

Facility Name & ID Number BIG MEADOWS

0021394 Report Period Beginning: 01/01/01 Ending: 12/31/01

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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	122	Intermediate (ICF)	122	44,530	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	122	TOTALS	122	44,530	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		Public Aid Recipient	Private Pay	Other		
8	SNF					8
9	SNF/PED					9
10	ICF	20,061	10,135		30,196	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,061	10,135		30,196	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4) 67.81%

D. How many bed-hold days during this year were paid by Public Aid? NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

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

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 11/11/76

J. Was the facility purchased or leased after January 1, 1978?
YES Date 9/19/2001 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRAU MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year YES NO

Tax Year: 12/31/01 Fiscal Year: 12/31/01

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

STATE OF ILLINOIS

Facility Name & ID Number **BIG MEADOWS** # **0021394** Report Period Beginning: **01/01/01** Ending: **12/31/01**

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
1	A. General Services										
1	Dietary	200,730	19,514	9,375	229,619	1,358	230,977		230,977		1
2	Food Purchase		207,932		207,932		207,932	(5,180)	202,752		2
3	Housekeeping	61,179	20,963		82,142	295	82,437		82,437		3
4	Laundry	60,807	11,108		71,915	295	72,210	(5,630)	66,580		4
5	Heat and Other Utilities			98,986	98,986		98,986	(7,755)	91,231		5
6	Maintenance	54,467	31,615	12,756	98,838		98,838	(3,969)	94,869		6
7	Other (specify):*										7
8	TOTAL General Services	377,183	291,132	121,117	789,432	1,948	791,380	(22,534)	768,846		8
	B. Health Care and Programs										
9	Medical Director			3,250	3,250		3,250		3,250		9
10	Nursing and Medical Records	891,392	72,362	7,920	971,674	(18,407)	953,267		953,267		10
10a	Therapy	11,389	447	2,617	14,453		14,453		14,453		10a
11	Activities	58,189	8,143		66,332		66,332		66,332		11
12	Social Services	52,914			52,914		52,914		52,914		12
13	Nurse Aide Training			3,245	3,245	20,592	23,837		23,837		13
14	Program Transportation	16,614	4,570		21,184	(1,828)	19,356		19,356		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,030,498	85,522	17,032	1,133,052	357	1,133,409		1,133,409		16
	C. General Administration										
17	Administrative			123,673	123,673		123,673	(1,343)	122,330		17
18	Directors Fees										18
19	Professional Services			5,368	5,368		5,368	2,005	7,373		19
20	Dues, Fees, Subscriptions & Promotion			20,471	20,471		20,471	(9,101)	11,370		20
21	Clerical & General Office Expense	71,876	12,457	18,601	102,934		102,934	843	103,777		21
22	Employee Benefits & Payroll Tax			185,217	185,217	(4,133)	181,084		181,084		22
23	Inservice Training & Education										23
24	Travel and Seminar			8,055	8,055		8,055	138	8,193		24
25	Other Admin. Staff Transportation							859	859		25
26	Insurance-Prop.Liab.Malpractice			35,141	35,141		35,141	133	35,274		26
27	Other (specify):* SALES TAX			738	738		738	16,172	16,910		27
28	TOTAL General Administration	71,876	12,457	397,264	481,597	(4,133)	477,464	9,706	487,170		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,479,557	389,111	535,413	2,404,081	(1,828)	2,402,253	(12,828)	2,389,425		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 **BIG MEADOWS**

#0021394

Report Period Beginning:

01/01/01

Ending:

12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			78,801	78,801		78,801	70,669	149,470			30
31	Amortization of Pre-Op. & Org											31
32	Interest			15,052	15,052		15,052	142,285	157,337			32
33	Real Estate Taxes			69,948	69,948		69,948	(1,716)	68,232			33
34	Rent-Facility & Grounds			279,078	279,078		279,078	(279,672)	(594)			34
35	Rent-Equipment & Vehicle:			6,000	6,000		6,000		6,000			35
36	Other (specify): ³											36
37	TOTAL Ownership			448,879	448,879		448,879	(68,434)	380,445			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportatior					1,828	1,828		1,828			38
39	Ancillary Service Center:		7,995		7,995		7,995		7,995			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shop:											41
42	Provider Participation Fee			66,795	66,795		66,795		66,795			42
43	Other (specify): ³											43
44	TOTAL Special Cost Centers		7,995	66,795	74,790	1,828	76,618		76,618			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,479,557	397,106	1,051,087	2,927,750		2,927,750	(81,262)	2,846,488			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 **BIG MEADOWS**

