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.

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

I. IDPH License ID Number: 0018275

Facility Name: Alpine Fireside Health Center, Ltd.

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 10/1/10 to 9/30/11 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' PREPARATION 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

Facility Name & ID Number Alpine Fireside Health Center, Ltd. # 0018275 Report Period Beginning: 10/1/10 Ending: 9/30/11

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	33	Intermediate (ICF)	33	12,045	3
4		Intermediate/DD			4
5	33	Sheltered Care (SC)	33	12,045	5
6		ICF/DD 16 or Less			6
7	98	TOTALS	98	35,770	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	1,102	1,149	3,710	5,961	8
9	SNF/PED					9
10	ICF	6,567	3,743		10,310	10
11	ICF/DD					11
12	SC			10,814	10,814	12
13	DD 16 OR LESS					13
14	TOTALS	7,669	4,892	14,524	27,085	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.72%

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 3,710

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: 9/30/11 Fiscal Year: 9/30/11

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

Facility Name & ID Number Alpine Fireside Health Center, Ltd. # 0018275 Report Period Beginning: 10/1/10 Ending: 9/30/11

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	248,646	15,334	14,682	278,662		278,662		278,662			1
2	Food Purchase		220,577		220,577		220,577	(24,512)	196,065			2
3	Housekeeping	73,525	10,613		84,138		84,138		84,138			3
4	Laundry	35,560	12,903	8,229	56,692		56,692	(8,229)	48,463			4
5	Heat and Other Utilities			108,089	108,089		108,089		108,089			5
6	Maintenance	99,717	87,271	78,120	265,108		265,108		265,108			6
7	Other (specify):*											7
8	TOTAL General Services	457,448	346,698	209,120	1,013,266		1,013,266	(32,741)	980,525			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	1,480,662	130,326	6,630	1,617,618		1,617,618		1,617,618			10
10a	Therapy			320,168	320,168		320,168		320,168			10a
11	Activities	62,650	24,737	2,526	89,913		89,913		89,913			11
12	Social Services	41,750		2,526	44,276		44,276		44,276			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,585,062	155,063	349,850	2,089,975		2,089,975		2,089,975			16
	C. General Administration											
17	Administrative	198,143			198,143		198,143	25,000	223,143			17
18	Directors Fees											18
19	Professional Services			158,518	158,518		158,518	(506)	158,012			19
20	Dues, Fees, Subscriptions & Promotions			25,960	25,960		25,960	(1,637)	24,323			20
21	Clerical & General Office Expenses	154,938	23,119	61,968	240,025		240,025	4,566	244,591			21
22	Employee Benefits & Payroll Taxes			439,981	439,981		439,981	7,316	447,297			22
23	Inservice Training & Education											23
24	Travel and Seminar			18,787	18,787		18,787		18,787			24
25	Other Admin. Staff Transportation			16,422	16,422		16,422		16,422			25
26	Insurance-Prop.Liab.Malpractice			75,978	75,978		75,978		75,978			26
27	Other (specify):*											27
28	TOTAL General Administration	353,081	23,119	797,614	1,173,814		1,173,814	34,739	1,208,553			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,395,591	524,880	1,356,584	4,277,055		4,277,055	1,998	4,279,053			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.

Facility Name & ID Number Alpine Fireside Health Center, Ltd. #0018275 Report Period Beginning: 10/1/10 Ending: 9/30/11

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			97,757	97,757		97,757	74,451	172,208			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			17,042	17,042		17,042	(17,042)				32
33	Real Estate Taxes							74,385	74,385			33
34	Rent-Facility & Grounds			254,385	254,385		254,385	(254,385)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			369,184	369,184		369,184	(122,591)	246,593			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		42,870		42,870		42,870		42,870			39
40	Barber and Beauty Shops		1,276	14,498	15,774		15,774		15,774			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			36,135	36,135		36,135		36,135			42
43	Other (specify):* **Non-Allow Costs**			122,853	122,853		122,853	(122,853)				43
44	**TOTAL Special Cost Centers**		44,146	173,486	217,632		217,632	(122,853)	94,779			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,395,591	569,026	1,899,254	4,863,871		4,863,871	(243,446)	4,620,425			45

