

		FOR BHF USE					

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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 Rockford 61114
Number City 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	☒	PROPRIETARY	☐	GOVERNMENTAL
☐	Charitable Corp.	☐	Individual	☐	State
☐	Trust	☐	Partnership	☐	County
IRS Exemption Code		☐	Corporation	☐	Other
		☒	"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 01/01/2025 to 12/31/2025 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)			
	(Print Name and Title)			
	(Firm Name & Address)	RSM US LLP 1450 American Way Suite 1400 Schaumburg, IL 60173-6084		
	(Telephone)	(847) 517-7070 Fax # ((847) 517-7070		
	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 2200 Churchill Rd. Springfield, IL 62702-3406 Phone # (217) 782-1630			

Facility Name & ID Number

Alpine Fireside Health Ctr

0018275

Report Period Beginning: 01/01/2025

Ending: 12/31/2025

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

1

2

3

4

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

B. Census-For the entire report period.

1

2

3

4

5

6

7

8

9

	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF			276		14	4,872	674	5,836	8
9	SNF/PED									9
10	ICF	2,005	1,729			2,955			6,689	10
11	ICF/DD									11
12	SC							9,342	9,342	12
13	DD 16 OR LESS									13
14	TOTALS	2,005	1,729	276		2,969	4,872	10,016	21,867	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.)

60.51%

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 ☒ NO ☐

Note : Non-allowable costs have been eliminated in Schedule V, Column

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

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

Date started 1973

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐

If YES, enter certified beds.

number of certified beds 32

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒ NO ☐

Tax Year: 12/31/25 Fiscal Year: 12/31/25

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

STATE OF ILLINOIS

Facility Name & ID Number

Alpine Fireside Health Ctr

0018275

Report Period Beginning:

01/01/2025

Ending:

12/31/2025

Page 3

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	415,520	351,403	59,440	826,363		826,363	(8,590)	817,773			1
2	Food Purchase											2
3	Housekeeping	80,159	18,310		98,469		98,469		98,469			3
4	Laundry	71,018	56,726	3,594	131,338		131,338		131,338			4
5	Heat and Other Utilities			167,509	167,509		167,509		167,509			5
6	Maintenance	90,500	10,884	199,750	301,134		301,134	1,023	302,157			6
7	Other (specify):*											7
8	TOTAL General Services	657,197	437,323	430,293	1,524,813		1,524,813	(7,567)	1,517,246			8
	B. Health Care and Programs											
9	Medical Director			16,500	16,500		16,500		16,500			9
10	Nursing and Medical Records	1,612,298		994,637	2,606,935		2,606,935		2,606,935			10
10a	Therapy											10a
11	Activities	153,917	25,311	3,033	182,261		182,261		182,261			11
12	Social Services	160,957		3,351	164,308		164,308		164,308			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,927,172	25,311	1,017,521	2,970,004		2,970,004		2,970,004			16
	C. General Administration											
17	Administrative	163,800		144,000	307,800		307,800	(144,000)	163,800			17
18	Directors Fees											18
19	Professional Services			217,449	217,449		217,449	587	218,036			19
20	Dues, Fees, Subscriptions & Promotions			37,649	37,649		37,649	(1,043)	36,606			20
21	Clerical & General Office Expenses	170,104	14,996	41,427	226,527		226,527	77,215	303,742			21
22	Employee Benefits & Payroll Taxes			557,369	557,369		557,369	18,128	575,497			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,200	6,200		6,200		6,200			24
25	Other Admin. Staff Transportation			4,708	4,708		4,708		4,708			25
26	Insurance-Prop.Liab.Malpractice			241,052	241,052		241,052	1,932	242,984			26
27	Other (specify):*											27
28	TOTAL General Administration	333,904	14,996	1,249,854	1,598,754		1,598,754	(47,181)	1,551,573			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,918,273	477,630	2,697,668	6,093,571		6,093,571	(54,748)	6,038,823			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.

