		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.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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: Amanda Springborn **Telephone Number:** (314) 925-3838
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 10/1/11 to 9/30/12 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)
(Date)
(Print Name and Title)
(Firm Name & Address) McGladrey 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 # 0018275 Report Period Beginning: 10/1/11 Ending: 9/30/12

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	11,712	1
2		Skilled Pediatric (SNF/PED)			2
3	34	Intermediate (ICF)	34	12,444	3
4		Intermediate/DD			4
5	33	Sheltered Care (SC)	33	12,078	5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,234	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	886	1,969	3,661	6,516	8
9	SNF/PED					9
10	ICF	7,181	3,096		10,277	10
11	ICF/DD					11
12	SC			10,383	10,383	12
13	DD 16 OR LESS					13
14	TOTALS	8,067	5,065	14,044	27,176	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.00%

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 3,661

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: 9/30/12 Fiscal Year: 9/30/12

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

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/1/11 Ending: 9/30/12

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	249,552	14,624	13,443	277,619		277,619		277,619			1
2	Food Purchase		241,241		241,241		241,241	(17,296)	223,945			2
3	Housekeeping	72,344	17,360		89,704		89,704		89,704			3
4	Laundry	37,210	7,783	10,395	55,388		55,388		55,388			4
5	Heat and Other Utilities			88,883	88,883		88,883		88,883			5
6	Maintenance	98,404	74,109	65,574	238,087		238,087		238,087			6
7	Other (specify):*											7
8	TOTAL General Services	457,510	355,117	178,295	990,922		990,922	(17,296)	973,626			8
	B. Health Care and Programs											
9	Medical Director			17,000	17,000		17,000		17,000			9
10	Nursing and Medical Records	1,520,328	156,255	8,370	1,684,953		1,684,953		1,684,953			10
10a	Therapy	38,718			38,718		38,718		38,718			10a
11	Activities	63,816	24,908	2,968	91,692		91,692		91,692			11
12	Social Services	49,143		2,968	52,111		52,111		52,111			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,672,005	181,163	31,306	1,884,474		1,884,474		1,884,474			16
	C. General Administration											
17	Administrative	156,071			156,071		156,071	25,000	181,071			17
18	Directors Fees											18
19	Professional Services			194,952	194,952		194,952	(13,916)	181,036			19
20	Dues, Fees, Subscriptions & Promotions			9,016	9,016		9,016	(2,211)	6,805			20
21	Clerical & General Office Expenses	85,638	23,677	62,650	171,965		171,965	(1,183)	170,782			21
22	Employee Benefits & Payroll Taxes			530,163	530,163		530,163	8,060	538,223			22
23	Inservice Training & Education			3,848	3,848		3,848		3,848			23
24	Travel and Seminar			11,222	11,222		11,222		11,222			24
25	Other Admin. Staff Transportation			12,547	12,547		12,547		12,547			25
26	Insurance-Prop.Liab.Malpractice			83,531	83,531		83,531		83,531			26
27	Other (specify):*											27
28	TOTAL General Administration	241,709	23,677	907,929	1,173,315		1,173,315	15,750	1,189,065			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,371,224	559,957	1,117,530	4,048,711		4,048,711	(1,546)	4,047,165			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 #0018275 **Report Period Beginning:** 10/1/11 **Ending:** 9/30/12

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			137,266	137,266		137,266	26,023	163,289			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			98,119	98,119		98,119	(8,773)	89,346			32
33	Real Estate Taxes							73,516	73,516			33
34	Rent-Facility & Grounds			76,516	76,516		76,516	(76,516)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			311,901	311,901		311,901	14,250	326,151			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		134,250	357,306	491,556		491,556		491,556			39
40	Barber and Beauty Shops		1,174	4,353	5,527		5,527		5,527			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			145,703	145,703		145,703		145,703			42
43	Other (specify):* **Non-Allowable Cos**			22,562	22,562		22,562	(22,562)				43
44	**TOTAL Special Cost Centers**		135,424	529,924	665,348		665,348	(22,562)	642,786			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,371,224	695,381	1,959,355	5,025,960		5,025,960	(9,858)	5,016,102			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 # 0018275 Report Period Beginning: 10/1/11 Ending: 9/30/12

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	(9,236)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(1,353)	30		9
10	Interest and Other Investment Income	(8,773)	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	(13,916)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	3,305	43		24
25	Fund Raising, Advertising and Promotional	(1,032)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(13,315)	43		28
29	Other-Attach Schedule See Pg 5A	(14,914)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (59,234)		$	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)	49,376		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 49,376		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (9,858)		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