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

Facility Name & ID Number Alpine Fireside Health Center, Ltd. # 0018275 Report Period Beginning: 10/1/10 Ending: 9/30/11

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	(17,196)	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	(8,229)	4		8
9	Non-Straightline Depreciation	43,920	30		9
10	Interest and Other Investment Income	(17,042)	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	(102,335)	43		24
25	Fund Raising, Advertising and Promotional	(6,412)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(120)	43		28
29	Other-Attach Schedule See Pg 5A	(55,109)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (162,523)		$	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)	(80,923)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (80,923)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (243,446)		37

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

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

		1 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

Alpine Fireside Health Center, Ltd.

ID# 0018275

Report Period Beginning: 10/1/10

Ending: 9/30/11

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	X-Rays - Part A	$ (2,933)	43	1
2	Ambulance	(515)	43	2
3	Income Tax/Other Taxes	(51)	43	3
4	Nonallowable Marketing	(7,621)	43	4
5	Contributions	(300)	43	5
6	Miscellaneous Exp/Suspense Acct.	(2,566)	43	6
7	Miscellaneous Income	4,267	21	7
8	Lobbying	(1,637)	20	8
9	Employee Meal Reclass	7,316	22	9
10	Employee Meal Reclass	(7,316)	2	10
11	Nonallowable Legal	(506)	19	11
12	Disallow related party interest	(43,247)	32	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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32				32
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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**	(55,109)		49

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Alpine Fireside Health Center, Ltd. # 0018275 Report Period Beginning: 10/1/10 Ending: 9/30/11

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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%	$	$	1
2	V	21	Office		Johs Oksnevad	100.00%	299	299	2
3	V	24	Travel and seminar		Johs Oksnevad	100.00%			3
4	V	30	Depreciation		Johs Oksnevad	100.00%	30,531	30,531	4
5	V	32	Interest		Johs Oksnevad	100.00%	43,247	43,247	5
6	V	33	Reat Estate taxes		Johs Oksnevad	100.00%	74,385	74,385	6
7	V	34	Rent-facility and grounds	254,385	Johs Oksnevad	100.00%		(254,385)	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			$ 254,385			$ 173,462	$ * (80,923)	14

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

Facility Name & ID Number Alpine Fireside Health Center, Ltd. # 0018275 Report Period Beginning: 10/1/10 Ending: 9/30/11

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	198,143	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	$ 223,143		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, Ltd. # 0018275 Report Period Beginning: 10/1/10 Ending: 9/30/11

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				N/A						3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Alpine Fireside Health Center, Ltd. # 0018275 Report Period Beginning: 10/1/10 Ending: 9/30/11

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	Interest Only	06/12	$ 997,396	$ 997,396	05/05/16	0.0590	$ 17,042	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Johs Oksnevad	X		Working Capital	None	9/30/99	169,000		Demand	0.0600	43,247	6
7												7
8												8
9	TOTAL Facility Related						$ 1,166,396	$ 997,396			$ 60,289	9
	B. Non-Facility Related*											
10								Offset interest against income			(17,042)	10
11								Eliminate related party interest			(43,247)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (60,289)	14
15	TOTALS (line 9+line14)						$ 1,166,396	$ 997,396			$	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.)**

Facility Name & ID Number Alpine Fireside Health Center, Ltd. # 0018275 **Report Period Beginning:** 10/1/10 **Ending:** 9/30/11

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 52,500	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.)	2010	$ 70,985	2
3. Under or (over) accrual (line 2 minus line 1).		$ 18,485	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 55,900	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.		$ 74,385	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2006	59,701	8
2007	62,424	9
2008	66,238	10
2009	67,815	11
2010	70,985	12