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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation							125,206	125,206			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			10,089	10,089		10,089	(7,082)	3,007			32
33	Real Estate Taxes			91,758	91,758		91,758		91,758			33
34	Rent-Facility & Grounds			267,600	267,600		267,600	(267,600)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			369,447	369,447		369,447	(149,476)	219,971			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		242,650	840,993	1,083,643		1,083,643		1,083,643			39
40	Barber and Beauty Shops		287	9,850	10,137		10,137	(7,081)	3,056			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			73,419	73,419		73,419		73,419			42
43	Other (specify):* Non-Allowable Cost			74,996	74,996		74,996	(74,996)				43
44	TOTAL Special Cost Centers		242,937	999,258	1,242,195		1,242,195	(82,077)	1,160,118			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,918,273	720,567	4,066,373	7,705,213		7,705,213	(286,301)	7,418,912			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	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				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	125,206	30		9
10	Interest and Other Investment Income	(10,089)	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	(1,755)	43		18
19	Entertainment				19
20	Contributions	(1,010)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(9,720)	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 Page 5A	(81,849)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 20,783		\$	30

BHF USE ONLY							
48		49		50		51	

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)	(307,084)	34
35	Other- Attach Schedule		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (307,084)	36
	(sum of SUBTOTALS		
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (286,301)	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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ (3,174)	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Medicare Part A-Bundled Services	(62,230)	43	3
4	Medicare Private-Bundled Services	(26)	43	4
5	Miscellaneous Income	(9,083)	21	5
6	Barber and Beauty Expense	(7,081)	40	6
7	Private Transportation	255	43	7
8	Bank Charges	(510)	43	8
9	Employee Meal reclass	(8,590)	2	9
10	Employee Meal reclass	8,590	22	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
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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	Total	(81,849)		48
49				49

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Ownership-1	100	Medina Nursing Center	Durand	Alpine Fireside Properties LLC		Real estate lessor
				Oxmati Management		Mgmt Co

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	33	Real Estate Taxes	\$ 91,758	Alpine Fireside Properties LLC	100.00%	\$ 91,758	\$	1
2	V	34	Rent-facility and grounds	267,600	Alpine Fireside Properties LLC	100.00%		(267,600)	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			\$ 359,358			\$ 91,758	\$ *	(267,600) 14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	Maintenance	\$	Oxmati Management		\$ 1,023	\$ 1,023	15
16	V	17	Management Fees	144,000	Oxmati Management			(144,000)	16
17	V	19	Professional Fees		Oxmati Management		587	587	17
18	V	20	Dues & Subscriptions		Oxmati Management		2,131	2,131	18
19	V	21	Clerical-Salary		Oxmati Management		78,986	78,986	19
20	V	21	Office Expense		Oxmati Management		7,312	7,312	20
21	V	22	Employee Benefits		Oxmati Management		9,538	9,538	21
22	V	26	Insurance		Oxmati Management		1,932	1,932	22
23	V	32	Interest		Oxmati Management		3,007	3,007	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 144,000			\$ 104,516	\$ * (39,484)	39

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

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Holgeir Oksnevad	President	Administrative	40.00	46,039	20	50.00	Mgmt Fees	\$ 53,505	L21, C7	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	\$ 53,505		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: 01/01/2025 Ending: 2/31/2025

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 ☒

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

Facility Name & ID Number Alpine Fireside Health Ctr # 0018275 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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 ☐