ID# 0018275

Report Period Beginning: 10/1/11

Ending: 9/30/12

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	X-Rays - Part A	$ (4,388)	43	1
2	Labs-Part A	(5,743)	43	2
3	Income Tax/Other Taxes	(46)	43	3
4	Miscellaneous Exp/Suspense Acct.	(1,343)	43	4
5	Lobbying	(2,211)	20	5
6	Offset Miscellaneous Income	(1,183)	21	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
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28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(14,914)		49

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/1/11 Ending: 9/30/12

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	30	Depreciation	$	Johs Oksnevad	100.00%	$ 27,376	$ 27,376	1
2	V	33	Real Estate Taxes		Johs Oksnevad	100.00%	73,516	73,516	2
3	V	34	Rent-facility and grounds	76,516	Johs Oksnevad	100.00%		(76,516)	3
4	V	17	Assistant Administrator Salary		Johs Oksnevad	100.00%	25,000	25,000	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 76,516			$ 125,892	$ * 49,376	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: 10/1/11 Ending: 9/30/12

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,C7	1
2	Gordon Oksnevad	Administrator	Administrator	0.00	0	50	100.00	Salary	156,071	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	$ 181,071		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: 10/1/11 Ending: 9/30/12

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				N/A		$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/1/11 Ending: 9/30/12

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	$ 1,667,288	05/05/16	0.0595	$ 98,119	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 997,396	$ 1,667,288			$ 98,119	9
	B. Non-Facility Related*											
10								Offset interest against income			(8,773)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (8,773)	14
15	TOTALS (line 9+line14)						$ 997,396	$ 1,667,288			$ 89,346	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 # 0018275 Report Period Beginning: 10/1/11 Ending: 9/30/12

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 55,900	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.)	2011	$ 72,416	2
3. Under or (over) accrual (line 2 minus line 1).		$ 16,516	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 57,000	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.		$ 73,516	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	62,424	8
	2008	66,238	9
	2009	67,815	10
	2010	70,985	11
	2011	72,416	12

Accrual calculation

2011 tax bill 72,416

% Increase x1.05

Estimate of 2012 taxes 76,036 x 9/12=$57,027. Use 57,000

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

2011 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 2011 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 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	12-05-376-003	Nursing Home	$ 72,415.82	$ 72,415.82
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 72,415.82	$ 72,415.82

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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: 10/1/11 Ending: 9/30/12

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 [ ] (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 # 0018275 Report Period Beginning: 10/1/11 Ending: 9/30/12

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	680	11
12				1973	201		25			201	12
13				1973	93,791		11			93,791	13
14				1973	96,886		34	414	414	96,886	14
15				1974	8,366		11			8,366	15
16				1975	3,593		10			3,593	16
17				1977	10,055		10			10,055	17
18				1981	2,656		15			2,656	18
19				1982	5,132		11			5,132	19
20				1982	1,063		15			1,063	20
21				1984	21,939		15			21,939	21
22	Smoke detectors			1984	1,145		10			1,145	22
23				1985	3,300		15			3,300	23
24	Roof			1986	19,094		15			19,094	24
25	Kitchen addition and storm sewers			1988	235,818		20			235,818	25
26	Kitchen improvements			1989	9,541		20			9,541	26
27	Black top			1990	5,000		10			5,000	27
28	Broiler			1991	29,033		20			29,033	28
29	Lawn sprinkler			1992	5,000		15			5,000	29
30	Leasehold improvements			1993	13,972		15			13,972	30
31	Roof improvements			1994	57,648		15			57,648	31
32	Generator			1995	34,924		15			34,924	32
33	Air conditioning system			1999	280,820		15	18,721	18,721	252,734	33
34	Carpeting / flooring / wallcovering			1999	81,812		15	5,454	5,454	73,629	34
35	Parking lot lights			1999	16,900		15	1,126	1,126	15,201	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: 10/1/11 Ending: 9/30/12