0021394

Report Period Beginning: **01/01/01**

Ending: **12/31/01**

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Program				3
4	Non-Patient Meals	(5,180)	2		4
5	Telephone, TV & Radio in Resident Room	(7,755)	5		5
6	Rented Facility Space	(595)	34		6
7	Sale of Supplies to Non-Patient				7
8	Laundry for Non-Patients	(5,630)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refund				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(738)	27		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transaction				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainer				22
23	Malpractice Insurance for Individual				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotions	(9,127)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employee				27
28	Yellow Page Advertising	(259)	20		28
29	Other-Attach Schedule	(7,247)	21,33,6		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (36,531)		\$	30

OHF 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	2	
		Amount	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)	(44,731)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (44,731)		36
	(sum of SUBTOTALS)			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (81,262)		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	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport	X		\$ 1,828	14,38	38
39						39
40	Gift and Coffee Shop					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 1,828		47

BIG MEADOWS

ID# 0021394

Report Period Beginning: 01/01/01

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	DISALLOWED FLOWERS	\$ (1,562)	21 1
2	NON ALLOWED REAL ESTATE TAXES	(1,716)	33 2
3	MAINTENANCE REVENUE	(3,969)	6 3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			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	(7,247)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number **BIG MEADOWS**# **0021394**

Report Period Beginning:

01/01/01

Ending:

12/31/01**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(5,180)	0	0	0	0	0	0	0	0	0	0	(5,180)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(5,630)	0	0	0	0	0	0	0	0	0	0	(5,630)	4
5	Heat and Other Utilities	(7,755)	0	0	0	0	0	0	0	0	0	0	(7,755)	5
6	Maintenance	(3,969)	0	0	0	0	0	0	0	0	0	0	(3,969)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(22,534)	0	0	0	0	0	0	0	0	0	0	(22,534)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(1,343)	0	0	0	0	0	0	0	0	0	(1,343)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	2,005	0	0	0	0	0	0	0	0	0	2,005	19
20	Fees, Subscriptions & Promotions	(9,386)	285	0	0	0	0	0	0	0	0	0	(9,101)	20
21	Clerical & General Office Expenses	(1,562)	2,405	0	0	0	0	0	0	0	0	0	843	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	138	0	0	0	0	0	0	0	0	0	138	24
25	Other Admin. Staff Transportation	0	859	0	0	0	0	0	0	0	0	0	859	25
26	Insurance-Prop.Liab.Malpractice	0	133	0	0	0	0	0	0	0	0	0	133	26
27	Other (specify):*	(738)	16,910	0	0	0	0	0	0	0	0	0	16,172	27
28	TOTAL General Administration	(11,686)	21,392	0	9,706	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(34,220)	21,392	0	(12,828)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number **BIG MEADOWS**# **0021394**

Report Period Beginning:

01/01/01

Ending:

12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	D. Ownership												
30	Depreciation	0	3,013	48,670	18,986	0	0	0	0	0	0	0	70,669 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	0	3,025	107,050	32,210	0	0	0	0	0	0	0	142,285 32
33	Real Estate Taxes	(1,716)	0	0	0	0	0	0	0	0	0	0	(1,716) 33
34	Rent-Facility & Grounds	(595)	0	(212,140)	(66,937)	0	0	0	0	0	0	0	(279,672) 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	(2,311)	6,038	(56,420)	(15,741)	0	(68,434) 37						
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(36,531)	27,430	(56,420)	(15,741)	0	(81,262) 45						

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
AMERICAN HEALTH ENTERPRISES, INC	100%	PLEASANT VIEW NURSING HOME	MORRISON			
ALAN GAPINSKI	100%					
	*	WINNING WHEELS, INC.	PROPHETSTOWN			
	0%	S.T.R.I.V.E.	PROPHETSTOWN			
* VINCE AND NORMA ARIOSIO OWNED FACILITY UNTIL SEPT. 19TH, 2001						
* WINNING WHEELS, INC. NOW OWNS THE BIG MEADOWS NURSING HOME BUILDING						

