FOR BHF USE

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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.

I. IDPH License ID Number: 0018275

Facility Name: Alpine Fireside Health Ctr

Address: 3650 North Alpine Rd (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 01/01/20 to 12/31/20 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) Michelle Cruden
(Title) Administrator

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address) RSM US 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 Ctr # 0018275 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		255	4,280	4,535	8
9	SNF/PED					9
10	ICF	1,586	2,802		4,388	10
11	ICF/DD					11
12	SC			9,128	9,128	12
13	DD 16 OR LESS					13
14	TOTALS	1,586	3,057	13,408	18,051	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 49.82%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1973

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 32 and days of care provided 4,098

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: 12/31/2020 Fiscal Year: 12/31/2020

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

Facility Name & ID Number Alpine Fireside Health Ctr # 0018275 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	245,308	83,921	10,902	340,131		340,131		340,131			1
2	Food Purchase		247,862		247,862		247,862	(22,893)	224,969			2
3	Housekeeping	75,090	22,834	-	97,924		97,924		97,924			3
4	Laundry	52,433	11,616	6,527	70,576		70,576		70,576			4
5	Heat and Other Utilities			114,704	114,704		114,704		114,704			5
6	Maintenance	85,597	67,468	85,676	238,741		238,741		238,741			6
7	Other (specify):*	-	-	-								7
8	**TOTAL General Services**	458,428	433,701	217,809	1,109,938		1,109,938	(22,893)	1,087,045			8
	B. Health Care and Programs											
9	Medical Director	-	-	18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	1,417,801	135,005	2,855	1,555,661		1,555,661	19,562	1,575,223			10
10a	Therapy	-	-	-								10a
11	Activities	94,990	43,394	3,853	142,237		142,237		142,237			11
12	Social Services	40,234	-	3,987	44,221		44,221		44,221			12
13	CNA Training	-	-	-								13
14	Program Transportation	-	-	-								14
15	Other (specify):*	-	-	-								15
16	**TOTAL Health Care and Programs**	1,553,025	178,399	28,695	1,760,119		1,760,119	19,562	1,779,681			16
	C. General Administration											
17	Administrative	407,794	-	-	407,794		407,794		407,794			17
18	Directors Fees			-								18
19	Professional Services			263,707	263,707		263,707	(6,927)	256,780			19
20	Dues, Fees, Subscriptions & Promotions			62,730	62,730		62,730	(21,930)	40,800			20
21	Clerical & General Office Expenses	135,242	59,287	79,975	274,504		274,504	(9,500)	265,004			21
22	Employee Benefits & Payroll Taxes			633,962	633,962		633,962	8,134	642,096			22
23	Inservice Training & Education			-								23
24	Travel and Seminar			12,757	12,757		12,757		12,757			24
25	Other Admin. Staff Transportation		-	222	222		222		222			25
26	Insurance-Prop.Liab.Malpractice			162,198	162,198		162,198		162,198			26
27	Other (specify):*			-								27
28	**TOTAL General Administration**	543,036	59,287	1,215,551	1,817,874		1,817,874	(30,223)	1,787,651			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,554,489	671,387	1,462,055	4,687,931		4,687,931	(33,554)	4,654,377			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 Ctr #0018275 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			143,795	143,795		143,795	1,737	145,532			30
31	Amortization of Pre-Op. & Org.			-								31
32	Interest			74,712	74,712		74,712	(46,646)	28,066			32
33	Real Estate Taxes			135,508	135,508		135,508		135,508			33
34	Rent-Facility & Grounds			3,000	3,000		3,000	(3,000)				34
35	Rent-Equipment & Vehicles			339	339		339		339			35
36	Other (specify):*			-								36
37	**TOTAL Ownership**			357,354	357,354		357,354	(47,909)	309,445			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	-	-	-								38
39	Ancillary Service Centers	-	105,278	700,443	805,721		805,721		805,721			39
40	Barber and Beauty Shops	-	290	2,496	2,786		2,786		2,786			40
41	Coffee and Gift Shops	-	-	-								41
42	Provider Participation Fee			72,733	72,733		72,733		72,733			42
43	Other (specify):* Non-Allowable Cos	-	-	19,505	19,505		19,505	(19,505)				43
44	**TOTAL Special Cost Centers**		105,568	795,177	900,745		900,745	(19,505)	881,240			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,554,489	776,955	2,614,586	5,946,030		5,946,030	(100,968)	5,845,062			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 Ctr # 0018275 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	(14,759)	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	1,737	30		9
10	Interest and Other Investment Income	(46,646)	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	(4,907)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(6,927)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(6,809)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG5A	(19,657)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (97,968)		$	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)	(3,000)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (3,000)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (100,968)		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 Ctr