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	$ 18,905	37
38	Parking lot	2002	42,683	1,764	15	2,846	1,082	29,883	38
39	Boiler electrical improvements	2002	11,560		20	578	578	6,069	39
40	Gazebo pad	2002	12,657	70	20	633	563	6,646	40
41	Painting and wallpapering hallways	2003	27,403	996	20	1,370	374	13,015	41
42	Gazebo	2003	35,825	1,303	20	1,792	489	17,024	42
43	Fence	2003	3,400	214	20	170	(44)	1,615	43
44	Sign	2003	1,675	82	20	84	2	798	44
45	Garage	2003	3,077	152	20	154	2	1,462	45
46	Fire alarm	2003	30,208		20	1,510	1,510	14,345	46
47	Boiler	2004	31,880	1,054	20	1,594	540	13,552	47
48	Sign	2004	3,487	127	20	174	47	1,479	48
49	Smoke detectors	2004	2,153		20	108	108	918	49
50	Boiler	2005	7,060	257	20	352	95	2,640	50
51	Commercial disposal	2005	826		20	42	42	315	51
52	Fire supression system	2005	1,866	68	20	94	26	705	52
53	Pond	2006	11,930	796	20	596	(200)	3,874	53
54	Fire alarm system	2006	2,738	99	20	137	38	890	54
55	Floor tile, baseboards	2006	5,759	209	20	288	79	1,872	55
56	Air conditioning	2006	13,634	496	20	682	186	4,433	56
57	Sidewalk	2006	1,196	80	20	60	(20)	390	57
58	Remodel grieving room	2006	2,198	80	20	110	30	715	58
59	Fire sprinkler system	2007	169,761	6,173	20	8,487	2,314	46,679	59
60	Nurse call system	2007	69,282	954	20	3,464	2,510	19,052	60
61	Remodel fireplace	2007	39,855	1,449	20	1,993	544	10,961	61
62	Ceiling tiles	2007	12,820	466	20	641	175	3,526	62
63	Drywall stairways	2007	8,000	291	20	400	109	2,200	63
64	20 ton rooftop unit	2007	34,100	1,240	20	1,705	465	9,377	64
65	Ductless heat pump	2007	7,760	282	20	388	106	2,134	65
66	Remodel fireplace	2007	6,631	241	20	332	91	1,826	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,386,638	$ 18,943		$ 58,160	$ 39,217	$ 1,959,877	70

**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: 10/1/11 Ending: 9/30/12

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	$ 18,943		$ 58,160	$ 39,217	$ 1,959,877	1
2	Circuit panel in kitchen	2007	4,045	147	20	202	55	909	2
3	Replace ceiling tiles	2008	11,366	413	20	568	155	2,556	3
4	New boiler and expanstion tank	2008	10,635	387	20	532	145	1,862	4
5	Nurses station	2009	12,283	447	20	614	167	2,149	5
6	Carpeting	2009	12,306		20	615	615	2,153	6
7	Zone controls for main rooftop unit	2009	14,640	532	20	732	200	2,562	7
8	3 garage doors	2009	3,670	133	20	184	51	644	8
9									9
10	Basement A/C	2010	13,395	1,527	20	670	(857)	1,675	10
11	200 AMP Breaker/Conduit	2010	12,426	452	20	621	169	1,553	11
12	Drywall/Ceiling Tile/Metal Grid for Pt Rooms & Hallway	2010	10,563	384	20	528	144	1,320	12
13	Repl Hot Water Holding Tank	2010	5,269	192	20	263	71	658	13
14	Roofer Sealer Paint	2010	9,085	927	20	454	(473)	1,135	14
15	Driveway Sealer Coat	2010	10,608	471	20	530	59	1,325	15
16	Transfer Switch in Kohler Cabinet	2010	3,669	286	20	183	(103)	458	16
17	New Addition - Activity Room	2010	2,953	107	20	148	41	370	17
18									18
19									19
20	Windows	2011	42,307	1,538	20	2,115	577	3,173	20
21	Wanderguard	2011	113,678	4,134	20	5,684	1,550	8,526	21
22	Stove Hood	2011	40,750	1,482	20	2,038	556	3,056	22
23	Kitchen Air Conditioning	2011	36,470	1,326	20	1,824	498	2,735	23
24	Rooftop A/C Unit	2011	5,995	218	20	300	82	450	24
25	Water Cooler Coil on Heat Pump	2011	9,675	352	20	484	132	726	25
26	New Interior Paint front door	2011	4,104	149	20	205	56	308	26
27									27
28	Therapy Room Addition : framing, drywall, electrical, HVAC,	2011	619,228	26,102	20	15,481	(10,621)	15,481	28
29	flooring, paint, architect services, etc.								29
30	Generator	2011	168,336	4,336	20	4,208	(128)	4,208	30
31	New Front Door	2012	4,385	86	20	110	24	110	31
32	2 Pressure Tanks & 2 Ductless Heat Pumps for new Laundry Area	2012	14,160	94	20	354	260	354	32
33	Replace Glass in Windows in Offices, Dining Room & Lobby	2012	7,236	11	20	181	170	181	33
34	TOTAL (lines 1 thru 33)		$ 3,589,875	$ 65,176		$ 97,987	$ 32,811	$ 2,020,513	34