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	17	MANAGEMENT FEES	\$ 123,673	AMERICAN HEALTH ENTERPRISES, INC.	100.00%	\$ 151,103	\$ 27,430	1
2	V								2
3	V	34	RENT	66,937	WINNING WHEELS, INC. - 100% BUILDING OWNER	0.00%		(66,937)	3
4	V	32	INTEREST				32,210	32,210	4
5	V	30	DEPRECIATION				18,986	18,986	5
6	V	34	RENT	212,140	VINCE AND NORMA ARIOSIO	0.00%		(212,140)	6
7	V	32	MORT. INTEREST		FORMER BUILDING OWNERS		107,050	107,050	7
8	V	30	DEPRECIATION				48,670	48,670	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total		\$ 402,750				\$ 358,019	\$ * (44,731)	14

* Total must agree with the amount recorded on line 34 of Schedule V1

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 01/01/01 Ending: 12/31/01

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	AMERICAN HEALTH ENTERPRISES, INC.							\$		1	
2			DIRECT							2	
3	ALAN GAPINSKI	PRESIDENT	MANAGEMENT	100.00						3	
4										4	
5	BIG MEADOWS, INC.			100.00	20,730	10	20.00	MANAGEMENT	123,673	17,3	5
6	PLEASANT VIEW			100.00	20,730	10	20.00	FEES	112,577	N/A	6
7	WINNING WHEELS, INC.			0.00	33,170	16	32.00	"	216,000	N/A	7
8	S.T.R.I.V.E.			0.00	16,585	8	16.00	"	102,000	N/A	8
9	OTHERS (NON-COST REPORTING)			0.00	12,440	6	12.00	"	118,330	N/A	9
10											10
11											11
12											12
13								TOTAL	\$ 672,580		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 BIG MEADOWS # 0021394 Report Period Beginning: 01/01/01 Ending: 12/31/01

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

Name of Related Organization AMERICAN HEALTH ENTERPRISES, INC.
 Street Address 501 6TH AVE. WEST
 City / State / Zip Code LYNDON, IL 61261
 Phone Number (815-778-3683
 Fax Number (815-778-4503

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

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	17	ADMINISTRATIVE	DIRECT COST	1	\$ 51,219	\$ 51,219	1	\$ 51,219	1
2	17	ADMINISTRATIVE	DIRECT COST	1	1,772	1,772	1	1,772	2
3	17	ADMINISTRATIVE	GROSS REVENUE	10,444,000	252,152	252,152	2,691,000	64,969	3
4	17	ADMINISTRATIVE	GROSS REVENUE	10,444,000	16,959	16,959	2,691,000	4,370	4
5	19	DATA PROCESSING	GROSS REVENUE	10,444,000	6,368	0	2,691,000	1,641	5
6	19	ACCOUNTING	GROSS REVENUE	10,444,000	1,414	0	2,691,000	364	6
7	20	DUES,FEES,SUBSCRIPTIONS	GROSS REVENUE	10,444,000	1,108	0	2,691,000	285	7
8	21	SUPPLIES,PHONE	GROSS REVENUE	10,444,000	9,334	0	2,691,000	2,405	8
9	24	TRAINING, SEMINARS	GROSS REVENUE	10,444,000	537	0	2,691,000	138	9
10	25	ADMIN. TRANSPORTATION	GROSS REVENUE	10,444,000	3,332	0	2,691,000	859	10
11	26	INSURANCE	GROSS REVENUE	10,444,000	516	0	2,691,000	133	11
12	27	BENEFITS	% SALARY	483,938	70,379	0	116,274	16,910	12
13	30	DEPR'N VEHICLES	GROSS REVENUE	10,444,000	6,892	0	2,691,000	1,776	13
14	30	DEPR'N EQUIPMENT	GROSS REVENUE	10,444,000	4,799	0	2,691,000	1,237	14
15	32	INTEREST (VEHICLES)	GROSS REVENUE	10,444,000	3,146	0	2,691,000	811	15
16	32	INTEREST (WORKING CAP)	DIRECT COST	2	4,428	0	1	2,214	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 434,355	\$ 322,102		\$ 151,103	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	Name of Lender	2		3	4	5	6		8	9	10
			Related**					Purpose of Loan	Monthly Payment Required			
			YES	NO				Original	Balance			
		A. Directly Facility Related										
		Long-Term										
1		FIRST BANK - SAVANNA		X	BUILDING MORTGAGE	\$15,368.00	9/01	\$ 1,597,056	\$ 1,583,161	9/21/02	8.0000	\$ 32,210
2												
3		FIRST BANK - SAVANNA		X	BUILDING MORTGAGE	\$21,302.00					9.0000	107,050
4					(ARIOSO'S)							
5												
		Working Capital										
6		AMCORE BANK		X	CORPORATE VEHICLES	\$624.50	01/01	30,000	24,856	01/06	9.0000	811
7		VIRGINIA GAPINSKI TRUST	X		WORKING CAPITAL			25,000	23,370	DEMAND	9.0000	2,214
8		VINCENT ARIOSO	X		WORKING CAPITAL	NONE		197,389	197,389	DEMAND	8.0000	15,052
9		TOTAL Facility Related				\$37,294.50		\$ 1,849,445	\$ 1,828,776			\$ 157,337
		B. Non-Facility Related*										
10												
11												
12												
13												
14		TOTAL Non-Facility Related						\$	\$			\$
15		TOTALS (line 9+line14)						\$ 1,849,445	\$ 1,828,776			\$ 157,337