ID# 0018275

Report Period Beginning: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	X-Rays - Part A	$ (4,689)	43	1
2	Income Tax/ Other Taxes	(3,100)	43	2
3	Lobbying	(2,570)	20	3
4	Offset Miscellaneous Income	(9,500)	21	4
5	Reclass Employee Meal Expense	(8,134)	2	5
6	Reclass Employee Meal Expense	8,134	22	6
7	Reclass software	(19,562)	20	7
8	Reclass software	19,562	10	8
9	Dues and Subscription	202	20	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(19,657)		49

Facility Name & ID Number Alpine Fireside Health Ctr # 0018275 Report Period Beginning: 01/01/20 Ending: 12/31/20

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
Estate of Johs Oksnevad	100	N/A		Estate of Johs Oksneva	Rockford, IL	Real estate lessor

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	33	Real Estate Taxes	$ 135,508	Estate of Johs Oksnevad	100%	$ 135,508	$	1
2	V	34	Rent-facility and grounds	3,000	Estate of Johs Oksnevad	100%		(3,000)	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 138,508			$ 135,508	$ * (3,000)	14

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

Facility Name & ID Number Alpine Fireside Health Ctr # 0018275 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	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								TOTAL	$		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 Ctr # 0018275 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 Ctr # 0018275 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	11/30/2016	$ 1,451,001	$ 1,173,035	1/31/2024	0.0535	$ 59,312	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Durand State Bank		X	Line of Credit	Interest Only	11/30/2018	500,000	-	11/30/2020	0.05	10,791	6
7	Durand State Bank		X	Line of Credit	Interest Only	4/27/2020	425,000	-	4/27/2021	0.0425	4,609	7
8												8
9	TOTAL Facility Related						$ 2,376,001	$ 1,173,035			$ 74,712	9
	B. Non-Facility Related*											
10												10
11								Interest Income Offset			(46,646)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (46,646)	14
15	TOTALS (line 9+line14)						$ 2,376,001	$ 1,173,035			$ 28,066	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 Ctr # 0018275 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$ 20,880	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.)	2019	$ 77,420	2
3. Under or (over) accrual (line 2 minus line 1).		$ 56,540	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 78,968	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
	Alloc. Fr. Mgmt. Co.		
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 135,508	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	79,028	8
	2016	78,139	9
	2017	78,687	10
	2018	80,322	11
	2019	77,420	12

Accrual calculation
2019 Tax Bill 77,420
% Increase x1.02
Estimate of 2020 taxes 78,968.4 (77420*1.02)

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	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.

2019 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 Michelle Cruden

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 2019 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 2019.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	12-05-376-003	Nursing Home	$ 77,420.00	$ 77,420.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 77,420.00	$ 77,420.00

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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 Ctr # 0018275 Report Period Beginning: 01/01/20 Ending: 12/31/20

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. [X] (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:
(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 Ctr # 0018275 Report Period Beginning: 01/01/20 Ending: 12/31/20