Accrual calculation

2010 tax bill 70,984.96

% Increase x1.0467

Estimate of 2010 taxes $74,534.21 x 9/12=$55,900.66

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 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 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	12-05-376-003	Nursing Home	$ 70,984.96	$ 70,984.96
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 70,984.96	$ 70,984.96

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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, Ltd. # 0018275 Report Period Beginning: 10/1/10 Ending: 9/30/11

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

Facility Name & ID Number Alpine Fireside Health Center, Ltd. # 0018275 Report Period Beginning: 10/1/10 Ending: 9/30/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	663	11
12				1973	201		25			201	12
13				1973	93,791		11			93,791	13
14				1973	96,886		34	2,850	2,850	96,472	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	719	719	29,033	28
29	Lawn sprinkler			1992	5,000		15			5,000	29
30	Leasehold improvements			1993	13,972		15			13,972	30
31	Roof improvements			1994	57,648		15			57,648	31
32	Generator			1995	34,924		15			34,924	32
33	Air conditioning system			1999	280,820		15	18,721	18,721	234,013	33
34	Carpeting / flooring / wallcovering			1999	81,812		15	5,454	5,454	68,175	34
35	Parking lot lights			1999	16,900		15	1,126	1,126	14,075	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, Ltd. # 0018275 Report Period Beginning: 10/1/10 Ending: 9/30/11

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	
37	Air conditioning	2000	$ 24,655	$	15	$ 1,644	$ 1,644	$ 17,261	37
38	Parking lot	2002	42,683	2,846	15	2,846		27,037	38
39	Boiler electrical improvements	2002	11,560	578	20	578		5,491	39
40	Gazebo pad	2002	12,657	633	20	633		6,013	40
41	Painting and wallpapering hallways	2003	27,403	1,370	20	1,370		11,645	41
42	Gazebo	2003	35,825	1,792	20	1,792		15,232	42
43	Fence	2003	3,400	170	20	170		1,445	43
44	Sign	2003	1,675	84	20	84		714	44
45	Garage	2003	3,077	154	20	154		1,308	45
46	Fire alarm	2003	30,208	1,510	20	1,510		12,835	46
47	Boiler	2004	31,880	1,594	20	1,594		11,958	47
48	Sign	2004	3,487	174	20	174		1,305	48
49	Smoke detectors	2004	2,153	108	20	108		810	49
50	Boiler	2005	7,060	352	20	352		2,288	50
51	Commercial disposal	2005	826	42	20	42		273	51
52	Fire supression system	2005	1,866	94	20	94		611	52
53	Pond	2006	11,930	596	20	596		3,278	53
54	Fire alarm system	2006	2,738	137	20	137		753	54
55	Floor tile, baseboards	2006	5,759	288	20	288		1,584	55
56	Air conditioning	2006	13,634	682	20	682		3,751	56
57	Sidewalk	2006	1,196	60	20	60		330	57
58	Remodel grieving room	2006	2,198	110	20	110		605	58
59	Fire sprinkler system	2007	169,761	8,487	20	8,487		38,192	59
60	Nurse call system	2007	69,282	3,464	20	3,464		15,588	60
61	Remodel fireplace	2007	39,855	1,993	20	1,993		8,968	61
62	Ceiling tiles	2007	12,820	641	20	641		2,885	62
63	Drywall stairways	2007	8,000	400	20	400		1,800	63
64	20 ton rooftop unit	2007	34,100	1,705	20	1,705		7,672	64
65	Ductless heat pump	2007	7,760	388	20	388		1,746	65
66	Remodel fireplace	2007	6,631	332	20	332		1,494	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,386,638	$ 30,784		$ 61,315	$ 30,531	$ 1,901,717	70

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

Facility Name & ID Number Alpine Fireside Health Center, Ltd. # 0018275 Report Period Beginning: 10/1/10 Ending: 9/30/11