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

Name of Related Organization Oxmati Management
Street Address 5247 American Road
City / State / Zip Code Rockford, IL 61109-6312
Phone Number (815) 306-8039
Fax Number ()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	6	Maintenance	Management Fees	370,837	8	\$ 2,635	\$	144,000	\$ 1,023	1
2	19	Professional Fees	Management Fees	370,837	8	1,512		144,000	587	2
3	20	Dues & Subscriptions	Management Fees	370,837	8	5,488		144,000	2,131	3
4	21	Clerical-Salary	Management Fees	370,837	8	203,410	2,023,410	144,000	78,986	4
5	21	Office Expense	Management Fees	370,837	8	18,831		144,000	7,312	5
6	22	Employee Benefits	Management Fees	370,837	8	24,564		144,000	9,538	6
7	26	Insurance	Management Fees	370,837	8	4,975		144,000	1,932	7
8	32	Interest	Management Fees	370,837	8	7,744		144,000	3,007	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					\$ 269,159	\$ 2,023,410		\$ 104,516	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Solutions Bank		X	Working Capital	Interest Only	11/30/2023	500,000		11/30/2024	0.0825	7,576	1	
2	Solutions Bank		X	Working Capital	\$1,018.24	05/15/2023	50,500	27,740	06/01/2028	0.0750	2,513	2	
3												3	
4												4	
5	Working Capital												
6												6	
7												7	
8					\$1,018.24		\$ 550,500	\$ 27,740			\$ 10,089	8	
	TOTAL Facility Related											8	
9	B. Non-Facility Related*												
10								Allocation from Mgmt. Co.			3,007	10	
11								Interest Income			(10,089)	11	
12												12	
13							\$	\$			\$ (7,082)	13	
	TOTAL Non-Facility Related											14	
14							\$ 550,500	\$ 27,740			\$ 3,007	14	
	TOTALS (line 9+line14)											15	
15													

Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # N/A

16)

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.)

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.

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Alpine Fireside Health Ctr 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 2024 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 2024.

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
			<u>Nursing Home</u>
1. 12-05-376-014	Nursing Home	\$ 91,758.00	\$ 91,758.00
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 91,758.00	\$ 91,758.00

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 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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

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. List the bed capacity for the building if it differs from the licensed total. N/A
G. Have you properly capitalized all major repairs and equipment purchases? Y
H. Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
I. Are you presently operating under a sublease agreement? No
J. 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.

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

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	99		1973	1973	\$ 717,727	\$	30	\$	\$	717,727	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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	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			11,560	39
40	Gazebo pad	2002	12,657		20			12,657	40
41	Painting and wallpapering hallways	2003	27,403		20			27,403	41
42	Gazebo	2003	35,825		20			35,825	42
43	Fence	2003	3,400		20			3,400	43
44	Sign	2003	1,675		20			1,675	44
45	Garage	2003	3,077		20			3,077	45
46	Fire alarm	2003	30,208		20			30,208	46
47	Boiler	2004	31,880		20			31,880	47
48	Sign	2004	3,487		20			3,487	48
49	Smoke detectors	2004	2,153		20			2,153	49
50	Boiler	2005	7,060		20	108	108	7,060	50
51	Commercial disposal	2005	826		20			826	51
52	Fire supression system	2005	1,866		20	10	10	1,866	52
53	Pond	2006	11,930		20	596	596	11,771	53
54	Fire alarm system	2006	2,738		20	137	137	2,705	54
55	Floor tile, baseboards	2006	5,759		20	288	288	5,688	55
56	Air conditioning	2006	13,634		20	682	682	13,470	56
57	Sidewalk	2006	1,196		20	60	60	1,185	57
58	Remodel grieving room	2006	2,198		20	110	110	2,173	58
59	Fire sprinkler system	2007	169,761		20	8,487	8,487	159,132	59
60	Nurse call system	2007	69,282		20	3,464	3,464	64,950	60
61	Remodel fireplace	2007	39,855		20	1,993	1,993	37,368	61
62	Ceiling tiles	2007	12,820		20	641	641	12,019	62
63	Drywall stairways	2007	8,000		20	400	400	7,500	63
64	20 ton rooftop unit	2007	34,100		20	1,705	1,705	31,968	64
65	Ductless heat pump	2007	7,760		20	388	388	7,275	65
66	Remodel fireplace	2007	6,631		20	332	332	6,225	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,386,638	\$		\$ 19,401	\$ 19,401	\$ 2,364,403	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:

01/01/2025

Ending:

12/31/2025

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	\$		\$ 19,401	\$ 19,401	\$ 2,364,403	1
2	Circuit panel in kitchen	2007	4,045		20	202	202	3,586	2
3	Replace ceiling tiles	2008	11,366		20	568	568	10,082	3
4	New boiler and expansion tank	2008	10,635		20	532	532	8,911	4
5	Nurses station	2009	12,283		20	614	614	10,285	5
6	Carpeting	2009	12,306		20	615	615	10,302	6
7	Zone controls for main rooftop unit	2009	14,640		20	732	732	12,261	7
8	3 garage doors	2009	3,670		20	184	184	3,082	8
9									9
10	Basement A/C	2010	13,395		20	670	670	10,553	10
11	200 AMP Breaker/Conduit	2010	12,426		20	621	621	9,781	11
12	Drywall/Ceiling Tile/Metal Grid for Pt Rooms & Hallway	2010	10,563		20	528	528	8,316	12
13	Repl Hot Water Holding Tank	2010	5,269		20	263	263	4,143	13
14	Roofer Sealer Paint	2010	9,085		20	454	454	7,151	14
15	Driveway Sealer Coat	2010	10,608		20	530	530	8,348	15
16	Transfer Switch in Kohler Cabinet	2010	3,669		20	183	183	2,883	16
17	New Addition - Activity Room	2010	2,953		20	148	148	2,331	17
18									18
19									19
20	Windows	2011	42,307		20	2,115	2,115	31,201	20
21	Wanderguard	2011	113,678		20	5,684	5,684	83,838	21
22	Stove Hood	2011	40,750		20	2,038	2,038	30,053	22
23	Kitchen Air Conditioning	2011	36,470		20	1,824	1,824	26,897	23
24	Rooftop A/C Unit	2011	5,995		20	300	300	4,421	24
25	Water Cooler Coil on Heat Pump	2011	9,675		20	484	484	7,135	25
26	New Interior Paint front door	2011	4,104		20	205	205	3,027	26
27									27
28	Therapy Room Addition : framing, drywall, electrical, HVAC,	2011	619,228		20	30,961	30,961	425,719	28
29	flooring, paint, architect services, etc.								29
30	Generator	2011	168,336		20	8,417	8,417	115,731	30
31	New Front Door	2012	4,385		20	219	219	3,015	31
32	2 Pressure Tanks & 2 Ductless Heat Pumps for new Laundry Area	2012	14,160		20	708	708	9,735	32
33	Replace Glass in Windows in Offices, Dining Room & Lobby	2012	7,236		20	362	362	4,975	33
34	TOTAL (lines 1 thru 33)		\$ 3,589,875	\$		\$ 79,561	\$ 79,561	\$ 3,222,161	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:

01/01/2025

Ending:

12/31/2025

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	\$		\$ 79,561	\$ 79,561	\$ 3,222,161	1
2	<u>Countertop in Therapy Room</u>	2013	5,645		20	282	282	3,598	2
3									3
4	<u>Carpet - Hall 4</u>	2014	4,724		20	236	236	2,657	4
5	<u>Northeast Sidewalk Replacement</u>	2015	36,300		20	1,815	1,815	19,511	5
6	<u>Stonewall - Northeast side of building</u>	2015	3,407		20	170	170	1,831	6
7	<u>Blacktop work - Parking Lot</u>	2015	5,750		20	288	288	3,091	7
8	<u>Sealing - Roof</u>	2015	5,458		20	273	273	2,934	8
9	<u>Sealing - Roof</u>	2015	3,137		20	157	157	1,686	9
10									10
11	<u>Carpet/Tile - Lobby</u>	2016	28,437		20	1,422	1,422	13,863	11
12	<u>Water Softener - Garage</u>	2016	7,295		20	365	365	3,556	12
13									13
14	<u>Expansion Tank for Boiler</u>	2017	3,210		5			3,210	14
15	<u>Replaced Cedar Mansard Roof with Vinyl</u>	2017	114,959		27.5	4,180	4,180	36,577	15
16	<u>Bathroom Remodel - Therapy Room</u>	2017	5,334		5			5,334	16
17	<u>Plumbing, Electrical, Flooring</u>								17
18	<u>Fabricated Covers & Downspouts</u>	2016	18,926		27.5	688	688	6,020	18
19	<u>Cover Existing Walls & Floor in Walk In Freezer</u>	2017	9,326		27.5	339	339	2,967	19
20									20
21	<u>Roofing Project:</u>	2017	295,929		20	14,796	14,796	114,669	21
22	<u>-Stop Initial Leakage & Clean Up</u>								22
23	<u>-Reroof Dining Room and Kitchen Area (11,000 sq feet)</u>								23
24	<u>-Reroof 4 wings of Health Center (6,000 sq feet each)</u>								24
25	<u>- Tear off top roof to replace wet insulation</u>								25
26	<u>- Install new insulation to equal total R-Value of 30</u>								26
27	<u>- Fully adhere a 60 mil EPDM rubber roof</u>								27
28	<u>- Proper flashing for walls with term bar.</u>								28
29									29
30	<u>Roofing Project:</u>								30
31	<u>Additional Charges after 2018 Capital Report was filed</u>	2018	16,817		20	841	841	6,517	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,154,530	\$		\$ 105,413	\$ 105,413	\$ 3,450,183	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 4,154,530	\$		\$ 105,413	\$ 105,413	\$ 3,450,183	1
2	Air Conditioning Project - Roof	2017	34,159		20	1,708	1,708	13,237	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		20	1,094	1,094	8,479	6
7									7
8	Remove grab bars, mirrors, toilet tanks, sinks, linoleum floor	2018	12,208		20	610	610	4,728	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		20	513	513	3,976	14
15	- Mechanical Room								15
16									16
17	Install wall tile 54" on walls and vinyl flooring of 4 bathrooms	2019	42,285		20	2,114	2,114	14,270	17
18									18
19	Grind down, remove and replace loading dock	2019	2,750		20	138	138	932	19
20									20
21	Replace lobby circulating pump and new backup	2019	4,011		20	200	200	1,350	21
22									22
23	JACE controller - a device that provides connectivity	2019	6,038		20	302	302	2,039	23
24	to systems (HVAC, electrical, security)								24
25									25
26	replace all 16 hot water actuators on heating system	2019	16,916		20	846	846	5,711	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		20	311	311	1,711	29
30	Replace failed cube assembly from boiler - Mechanical Room	2021	13,833		20	692	692	3,113	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,325,092	\$		\$ 113,940	\$ 113,940	\$ 3,509,726	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 4,325,092	\$		\$ 113,940	\$ 113,940	\$ 3,509,726	1
2	Replace drive and cement in west parking area	2023	34,497		20	1,725	1,725	4,312	2
3	Installing new yard sprinkler system (down payment)	2023	7,450		20	373	373	931	3
4	Irrigation Installation	2023	9,500		20	475	475	1,188	4
5	Replace drive and cement in west parking area	2023	34,500		20	1,725	1,725	4,313	5
6	Replace drive and cement in west parking area	2023	25,000		20	1,250	1,250	3,125	6
7	Replace drive and cement in west parking area	2023	70,119		20	3,507	3,507	8,765	7
8									8
9	Basement Remodel, flooring	2024	6,398		20	320	320	480	9
10	Hall carpeting replacement	2025	46,830		20	1,171	1,171	1,171	10
11	Carpet room 406,408,414,402 and 404	2025	11,746		20	294	294	294	11
12	Flooring in dining room	2025	17,092		20	427	427	427	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	To tie book depreciation to financials								31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,588,224	\$		\$ 125,206	\$ 125,206	\$ 3,534,732	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$	\$	\$	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	187,617					187,617	73
74								74
75	TOTALS	\$ 187,617	\$	\$	\$		\$ 187,617	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		\$ 192,209	\$	\$	\$	5	\$ 192,209	76
77										77
78										78
79										79
80	TOTALS			\$ 192,209	\$	\$	\$		\$ 192,209	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$ 4,978,050	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 125,206	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 125,206	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,914,558	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: 12/31/2025