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			694	11
12				1973	201		25			201	12
13				1973	93,791		11			93,791	13
14				1973	96,886		34			96,886	14
15				1974	8,366		11			8,366	15
16				1975	3,593		10			3,593	16
17				1977	10,055		10			10,055	17
18				1981	2,656		15			2,656	18
19				1982	5,132		11			5,132	19
20				1982	1,063		15			1,063	20
21				1984	21,939		15			21,939	21
22	Smoke detectors			1984	1,145		10			1,145	22
23				1985	3,300		15			3,300	23
24	Roof			1986	19,094		15			19,094	24
25	Kitchen addition and storm sewers			1988	235,818		20			235,818	25
26	Kitchen improvements			1989	9,541		20			9,541	26
27	Black top			1990	5,000		10			5,000	27
28	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			280,820	33
34	Carpeting / flooring / wallcovering			1999	81,812		15			81,812	34
35	Parking lot lights			1999	16,900		15			16,900	35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Alpine Fireside Health Ctr # 0018275 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$	$	$ 24,655	37
38	Parking lot	2002	42,683		15			42,683	38
39	Boiler electrical improvements	2002	11,560		20	578	578	10,838	39
40	Gazebo pad	2002	12,657	7	20	633	626	11,868	40
41	Painting and wallpapering hallways	2003	27,403		20	1,370	1,370	24,318	41
42	Gazebo	2003	35,825		20	1,792	1,792	31,808	42
43	Fence	2003	3,400		20	170	170	3,018	43
44	Sign	2003	1,675		20	84	84	1,491	44
45	Garage	2003	3,077		20	154	154	2,733	45
46	Fire alarm	2003	30,208		20	1,510	1,510	26,803	46
47	Boiler	2004	31,880		20	1,594	1,594	26,703	47
48	Sign	2004	3,487		20	174	174	2,915	48
49	Smoke detectors	2004	2,153		20	108	108	1,809	49
50	Boiler	2005	7,060	257	20	352	95	5,544	50
51	Commercial disposal	2005	826	30	20	42	12	662	51
52	Fire supression system	2005	1,866	68	20	94	26	1,481	52
53	Pond	2006	11,930	448	20	596	148	8,791	53
54	Fire alarm system	2006	2,738	99	20	137	38	2,020	54
55	Floor tile, baseboards	2006	5,759	209	20	288	79	4,248	55
56	Air conditioning	2006	13,634	496	20	682	186	10,060	56
57	Sidewalk	2006	1,196	80	20	60	(20)	885	57
58	Remodel grieving room	2006	2,198	80	20	110	30	1,623	58
59	Fire sprinkler system	2007	169,761	6,173	20	8,487	2,314	116,697	59
60	Nurse call system	2007	69,282		20	3,464	3,464	47,630	60
61	Remodel fireplace	2007	39,855	1,690	20	1,993	303	27,403	61
62	Ceiling tiles	2007	12,820	466	20	641	175	8,814	62
63	Drywall stairways	2007	8,000	291	20	400	109	5,500	63
64	20 ton rooftop unit	2007	34,100	1,240	20	1,705	465	23,443	64
65	Ductless heat pump	2007	7,760	282	20	388	106	5,335	65
66	Remodel fireplace	2007	6,631		20	332	332	4,565	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,386,638	$ 11,916		$ 27,938	$ 16,022	$ 2,246,898	70