* 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 **BIG MEADOWS**

0021394 Report Period Beginning: **01/01/01** Ending: **12/31/01**

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and l must accompany the cost report</p>			
1. Real Estate Tax accrual used on 2000 report.		\$ 7,667	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.)		\$ 36,717	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 29,050	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 39,182	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 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		\$ 68,232	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1996	31,530	8
	1997	36,469	9
	1998	39,930	10
	1999	36,014	11
	2000	36,717	12
FOR OHF USE ONLY			
	13	FROM R. E. TAX STATEMENT FOR 2000 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
REAL ESTATE TAX BILLS HAVE BEEN UNDER ACCRUED FOR MANY YEARS. CORRECTED			
ACCRUAL THIS YEAR WHICH ACCOUNTS FOR THE BIG INCREASE IN EXPENSE.			

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 filec

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BIG MEADOWS COUNTY CARROLL

FACILITY IDPH LICENSE NUMBER 0021394

CONTACT PERSON REGARDING THIS REPORT ALAN GAPINSKI

TELEPHONE 815-778-3692 FAX #: 815-778-4503

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 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 2000.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>08-000-073-10</u>	<u>77 SAL L73 S3 T24 R3</u>	\$ <u>36,716.82</u>	\$ <u>36,716.82</u>
2. _____	<u>PT 660' X 880' SE. & .28 AC ADJ</u>	\$ _____	\$ _____
3. _____	<u>N SIDE B77 P347</u>	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>36,716.82</u>	\$ <u>36,716.82</u>

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 & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number BIG MEADOWS

0021394 Report Period Beginning:

01/01/01 Ending:

12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 55,835 B. General Construction Type: Exterior BRICK Frame CEMENT BLOCK Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (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? (a) Own the Equipment (b) Rent equipment from a Related Organization (c) Rent equipment from Completely Unrelated Organization

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, et List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

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

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	<u>FACILITY GROUNDS</u>	<u>13 ACRES</u>	<u>2001</u>	<u>\$ 139,000</u>	<u>1</u>
2					<u>2</u>
3	<u>TOTALS</u>	<u>13 ACRES</u>		<u>\$ 139,000</u>	<u>3</u>

Facility Name & ID Number **BIG MEADOWS**

0021394

Report Period Beginning:

01/01/01

Ending:

12/31/01

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	122	2001	1968	\$ 2,657,880	\$	40	\$ 18,986	\$ 18,986	\$ 18,986
5									
6									
7									
8									
Improvement Type**									
9	REPLACE TILE FLOOR		2001	1,182	13	7	13		13
10									
11									
12	BUILDING IMPROVEMENTS ON BIG MEADOWS BOOKS				35,418		35,418		
13	COMBINED AND TRANSFERRED NET OF DEPRECIATION								
14	TO NEW OWNER - WINNING WHEELS, INC.								
15	SEPTEMBER 2001								
16									
17									
18	PRIOR BUILDING OWNER DEPRECIATION ON BUILDING						48,670	48,670	
19	UNTIL TRANSFER OF PROPERTY IN SEPTEMBER OF 2001								
20	(SEE RELATED PARTY INFO - VINCE AND NORMA ARIOSO)								
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
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)