**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: 10/1/11 Ending: 9/30/12

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,589,875	$ 65,176		$ 97,987	$ 32,811	$ 2,020,513	1
2									2
3	To tie book depreciation to financials			9,338			(9,338)		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									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,589,875	$ 74,514		$ 97,987	$ 23,473	$ 2,020,513	34

**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: 10/1/11 Ending: 9/30/12

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	$ 670,574	$ 11,139	$ 43,492	$ 32,353	3-10	$ 649,330	71
72	Current Year Purchases	67,048	40,232	6,705	(33,527)	5	6,705	72
73	Fully Depreciated Assets	379,024					379,024	73
74								74
75	TOTALS	$ 1,116,646	$ 51,371	$ 50,197	$ (1,174)		$ 1,035,059	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		$ 243,317	$ 11,381	$ 15,105	$ 3,724	5	$ 167,375	76
77										77
78										78
79										79
80	TOTALS			$ 243,317	$ 11,381	$ 15,105	$ 3,724		$ 167,375	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)	$ 4,959,838	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 137,266	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 163,289	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 26,023	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,222,947	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	N/A	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	$	92
93			93
94			94
95		$	95

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

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

STATE OF ILLINOIS

Sch 13A

Facility Name & ID Number Alpine Fireside Health Center, Ltd. # 0018275 Report Period Beginning: 10/1/11 Ending: 9/30/12

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	321	564	243	5	1,410
Administrative	2011 Dodge Challenger	2011	55,605		11,121	11,121	5	16,682
Administrative	2011 Toyota Rav 4	2011	34,200	11,060	3,420	(7,640)	5	3,420
TOTALS			$ 243,317	$ 11,381	$ 15,105	$ 3,724		$ 167,375

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/1/11 Ending: 9/30/12

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:				$ N/A			3
4	Additions							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.	/2013	$
13.	/2014	$
14.	/2015	$

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			$ N/A	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/1/11 Ending: 9/30/12

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 # 0018275 Report Period Beginning: 10/1/11 Ending: 9/30/12

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	L39, C3	hrs	$	1,311	$ 129,809	$	1,311	$ 129,809	1
2	Licensed Speech and Language Development Therapist	L39, C3	hrs		371	36,859		371	36,859	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L39, C3	hrs		1,905	190,498		1,905	190,498	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				134,250		134,250	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			$	3,587	$ 357,166	$ 134,250	3,587	$ 491,416	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 # 0018275 Report Period Beginning: 10/1/11 Ending: 9/30/12

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 9/30/12 (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	$ 5	$ 5	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 130,000)	1,434,362	1,434,362	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	74,206	74,206	6
7	Other Prepaid Expenses	46,916	46,916	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Cafeteria Plan	2,069	2,069	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,557,558	$ 1,557,558	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		10,000	13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,799,975	3,589,875	15
16	Equipment, at Historical Cost	738,156	1,359,963	16
17	Accumulated Depreciation (book methods)	(788,957)	(3,222,947)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs	5,383	5,383	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,754,557	$ 1,742,274	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,312,115	$ 3,299,832	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 176,730	$ 176,730	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	121,340	121,340	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	274,026	274,026	32
33	Accrued Interest Payable	4,555	4,555	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Unemployment Tax	33,324	33,324	36
37	Accrued Rent			37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 609,975	$ 609,975	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,667,288	1,667,288	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,667,288	$ 1,667,288	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,277,263	$ 2,277,263	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,034,852	$ 1,022,569	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,312,115	$ 3,299,832	48

*(See instructions.)

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/1/11 Ending: 9/30/12

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 834,946	1	
2	Restatements (describe):		2	
3	**Prior Period Adjustment**	59,762	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 894,708	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	140,144	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)**	$ 140,144	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,034,852	24	*

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

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/1/11 Ending: 9/30/12

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,548,800	1
2	Discounts and Allowances for all Levels	(153,941)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,394,859	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	576,352	6
7	Oxygen	(1,008)	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 575,344	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	20,511	13
14	Non-Patient Meals	9,236	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	123,324	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,813	19
20	Radiology and X-Ray	5,994	20
21	Other Medical Services	13,045	21
22	Laundry	11,929	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 185,852	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	8,773	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 8,773	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Schedule 19A	1,276	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,276	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,166,104	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	990,922	31
32	Health Care	1,884,474	32
33	General Administration	1,173,315	33
	B. Capital Expense		
34	Ownership	311,901	34
	C. Ancillary Expense		
35	Special Cost Centers	519,645	35
36	Provider Participation Fee	145,703	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,025,960	40
41	**Income before Income Taxes (line 30 minus line 40)****	140,144	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 140,144	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,298,526	44
45	Private Pay - Net Inpatient Revenue	2,167,970	45
46	Medicare - Net Inpatient Revenue	928,363	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,394,859	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No***** If not, please attach a reconciliation.**