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

Facility Name & ID Number Alpine Fireside Health Ctr # 0018275 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$ 11,916		$ 27,938	$ 16,022	$ 2,246,898	1
2	Circuit panel in kitchen	2007	4,045	147	20	202	55	2,576	2
3	Replace ceiling tiles	2008	11,366	413	20	568	155	7,242	3
4	New boiler and expanstion tank	2008	10,635	387	20	532	145	6,251	4
5	Nurses station	2009	12,283	447	20	614	167	7,215	5
6	Carpeting	2009	12,306		20	615	615	7,227	6
7	Zone controls for main rooftop unit	2009	14,640	532	20	732	200	8,601	7
8	3 garage doors	2009	3,670	133	20	184	51	2,162	8
9									9
10	Basement A/C	2010	13,395		20	670	670	7,203	10
11	200 AMP Breaker/Conduit	2010	12,426	452	20	621	169	6,676	11
12	Drywall/Ceiling Tile/Metal Grid for Pt Rooms & Hallway	2010	10,563	384	20	528	144	5,676	12
13	Repl Hot Water Holding Tank	2010	5,269	192	20	263	71	2,828	13
14	Roofer Sealer Paint	2010	9,085		20	454	454	4,881	14
15	Driveway Sealer Coat	2010	10,608	313	20	530	217	5,698	15
16	Transfer Switch in Kohler Cabinet	2010	3,669		20	183	183	1,968	16
17	New Addition - Activity Room	2010	2,953	107	20	148	41	1,591	17
18									18
19									19
20	Windows	2011	42,307	1,538	20	2,115	577	20,625	20
21	Wanderguard	2011	113,678	4,134	20	5,684	1,550	55,418	21
22	Stove Hood	2011	40,750	1,482	20	2,038	556	19,866	22
23	Kitchen Air Conditioning	2011	36,470	1,326	20	1,824	498	17,779	23
24	Rooftop A/C Unit	2011	5,995	218	20	300	82	2,923	24
25	Water Cooler Coil on Heat Pump	2011	9,675	352	20	484	132	4,717	25
26	New Interior Paint front door	2011	4,104	149	20	205	56	2,001	26
27									27
28	Therapy Room Addition : framing, drywall, electrical, HVAC,	2011	619,228	22,347	20	30,961	8,614	270,912	28
29	flooring, paint, architect services, etc.								29
30	Generator	2011	168,336	6,121	20	8,417	2,296	73,647	30
31	New Front Door	2012	4,385	159	20	219	60	1,918	31
32	2 Pressure Tanks & 2 Ductless Heat Pumps for new Laundry Area	2012	14,160	515	20	708	193	6,195	32
33	Replace Glass in Windows in Offices, Dining Room & Lobby	2012	7,236	263	20	362	99	3,166	33
34	TOTAL (lines 1 thru 33)		$ 3,589,875	$ 54,027		$ 88,098	$ 34,071	$ 2,803,855	34

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

Facility Name & ID Number Alpine Fireside Health Ctr # 0018275 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$ 54,027		$ 88,098	$ 34,071	$ 2,803,855	1
2	Countertop in Therapy Room	2013	5,645	205	20	282	77	2,186	2
3									3
4	Carpet - Hall 4	2014	4,724		20	236	236	1,476	4
5	Northeast Sidewalk Replacement	2015	36,300	1,961	20	1,815	(146)	10,436	5
6	Stonewall - Northeast side of building	2015	3,407		20	170	170	980	6
7	Blacktop work - Parking Lot	2015	5,750	256	20	288	32	1,653	7
8	Sealing - Roof	2015	5,458	90	20	273	183	1,569	8
9	Sealing - Roof	2015	3,137		20	157	157	902	9
10									10
11	Carpet/Tile - Lobby	2016	28,437		20	1,422	1,422	6,754	11
12	Water Softener - Garage	2016	7,295		20	365	365	1,732	12
13									13
14	Expansion Tank for Boiler	2017	3,210	1,926	5	722	(1,204)	3,210	14
15	Replaced Cedar Mansard Roof with Vinyl	2017	114,959	1,568	27.5	4,180	2,612	15,676	15
16	Bathroom Remodel - Therapy Room	2017	5,334	3,201	5	1,067	(2,134)	4,000	16
17	Plumbing, Electrical, Flooring								17
18	Fabricated Covers & Downspouts	2016	18,926	602	27.5	688	86	2,580	18
19	Cover Existing Walls & Floor in Walk In Freezer	2017	9,326	14	27.5	339	325	1,272	19
20									20
21	Roofing Project:	2017	295,929		20	14,796	14,796	40,689	21
22	-Stop Initial Leakage & Clean Up								22
23	-Reroof Dining Room and Kitchen Area (11,000 sq feet)								23
24	-Reroof 4 wings of Health Center (6,000 sq feet each)								24
25	- Tear off top roof to replace wet insulation								25
26	- Install new insulation to equal total R-Value of 30								26
27	- Fully adhere a 60 mil EPDM rubber roof								27
28	- Propert flashing for walls with term bar.								28
29									29
30	Roofing Project:								30
31	Additional Charges after 2018 Capital Report was filed	2018	16,817		20	841	841	2,312	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,154,530	$ 63,850		$ 115,739	$ 51,889	$ 2,901,283	34