Schedule 13A

XI. Ownership Costs
Line 79 - Vehicle Depreciation

Use	Model, Make & Year	Year Acquired	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustments	Life in Years	Accumulated Depreciation
Dump Truck for Tractor	2010	2010	2,817			-	5	2,817
Administrative	2011 Dodge Challenger	2011	55,605			-	5	55,605
Administrative	GMC Denali	2013	63,981			-	5	63,981
Administrative	2013 Chevy Tahoe	2016	43,171			-	5	43,171
Maintenance Truck	2014 Dodge Ram	2016	26,635			-	5	26,635
						-		
						-		
TOTAL			192,209	-	-	-		192,209

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:
- *

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:
- (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

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.	/2026	\$
13.	/2027	\$
14.	/2028	\$

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

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

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ 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		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	\$	4,316	\$ 310,726	\$	4,316	\$ 310,726	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,864	134,185		1,864	134,185	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		5,501	396,082		5,501	396,082	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				131,967		131,967	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>See Sch 16A</u>	39(2)					110,683		110,683	12
13	Other (specify): <u></u>									13
14	TOTAL			\$	11,681	\$ 840,993	\$ 242,650	11,681	\$ 1,083,643	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:Alpine Fireside Health Ctr

IDPH License ID Number:0018275

Fiscal Year End:12/31/2025

Schedule 19A

Description	Amount
7009 MEDICAL:Private:Resident Purchase	-
7085 MEDICAL:Medicaid / IPAC:PT, OT, ST Medicaid	-
7125 MEDICAL:In-House Expenses:Oxygen-Nursing Supplies	15,835
7126 MEDICAL:In-House Expenses:Medical-Nursing Supplie	71,956
7130 MEDICAL:In-House Expenses:Wound Supplies	7,514
7132 MEDICAL:In-House Expenses:PPE Supplies	14,459
7920 THERAPY:Supplies	919
Total	110,683

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	\$ (115,659)	\$ (115,659)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance -)	642,399	642,399	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 526,740	\$ 526,740	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	2,609,635	4,588,224	15
16	Equipment, at Historical Cost	491,857	379,826	16
17	Accumulated Depreciation (book methods)	(1,803,104)	(3,914,558)	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 (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,298,388	\$ 1,063,492	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,825,128	\$ 1,590,232	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 300,410	\$ 300,410	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		84,122	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Sch 17A	(2,026)	(2,026)	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 298,384	\$ 382,506	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	27,740	27,740	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)	\$ 27,740	\$ 27,740	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 326,124	\$ 410,246	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,499,004	\$ 1,179,986	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,825,128	\$ 1,590,232	48

*(See instructions.)

Facility Name:Alpine Fireside Health Ctr

IDPH License ID Number:0018275

Fiscal Year End:12/31/2025

Schedule 17A

XV. Balance Sheet

Line 36 Other Current Liabilities (specify):

Description	Operating	After
		Consolidation
2210 Payroll Deductions Payable:Payroll Dump Account -	12,813	12,813
2240 Payroll Tax Payable Accounts:Fed Income Tax Withh	-	-
2250 Payroll Tax Payable Accounts:FICA Taxes Medicare	1,536	1,536
2255 Payroll Tax Payable Accounts:FICA SS OASDI Tax Wi	5,032	5,032
2260 Payroll Tax Payable Accounts:Illinois State Incom	-	-
2265 Payroll Tax Payable Accounts:Wisconsin State Inco	8,234	8,234
2350 Payroll Tax Payable Accounts:FICA SS & Medicare E	(23,036)	(23,036)
2375 Payroll Deductions Payable:401K Retirement	(7,656)	(7,656)
2380 Payroll Deductions Payable:Roth 401K	264	264
2390 Payroll Deductions Payable:Car Usage - Administra	780	780
2410 Payroll Deductions Payable:Wage Garnishments	7	7
Total - Line 36	(2,026)	(2,026)
	-	-

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,709,352	1
2	Restatements (describe):		2
3	Prior period Adjustments	(152,699)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,556,653	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(57,649)	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)	\$ (57,649)	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)	\$ 1,499,004	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Alpine Fireside Health Ctr