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

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

***** - Tax return is prepared on cash basis of accounting.

Alpine Fireside Health Center, Ltd.
Provider # 0018275
9/30/2012

Schedule 19A

E. Other Revenue (specify)
Line 28

Description	Amount
Store & Misc Sales	1,183
Petty Cash Adjustment	93
	1,276

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/1/11 Ending: 9/30/12

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	$ 74,265	$ 35.70	1
2	Assistant Director of Nursing	2,478	2,598	76,573	29.47	2
3	Registered Nurses	10,501	10,825	293,466	27.11	3
4	Licensed Practical Nurses	13,719	14,259	324,860	22.78	4
5	CNAs & Orderlies	55,781	57,889	634,600	10.96	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,354	2,546	38,718	15.21	8
9	Activity Director	2,112	2,232	32,365	14.50	9
10	Activity Assistants	3,288	3,396	31,451	9.26	10
11	Social Service Workers	2,864	3,028	49,143	16.23	11
12	Dietician					12
13	Food Service Supervisor	1,794	1,886	30,648	16.25	13
14	Head Cook	8,948	9,729	81,868	8.41	14
15	Cook Helpers/Assistants	15,230	16,189	137,036	8.46	15
16	Dishwashers					16
17	Maintenance Workers	6,390	6,834	98,404	14.40	17
18	Housekeepers	8,116	8,580	72,344	8.43	18
19	Laundry	2,822	2,990	37,210	12.44	19
20	Administrator	2,080	2,080	156,071	75.03	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,659	2,795	54,702	19.57	23
24	Clerical	2,429	2,485	30,936	12.45	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,964	3,132	64,011	20.44	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Care Plan Coordin	1,682	1,854	52,553	28.35	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	150,291	157,407	$ 2,371,224 *	$ 15.06	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	280	$ 13,443	L1,C3	35
36	Medical Director	Monthly	17,000	L9,C3	36
37	Medical Records Consultant	24	900	L10,C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,500	L10,C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	Monthly	140	L39,C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	49	2,968	L11,C3	44
45	Social Service Consultant	49	2,968	L12,C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	402	$ 41,919		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	21	$ 859	L10,C3	50
51	Licensed Practical Nurses	36	1,094	L10,C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	57	$ 1,953		53

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/1/11 Ending: 9/30/12

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
See Schedule 21A			$ 156,071
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 156,071

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		$ 194,952
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 194,952

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 102,102
Unemployment Compensation Insurance	61,908
FICA Taxes	192,633
Employee Health Insurance	136,244
Employee Meals	8,060
Illinois Municipal Retirement Fund (IMRF)*	
401 K	27,590
Uniforms	1,306
Pre-Employement Physicals	8,380
TOTAL (agree to Schedule V, line 22, col.8)	$ 538,223

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

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,167
Health Care Worker Background Check	
(Indicate # of checks performed)	(120)
Patient Background Checks	
Illinois Health Care Association	5,940
Rockford Register & City of Rockford	1,052
Miscellaneous Dues & Subscriptions	
Miscellaneous License	977
Lobbying Expense	(2,211)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,805

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	11,222
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 11,222

**See instructions.

Alpine Fireside Health Center, Ltd.
PROVIDER # 0018275
September 30, 2012

Schedule 21A

XIX. SUPPORT SCHEDULES
A. Administrative Salaries

Name	Funtion	Ownership %	Amount
Gordon Oksnevad	**Administrator**	0%	156,071
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)			181,071

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

Alpine Fireside Health Center, Ltd.
PROVIDER # 0018275
September 30, 2012

Schedule 21C

XIX. SUPPORT SCHEDULES
C. Professional Services

Vendor/Payee	Type	Amount
Duane Morris LLP	Legal	56,227
Reno & Zahm	Legal	19,758
McGladrey LLP	Accounting	51,309
3 Cubed, Inc.	Computer Services	34,465
NTT Data Long Term Care Solutions	Computer Services	19,419
E Health Data	Computer Services	3,357
Dell	Computer Services	7,525
Silverchari Learning Inc.	Computer Services	2,892
TOTAL (agree to Schedule V, line 19, column 3)		194,952
Out of period legal		(12,560)
TOTAL (agree to Schedule V, line 19, column 8)		182,392

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/1/11 Ending: 9/30/12

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 # 0018275 **Report Period Beginning:** 10/1/11 **Ending:** 9/30/12

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-$5,940**

(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. $ **11,324** 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. $ **145,703**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **8,060** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **9,236**

(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.