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

Facility Name & ID Number Alpine Fireside Health Ctr # 0018275 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 12C, Carried Forward		$ 4,154,530	$ 63,850		$ 115,739	$ 51,889	$ 2,901,283	1
2	Air Conditioning Project - Roof	2017	34,159	1,708	20	1,708	0	4,697	2
3	- Disconnect and Move A/C for new roof placement								3
4	- Install 1 condenser & 3 evaporators on ductless split.								4
5									5
6	Carpet - Lobby	2017	21,881	1,094	20	1,094	(0)	3,009	6
7									7
8	Remove grab bars, mirrors, toilet tanks, sinks, linoleum floor	2018	12,208	610	20	610	(0)	1,678	8
9	to install new floor & wall tile. Reinstall items. Repair walls								9
10	shower and tub. - All private & shared baths								10
11									11
12									12
13									13
14	Condenser & 3 evaporators on Mitsubishi Ductless Split	2018	10,260	513	20	513		1,411	14
15	- Mechanical Room								15
16									16
17	Install wall tile 54" on walls and vinyl flooring of 4 bathrooms	2019	42,285	1,057	20	2,114	1,057	3,700	17
18									18
19	Grind down, remove and replace loading dock	2019	2,750	69	20	138	69	242	19
20									20
21	Replace lobby circulating pump and new backup	2019	4,011	100	20	200	100	350	21
22									22
23	JACE controller - a device that provides connectivity	2019	6,038	151	20	302	151	529	23
24	to systems (HVAC, electrical, security)								24
25									25
26	replace all 16 hot water actuators on heating system	2019	16,916	423	20	846	423	1,481	26
27	loop for rooftop units								27
28									28
29	Install wall tile 54" on walls and vinyl flooring of 4 bathrooms	2020	6,222	156	20	156		156	29
30									30
31									31
32	To tie book depreciation to financials			69,723			(69,723)		32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,311,259	$ 139,454		$ 123,420	$ (16,034)	$ 2,918,533	34

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

Facility Name & ID Number Alpine Fireside Health Ctr # 0018275 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$ 79,589	$ 4,341	$ 8,151	$ 3,810	3-7	$ 53,037	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	166,448					166,447	73
74								74
75	TOTALS	$ 246,037	$ 4,341	$ 8,151	$ 3,810		$ 219,484	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		$ 192,210	$ -	$ 13,961	$ 13,961	5	$ 188,718	76
77										77
78										78
79										79
80	TOTALS			$ 192,210	$	$ 13,961	$ 13,961		$ 188,718	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)	$ 4,759,506	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 143,795	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 145,532	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 1,737	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,326,736	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name: **Alpine Fireside Health Ctr**
IDPH License ID Number: **0018275**
Fiscal Year End: **12/31/20**

Schedule 13A

XI. Vehicle Costs
Line 76 - Vehicle Depreciation

Use	Model, Make & Year	Year Acquired	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustments	Life in Years	Accumulated Depreciation
Dump Truck	2010	2010	2,817			-	5	2,817
Administrati	2011 Dodge Challenger	2011	55,605			-	5	55,605
Administrati	GMC Denali	2013	63,981			-	5	63,981
Administrati	2013 Chevy Tahoe	2016	43,171		8,634	-	5	41,012
Maintenance	2014 Dodge Ram	2016	26,635		5,327	-	5	25,304
						-		
						-		
TOTAL			**192,209**	**-**	**13,961**	**-**		**188,718**

Facility Name & ID Number Alpine Fireside Health Ctr # 0018275 Report Period Beginning: 01/01/20 Ending: 12/31/20

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.	/2021	$
13.	/2022	$
14.	/2023	$

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: $ 339 Description: Equipment Rental - $339
(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 Ctr # 0018275 Report Period Beginning: 01/01/20 Ending: 12/31/20

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.

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	39(3)	hrs	$	3,936	$ 283,383	$	3,936	$ 283,383	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		2,035	146,519		2,035	146,519	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		3,758	270,541		3,758	270,541	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				100,516		100,516	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Oxygen	39(2)					4,762		4,762	12
13	Other (specify):									13
14	TOTAL			$	9,729	$ 700,443	$ 105,278	9,729	$ 805,721	14

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

Facility Name & ID Number Alpine Fireside Health Ctr # 0018275 Report Period Beginning: 01/01/20 Ending: 12/31/20