0018275

Report Period Beginning: 01/01/2025

Ending: 12/31/2025

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**

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,660,832	1
2	Discounts and Allowances for all Levels	(875,042)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,785,791	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,550,394	6
7	Oxygen	1,079	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,551,473	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	7,081	13
14	Non-Patient Meals	24,489	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	117,166	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	25,223	19
20	Radiology and X-Ray	11,291	20
21	Other Medical Services	28,137	21
22	Laundry	19,707	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 233,094	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	50,640	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 50,640	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Schedule 19A</u>	26,566	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 26,566	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,647,564	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,524,813	31
32	Health Care	2,970,004	32
33	General Administration	1,598,754	33
	B. Capital Expense		
34	Ownership	369,447	34
	C. Ancillary Expense		
35	Special Cost Centers	1,168,776	35
36	Provider Participation Fee	73,419	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,705,213	40
41	Income before Income Taxes (line 30 minus line 40)**	(57,649)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (57,649)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 480,645.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	414,481.00	45
46	MMAI-Medicaid is the Primary Payer	66,164.00	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	837,423.00	48
49	Medicare Part A	1,720,630.00	49
50	Other-(specify) <u>Shelter Care</u>	2,266,448.00	50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,785,791	56

Facility Name: Alpine Fireside Health Ctr
IDPH License ID Number: 0018275
Fiscal Year End: 12/31/2025

Schedule 19A

XVII. Income Statement

Line 28 Other Revenue (specify):

Description		Amount
4201 PRIVATE:Transportation		13,410
4203 MEDICAID:Transportation		-
4512 MEDICAID:Quality/CNA-SNF-LTC QIP & Staffing Incen		4,073
4870 MISC SALES:Store & Misc. Sales		1,798
4880 PRIVATE:Miscellaneous Income		4,744
4940 Insurance/Damage Miscellaneous Income		1,650
4990 MISC SALES:Miscellaneous Income		891
Total - Line 28		26,566
		-

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	3,081	3,248	\$ 164,527	\$ 50.66	1
2	Assistant Director of Nursing	1,765	1,829	74,058	40.49	2
3	Registered Nurses	5,031	5,513	240,624	43.64	4
4	Licensed Practical Nurses	5,325	5,650	193,891	34.32	5
5	CNAs & Orderlies	38,729	40,589	872,367	21.49	6
6	CNA Trainees					7
7	SS					8
8	Activity Aides					9
9	Licensed Therapist					10
10	Rehab/Therapy Aides					11
11	Activity Director	1,335	1,611	39,875	24.74	12
12	Activity Assistants	6,505	6,713	114,042	16.99	13
13	Social Service Workers	6,258	6,384	160,957	25.21	14
14	Dietician	20,244	21,037	334,196	15.89	15
16	Food Service Supervisor					17
17	Head Cook	4,813	5,009	81,324	16.23	18
18	Cook Helpers/Assistants					19
19	Dishwashers					20
20	Maintenance Workers	3,740	3,864	90,500	23.42	21
21	Housekeepers	5,121	5,297	80,159	15.13	22
22	Laundry	4,412	4,691	71,018	15.14	23
23	Administrator	2,080	2,080	163,800	78.75	24
24	Assistant Administrator					25
25	Other Administrative					26
26	Office Manager	6,275	6,642	170,104	25.61	27
27	Clerical					28
28	Vocational Instruction					29
29	Academic Instruction					30
30	Medical Director					31
31	Qualified MR Prof. (QMRP)					32
32	Resident Services Coordinator					33
33	Habilitation Aides (DD Homes)					34
34	Medical Records	3,950	4,001	66,831	16.70	35
35	Alzheimer Supervisor RN					36
36	Admissions Coord(Asst/Clerk)					37
37	Maintenance _____					38

