertising	(1,987)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,612

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	23,595
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 23,595

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Alpine Fireside Health Center, Ltd.
PROVIDER # 0018275
September 30, 2010

Schedule 21A

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Funtion	Ownershi	Amount
Gordon Oksnevad	Administrator	0%	177,366
TOTAL (agree to Schedule V, line 17, col. 1)			
Johs Oksnevad	Assistant Administrator	100%	25,000
TOTAL (agree to Schedule V, line 17, col. 8)			202,366

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

See Accountants' Compilation Report

Alpine Fireside Health Center, Ltd.
PROVIDER # 0018275
September 30, 2010

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor/Payee	Type	Amount
Duane Morris LLP	Legal	22,580
Reno & Zahm	Legal	2,889
RSM McGladrey	Accounting	17,408
McGladrey & Pullen	Accounting	27,925
Business Management Services	Computer Services	37,272
Keane Care	Computer Services	15,007
E Health Data	Computer Services	3,357
Ingenix	Computer Services	2,276
Rock River Internext	Computer Services	700
Storm Consulting	Computer Services	3,801
Cubed, Inc	Computer Services	2,305
TOTAL (agree to Schedule V, line 19, column 3)		135,520
Less Non Allowable Legal		(1,462)
TOTAL (agree to Schedule V, line 19, column 8)		134,058

See Accountants' Compilation Report

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

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	Amount of Expense Amortized Per Year								
					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		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

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

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Assn-$5,619**

(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. $ **8,055** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **72,270**
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.

SEE ACCOUNTANTS' COMPILATION REPORT

(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. $ **7,004** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **19,011**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.