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/20 (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	$ 8,503	$ 8,503	1
2	Cash-Patient Deposits	-	-	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 243,757)	3,071,239	3,071,239	3
4	Supply Inventory (priced at)	-	-	4
5	Short-Term Investments	-	-	5
6	Prepaid Insurance	34,998	34,998	6
7	Other Prepaid Expenses	16,500	16,500	7
8	Accounts Receivable (owners or related parties)	-	-	8
9	Other(specify): Advances Employees	85,228	85,228	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,216,468	$ 3,216,468	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	2,479,393	4,311,259	15
16	Equipment, at Historical Cost	438,248	438,247	16
17	Accumulated Depreciation (book methods)	(1,535,518)	(3,326,736)	17
18	Deferred Charges	-	-	18
19	Organization & Pre-Operating Costs	-	-	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	-	-	20
21	Restricted Funds	-	-	21
22	Other Long-Term Assets (spe	-	-	22
23	Other(specify):	-	-	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,382,123	$ 1,432,770	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,598,591	$ 4,649,238	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 140,803	$ 140,803	26
27	Officer's Accounts Payable	-	-	27
28	Accounts Payable-Patient Deposits	-	-	28
29	Short-Term Notes Payable	-	-	29
30	Accrued Salaries Payable	32,619	32,619	30
31	Accrued Taxes Payable (excluding real estate taxes)	451	451	31
32	Accrued Real Estate Taxes(Sch.IX-B)	78,969	78,969	32
33	Accrued Interest Payable	2,908	2,908	33
34	Deferred Compensation	-	-	34
35	Federal and State Income Taxes	-	-	35
	Other Current Liabilities(specify):			
36	See Schedule 17A	537,220	537,220	36
37		-	-	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 792,970	$ 792,970	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,173,035	1,173,035	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)**	$ 1,173,035	$ 1,173,035	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,966,005	$ 1,966,005	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,632,586	$ 2,683,233	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,598,591	$ 4,649,238	48

***(See instructions.)**

Facility Name: **Alpine Fireside Health Ctr**
IDPH License ID Number: **0018275**
Fiscal Year End: **12/31/20**

Schedule 17A

XV. Balance Sheet
Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
Rent Accrued	2,666	2,666
Federal Stimulus Payments	523,914	523,914
State Stimulus Payments	10,640	10,640
Total - Line 36	**537,220**	**537,220**
	-	-

Facility Name & ID Number Alpine Fireside Health Ctr # 0018275 Report Period Beginning: 01/01/20 Ending: 12/31/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,476,350	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,476,350	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	156,236	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)**	$ 156,236	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,632,586	24 *

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

Facility Name & ID Number Alpine Fireside Health Ctr # 0018275 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$ 4,721,718	1
2	Discounts and Allowances for all Levels	(996,474)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,725,244	3
	B. Ancillary Revenue		
4	Day Care	-	4
5	Other Care for Outpatients	-	5
6	Therapy	1,590,198	6
7	Oxygen	-	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,590,198	8
	C. Other Operating Revenue		
9	Payments for Education	-	9
10	Other Government Grants	556,027	10
11	CNA Training Reimbursements	-	11
12	Gift and Coffee Shop	-	12
13	Barber and Beauty Care	6,264	13
14	Non-Patient Meals	14,759	14
15	Telephone, Television and Radio	-	15
16	Rental of Facility Space	-	16
17	Sale of Drugs	83,805	17
18	Sale of Supplies to Non-Patients	-	18
19	Laboratory	28,254	19
20	Radiology and X-Ray	4,741	20
21	Other Medical Services	16,378	21
22	Laundry	20,450	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 730,678	23
	D. Non-Operating Revenue		
24	Contributions	-	24
25	Interest and Other Investment Income***	46,646	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 46,646	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Schedule 19A	9,500	28
28a		-	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 9,500	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,102,266	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,109,938	31
32	Health Care	1,760,119	32
33	General Administration	1,817,874	33
	B. Capital Expense		
34	Ownership	357,354	34
	C. Ancillary Expense		
35	Special Cost Centers	828,012	35
36	Provider Participation Fee	72,733	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,946,030	40
41	**Income before Income Taxes (line 30 minus line 40)****	156,236	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 156,236	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 391,363	44
45	Private Pay - Net Inpatient Revenue	676,438	45
46	Medicare - Net Inpatient Revenue	934,270	46
47	Other-(specify) Shelter Care	1,723,173	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,725,244	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.**

^Entity is a cash basis taxpayer.