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 12A, Carried Forward		$ 2,386,638	$ 30,784		$ 61,315	$ 30,531	$ 1,901,717	1
2	Circuit panel in kitchen	2007	4,045	202	20	202		707	2
3	Replace ceiling tiles	2008	11,366	568	20	568		1,988	3
4	New boiler and expanstion tank	2008	10,635	532	20	532		1,330	4
5	Nurses station	2009	12,283	614	20	614		1,535	5
6	Carpeting	2009	12,306	615	20	615		1,538	6
7	Zone controls for main rooftop unit	2009	14,640	732	20	732		1,830	7
8	3 garage doors	2009	3,670	184	20	184		460	8
9									9
10	Basement A/C	2010	13,395	847	20	670	(177)	1,005	10
11	200 AMP Breaker/Conduit	2010	12,426		20	621	621	932	11
12	Drywall/Ceiling Tile/Metal Grid for Pt Rooms & Hallway	2010	10,563		20	528	528	792	12
13	Repl Hot Water Holding Tank	2010	5,269		20	263	263	395	13
14	Roofer Sealer Paint	2010	9,085		20	454	454	681	14
15	Driveway Sealer Coat	2010	10,608		20	530	530	795	15
16	Transfer Switch in Kohler Cabinet	2010	3,669		20	183	183	275	16
17	New Addition - Activity Room	2010	2,953		20	148	148	222	17
18									18
19									19
20	Windows	2011	42,307	833	20	1,058	225	1,058	20
21	Wanderguard	2011	113,678	172	20	2,842	2,670	2,842	21
22	Stove Hood	2011	40,750	679	20	1,019	340	1,019	22
23	Kitchen Air Conditioning	2011	36,470	497	20	912	415	912	23
24	Rooftop A/C Unit	2011	5,995	45	20	150	105	150	24
25	Water Cooler Coil on Heat Pump	2011	9,675	44	20	242	198	242	25
26	New Interior Paint front door	2011	4,104	6	20	103	97	103	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,776,530	$ 37,354		$ 74,483	$ 37,129	$ 1,922,526	34

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

Facility Name & ID Number Alpine Fireside Health Center, Ltd. # 0018275 Report Period Beginning: 10/1/10 Ending: 9/30/11

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	$ 578,052	$ 38,962	$ 76,284	$ 37,322	3-10	$ 651,155	71
72	Current Year Purchases	153,155	15,316	15,316		5	15,316	72
73	Fully Depreciated Assets	318,391					318,391	73
74								74
75	TOTALS	$ 1,049,598	$ 54,278	$ 91,600	$ 37,322		$ 984,862	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		$ 209,117	$ 6,125	$ 6,125	$	5	$ 152,270	76
77										77
78										78
79										79
80	TOTALS			$ 209,117	$ 6,125	$ 6,125	$		$ 152,270	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)	$ 4,045,245	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 97,757	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 172,208	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 74,451	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,059,658	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	$ 514,609	92
93			93
94			94
95		$ 514,609	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, Ltd. # 0018275 — Report Period Beginning: 10/1/10 Ending: 9/30/11

D. Vehicle Depreciation (See instructions.)*

1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
Administrative	2004 Yukon	2004	$ 53,115	$ 0	$ 0	$ 0	5	$ 53,115
Maintenance Truck	2006 GMC Sierra	2005	48,333	0	0	0	5	43,501
Resident Transportation	1998 Ford Supreme Bus	1999	49,247	0	0	0	5	49,247
Dump Trailer for Tractor	2010	2010	2,817	564	564	0	5	846
Administrative	2011 Dodge Challenger	2011	55,605	5,561	5,561		5	5,561
TOTALS			$ 209,117	$ 6,125	$ 6,125	$ 0		$ 152,270

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Alpine Fireside Health Center, Ltd. # 0018275 Report Period Beginning: 10/1/10 Ending: 9/30/11

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.	/2012	$
13.	/2013	$
14.	/2014	$

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.

Facility Name & ID Number Alpine Fireside Health Center, Ltd. # 0018275 Report Period Beginning: 10/1/10 Ending: 9/30/11

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.