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	988	\$ 55,412	L1,C3	35
36	Medical Director	Monthly	16,500	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	3,635	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	106	2,002	L11,C3	44
45	Social Service Consultant	52	926	L12,C3	45
46	Other(specify) MDS Consultant	17	1,898	L10,C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,175	\$ 80,373		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	3,052	\$ 242,607	L10,C3	50
51	Licensed Practical Nurses	4,627	301,483	L10,C3	51
52	Certified Nurse Assistants/Aides	11,704	445,014	L10,C3	52
53	TOTAL (lines 50 - 52)	19,383	\$ 989,104		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount		Description	Amount
Michelle Cruden	Administrator		\$ 163,800	Workers' Compensation Insurance	\$	28,215	IDPH License Fee	\$ 3,725
				Unemployment Compensation Insurance		18,147	Advertising: Employee Recruitment	5,958
				FICA Taxes		207,885	Health Care Worker Background Check	
				Employee Health Insurance		240,662	(Indicate # of checks performed 170)	2,460
				Employee Meals		8,590	Patient Background Checks	
				Illinois Municipal Retirement Fund (IMRF)*			Association Dues (total from pg 22, #4)	9,029
				401 K		38,221	Miscellaneous Dues & Subscriptions	16,477
				Uniforms		132		
				Pre-Employment Physicals		14,147	Allocated from Mgmt Co	2,131
				Allocated from Mgmt Co		9,538		
				Other Employee Benefits		9,960	Less: Public Relations Expense	()
							PAC and Lobbying payments	(3,174)
							All non-allowable advertising	()
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)								
			\$ 163,800					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Description			Amount		\$	575,497		\$ 36,606
Oxmati Management Fees			\$ 144,000					
Eliminated in Column 7								
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)								
			\$ 144,000					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Inovalon Provider, INC	Computer services		\$ 12,915				Out-of-State Travel	\$
iSolved	Computer services		4,353	N/A				
WellSky	Computer services		30,148					
AnyDesk Software GmbH	Computer services		275				In-State Travel	3,468
Amazon	Computer services		327					
3-Cubed Inc	Computer services		132,876					
Costco	Computer services		78					
Clark and Diffenderfer	Accounting		1,850				Seminar Expense	2,732
RSM LLP	Accounting		15,120					
Reno Zahm LLP	Legal		19,507					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)							Entertainment Expense	()
			\$ 217,449	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 6,200

* Attach copy of IMRF notifications

**See instructions.

Facility Name: Alpine Fireside Health Ctr
IDPH License ID Number: 0018275
Fiscal Year End: 12/31/2025

Schedule 21C

XIX. SUPPORT SCHEDULES
C. Professional Services

Vendor	Type	Amount
As per Page 21 Professional services		217,449
Total (agree to Schedule V, line 19, column 3)		217,449
Allocated from Management Company Legal Fees		587
Allocated from Management Company Professional Services		
Less: Non-Allowable Legal Fees		
Total (agree to Schedule V, line 19, column 8)		218,036

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below. Use the drop down list to identify the association.
- | Association Name | Amount |
|---|--------------------|
| <u>IL HEALTHCARE ASSOCIATION (IHCA)</u> | <u>5,855</u> |
| <u> </u> | <u> </u> |
| <u> </u> | <u> </u> |
| | <u>5,855</u> Total |
- (3) List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.
- | | |
|---|--------------------|
| <u>IL HEALTHCARE ASSOCIATION (IHCA)</u> | <u>3,174</u> |
| <u> </u> | <u> </u> |
| <u> </u> | <u> </u> |
| <u> </u> | <u> </u> |
| | <u>3,174</u> Total |
- (4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)
- | | |
|---|--------------------|
| <u>IL HEALTHCARE ASSOCIATION (IHCA)</u> | <u>9,029</u> |
| <u> </u> | <u> </u> |
| <u> </u> | <u> </u> |
| <u> </u> | <u> </u> |
| | <u>9,029</u> Total |
- (5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. \$ 35,741 Line 4(2)
- (6) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (7) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 73,419
This amount is to be recorded on line 42 of Schedule V.
- (8) 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.

- (9) 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
- (10) 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.
- (11) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 8,590 Has any meal income been offset against related costs? N/A Indicate the amount. \$
- (12) 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
- (13) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (14) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (15) 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.