Facility Name: **Alpine Fireside Health Ctr**
IDPH License ID Number: **0018275**
Fiscal Year End: **12/31/20**

Schedule 19A

XVII. Income Statement
Line 28 Other Revenue (specify):

Description	Amount
Store & Misc Sales	6,600
Miscellaneous Income	2,900
Total - Line 28	**9,500**
	-

Facility Name & ID Number Alpine Fireside Health Ctr # 0018275 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	1,654	1,886	$ 76,057	$ 40.33	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,762	14,035	482,792	34.40	3
4	Licensed Practical Nurses	9,129	9,328	267,595	28.69	4
5	CNAs & Orderlies	39,578	40,654	591,357	14.55	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,073	2,089	29,842	14.29	9
10	Activity Assistants	5,737	5,852	65,148	11.13	10
11	Social Service Workers	2,447	2,559	40,234	15.72	11
12	Dietician					12
13	Food Service Supervisor	1,759	1,803	37,563	20.83	13
14	Head Cook	2,855	2,855	34,652	12.14	14
15	Cook Helpers/Assistants	17,193	17,487	173,093	10.00	15
16	Dishwashers					16
17	Maintenance Workers	4,137	4,236	85,597	20.21	17
18	Housekeepers	7,342	7,464	75,090	10.06	18
19	Laundry	4,621	4,816	52,433	10.89	19
20	Administrator	2,522	2,522	193,537	76.74	20
21	Assistant Administrator	2,198	2,198	214,257	97.48	21
22	Other Administrative					22
23	Office Manager	3,749	3,970	91,140	22.96	23
24	Clerical	2,276	2,291	44,102	19.25	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	123,032	126,045	$ 2,554,489 *	$ 20.27	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	218	$ 10,902	L1,C3	35
36	Medical Director	180	18,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	57	2,855	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	77	3,853	L11,C3	44
45	Social Service Consultant	80	3,987	L12,C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	612	$ 39,597		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses		N/A		51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Alpine Fireside Health Ctr # 0018275 Report Period Beginning: 01/01/20 Ending: 12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Gordon Oksnevad	Asst Administrator	0%	$ 214,257
Michelle Cruden	Administrator	0%	193,537
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 407,794

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		$ 263,707
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 263,707

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 29,474
Unemployment Compensation Insurance	13,823
FICA Taxes	215,641
Employee Health Insurance	312,178
Employee Meals	8,134
Illinois Municipal Retirement Fund (IMRF)*	
401 K	43,677
Uniforms	13,778
Pre-Employement Physicals	4,744
Cafeteria Plan	729
Other Employee Benefits	(82)
TOTAL (agree to Schedule V, line 22, col.8)	$ 642,096

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	$ 3,980
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 61)	610
Patient Background Checks 55	530
Illinois Health Care Association	9,352
Ability Network	8,915
Miscellaneous Dues & Subscriptions	19,164
Miscellaneous License	819
Lobbying Expense	(2,570)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 40,800

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	12,757
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 12,757

**See instructions.

Facility Name: **Alpine Fireside Health Ctr**
IDPH License ID Number: **0018275**
Fiscal Year End: **12/31/20**

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
RSM US LLP	Accounting	76,166
Brian Law	Computer Services	121,985
BankAmericard	Computer Services	3,350
Chase	Computer Services	2,672
Duane Morris, LLP	Legal	52,614
Ram Import	Legal	(7)
Reno & Zahm LLP	Legal	6,927
	Total (agree to Schedule V, line 19, column 3)	263,707
Less: Non-Allowable Legal Fees		(6,927)
	Total (agree to Schedule V, line 19, column 8)	256,780

Facility Name & ID Number Alpine Fireside Health Ctr # 0018275 Report Period Beginning: 01/01/20 Ending: 12/31/20

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-$9,352**

(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? **3-7**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **15,842** Line **10(2)**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **72,733**
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. $ **8,134** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **14,759**

(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 out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.