Facility Name & ID Number Alpine Fireside Health Center, Ltd. # 0018275 Report Period Beginning: 10/1/10 Ending: 9/30/11

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10A, C3	hrs	$	1,654	$ 163,788	$	1,654	$ 163,788	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		227	22,518		227	22,518	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		1,339	133,862		1,339	133,862	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				42,870		42,870	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			$	3,220	$ 320,168	$ 42,870	3,220	$ 363,038	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.

STATE OF ILLINOIS

Facility Name & ID Number Alpine Fireside Health Center, Ltd. # 0018275 Report Period Beginning: 10/1/10 Ending: 9/30/11

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/30/11 (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 130,000)	854,781	854,781	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	76,925	76,925	6
7	Other Prepaid Expenses	38,976	38,976	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Cafeteria Plan	10,381	10,381	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 981,063	$ 981,063	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	991,314	2,776,530	15
16	Equipment, at Historical Cost	632,221	1,258,715	16
17	Accumulated Depreciation (book methods)	(653,159)	(3,059,658)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(489)	(489)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe CIP	514,610	514,610	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,484,497	$ 1,499,708	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,465,560	$ 2,480,771	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 181,820	$ 181,820	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	100,586	100,586	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	333,687	333,687	32
33	Accrued Interest Payable	2,440	2,440	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Unemployment Tax	15,685	15,685	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 634,218	$ 634,218	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	997,396	997,396	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)**	$ 997,396	$ 997,396	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,631,614	$ 1,631,614	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 833,946	$ 849,157	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,465,560	$ 2,480,771	48

*(See instructions.)

Facility Name & ID Number Alpine Fireside Health Center, Ltd. # 0018275 **Report Period Beginning:** 10/1/10 **Ending:** 9/30/11

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 811,702	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 811,702	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	21,244	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)**	$ 22,244	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)**	$ 833,946	24 *

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

Facility Name & ID Number Alpine Fireside Health Center, Ltd. # 0018275 Report Period Beginning: 10/1/10 Ending: 9/30/11

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	$ 4,385,801	1
2	Discounts and Allowances for all Levels	(129,560)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,256,241	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	440,135	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 440,135	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	28,007	13
14	Non-Patient Meals	17,196	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	62,729	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	927	19
20	Radiology and X-Ray	2,766	20
21	Other Medical Services	20,153	21
22	Laundry	18,010	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 149,788	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	29,846	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 29,846	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Schedule 19A	9,105	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 9,105	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,885,115	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,013,266	31
32	Health Care	2,089,975	32
33	General Administration	1,173,814	33
	B. Capital Expense		
34	Ownership	369,184	34
	C. Ancillary Expense		
35	Special Cost Centers	181,497	35
36	Provider Participation Fee	36,135	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,863,871	40
41	**Income before Income Taxes (line 30 minus line 40)****	21,244	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 21,244	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 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.**

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

Alpine Fireside Health Center, Ltd.
Provider # 0018275
9/30/2011

Schedule 19A

E. Other Revenue (specify)
Line 28

Description	Amount
Store & Misc Sales	3,994
Petty Cash Adjustment	335
Misc. Income	4,267
Gain on Sale of Assets	509
	9,105

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Alpine Fireside Health Center, Ltd. # 0018275 Report Period Beginning: 10/1/10 Ending: 9/30/11

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	2,258	2,574	$ 76,823	$ 29.85	1
2	Assistant Director of Nursing	2,178	2,904	88,703	30.55	2
3	Registered Nurses	11,173	11,423	296,649	25.97	3
4	Licensed Practical Nurses	10,816	11,222	253,961	22.63	4
5	CNAs & Orderlies	60,346	62,251	670,445	10.77	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,548	2,612	41,342	15.83	9
10	Activity Assistants	2,517	2,561	21,308	8.32	10
11	Social Service Workers	2,273	2,401	41,750	17.39	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	9,514	10,475	87,050	8.31	14
15	Cook Helpers/Assistants	18,342	19,101	161,596	8.46	15
16	Dishwashers					16
17	Maintenance Workers	6,613	6,801	99,717	14.66	17
18	Housekeepers	8,113	8,741	73,525	8.41	18
19	Laundry	2,710	2,902	35,560	12.25	19
20	Administrator	2,080	2,080	198,143	95.26	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,688	2,792	51,584	18.48	23
24	Clerical	2,466	2,561	39,145	15.29	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,897	3,081	64,209	20.84	29
30	Habilitation Aides (DD Homes)	2,396	2,596	39,827	15.34	30
31	Medical Records					31
32	Other Health C: Care Plan Coordir	1,817	1,953	54,254	27.78	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	153,745	161,031	$ 2,395,591 *	$ 14.88	34

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

** See instructions.

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	435	$ 14,682	L1,C3	35
36	Medical Director	832	18,000	L9,C3	36
37	Medical Records Consultant	48	1,200	L10,C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	28	4,227	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	2,526	L11,C3	44
45	Social Service Consultant	36	2,526	L12,C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,427	$ 43,161		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	13	$ 529	L10,C3	50
51	Licensed Practical Nurses	22	674	L10,C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	35	$ 1,203		53

Facility Name & ID Number Alpine Fireside Health Center, Ltd. # 0018275 Report Period Beginning: 10/1/10 Ending: 9/30/11

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
See Schedule 21A			$ 198,143
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 198,143

B. Administrative - Other

Description	Amount
N/A	$
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		$ 158,518
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 158,518

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 74,950
Unemployment Compensation Insurance	46,142
FICA Taxes	181,006
Employee Health Insurance	107,760
Employee Meals	7,316
Illinois Municipal Retirement Fund (IMRF)*	
401 K	18,402
Uniforms	3,796
Pre-Employement Physicals	7,925
TOTAL (agree to Schedule V, line 22, col.8)	$ 447,297

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	
Health Care Worker Background Check	
(Indicate # of checks performed 585)	
Patient Background Checks	120
Illinois Health Care Association	4,630
Rockford Register	6,613
Miscellaneous Dues & Subscriptions	9,193
Miscellaneous License	5,404
Lobbying Expense	(1,637)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 24,323

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	18,787
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 18,787

* Attach copy of IMRF notifications

**See instructions.

Alpine Fireside Health Center, Ltd.
PROVIDER # 0018275
September 30, 2011

Schedule 21A

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Funtion	Ownership	Amount
Gordon Oksnevad	**Administrator**	0%	198,143
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)			223,143

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

SEE ACCOUNTANTS' PREPARATION REPORT

Alpine Fireside Health Center, Ltd.
PROVIDER # 0018275
September 30, 2011

Schedule 21C

XIX. SUPPORT SCHEDULES
C. Professional Services

Vendor/Payee	Type	Amount
Duane Morris LLP	Legal	25,924
Glenn Scott	Legal	2,000
Reno & Zahm	Legal	17,098
RSM McGladrey	Accounting	10,868
McGladrey & Pullen	Accounting	37,744
Stanley Security	Computer Services	815
Keane Care	Computer Services	41,087
E Health Data	Computer Services	3,357
George Storm	Computer Services	200
Rock River Internext	Computer Services	325
Storm Consulting	Computer Services	1,200
Bank of America	Computer Services	1,783
Duane Morris LLP	Computer Services	3,665
Cubed, Inc	Computer Services	38,660
Add: Reclass of 3 Cubed on 08/16/11		1,340
Less: Capitalized Amount		(22,579)
Less: Duane Morris reclassed to Legal		(3,665)
Less: Entry to reverse AP @ 09/30/10		(1,304)
TOTAL (agree to Schedule V, line 19, column 3)		158,518
Out of period legal		506
TOTAL (agree to Schedule V, line 19, column 8)		158,012

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Alpine Fireside Health Center, Ltd. # 0018275 Report Period Beginning: 10/1/10 Ending: 9/30/11

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		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Alpine Fireside Health Center, Ltd. # 0018275 **Report Period Beginning:** 10/1/10 **Ending:** 9/30/11

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-$4,630**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **7,583** 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. $ **36,135**
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. $ **7,316** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **17,196**

(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.