C. Equipment Depreciation-Excluding Transportation. (See instruction

	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	\$ 343,439	\$ 35,894	\$ 35,894	\$	VARIOUS	\$ 205,066	71
72	Current Year Purchases	12,479	997	997		VARIOUS	997	72
73	Fully Depreciated Assets	246,959					246,959	73
74	HOME OFFICE		1,237	1,237				74
75	TOTALS	\$ 602,877	\$ 38,128	\$ 38,128	\$		\$ 453,022	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	SNOW PLOWING/MAINT	CHEVROLET TRUCK 98	1997	\$ 29,205	\$ 5,841	\$ 5,841	\$	5	\$ 26,285	76
77	TRANSPORTATION	FORD VAN 91	2001	6,378	638	638		5	638	77
78	HOME OFFICE ALLOCATION				1,776	1,776				78
79										79
80	TOTALS			\$ 35,583	\$ 8,255	\$ 8,255	\$		\$ 26,923	80

E. Summary of Care-Related Asset

	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)	\$ 3,436,522	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 81,814	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 149,470	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 67,656	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 498,944	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		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progres

	Description	Cost	
92		\$	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 1

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: WINNING WHEELS INC

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 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1967,68	122	09/19/01	\$ *	20		3
4	Additions							4
5								5
6								6
7	TOTAL		122		\$ 279,078			7

10. Effective dates of current rental agreement:

Beginning 09/19/01
Ending 09/30/2021

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. 12/31/2002 \$ 238,417
 13. 12/31/2003 \$ 238,417
 14. 12/31/2004 \$ 238,417

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: VARIES STARTING 7/1/03 - 7/1,*

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	TRANSPORTATION	1996 VAN	\$ 500.00	\$ 6,000	17
18					18
19					19
20					20
21	TOTAL		\$ 500.00	\$ 6,000	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.

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

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

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input checked="" type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE <u>96</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input checked="" type="checkbox"/></p> <p>HOURS PER AIDE <u>48</u></p>
---	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

	Facility			
	1	2	3	4
	Drop-outs	Completed	Contract	Total
1 Community College Tuition	\$	\$	\$	\$
2 Books and Supplies			900	900
3 Classroom Wages (a)	3,744	11,232		14,976
4 Clinical Wages (b)		5,616		5,616
5 In-House Trainer Wage (c)				
6 Transportation				
7 Contractual Payment:			2,345	2,345
8 Nurse Aide Competency Tests				
9 TOTALS	\$ 3,744	\$ 16,848	\$ 3,245	\$ 23,837
10 SUM OF line 9, col. 1 and 2 (c)	\$ 20,592			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities:

\$ NONE

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	15
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	5
2. From other facilities (f)	
TOTAL TRAINED	20

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefit;
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefit;
- (c) For in-house training programs only. Do not include fringe benefit;
- (d) Allocate based on if the aide 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 aides

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides

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

	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		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

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

Facility Name & ID Number **BIG MEADOWS**# **0021394**Report Period Beginning: **01/01/01**

Ending:

12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/01**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 65,872	\$ 136,225	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 51,670)	254,190	569,089	3
4	Supply Inventory (priced at)	46,634	77,343	4
5	Short-Term Investments			5
6	Prepaid Insurance	8,286	12,682	6
7	Other Prepaid Expenses	11,476	15,659	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): SEE ATTACHED	4,837	4,837	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 391,295	\$ 815,835	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,182	198,011	15
16	Equipment, at Historical Cost	638,460	817,748	16
17	Accumulated Depreciation (book methods)	(479,957)	(603,975)	17
18	Deferred Charges		112,422	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)	\$ 159,685	\$ 524,206	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 550,980	\$ 1,340,041	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 175,829	\$ 331,659	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	10,380	75,380	29
30	Accrued Salaries Payable	74,749	140,742	30
31	Accrued Taxes Payable (excluding real estate taxes)	18,943	34,432	31
32	Accrued Real Estate Taxes(Sch.IX-B)	39,182	76,347	32
33	Accrued Interest Payable	1,576	4,596	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	SEE ATTACHED	(153,071)	3,042	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 167,588	\$ 666,198	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	128,378	412,393	39
40	Mortgage Payable	197,389	327,133	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	DEFERRED TAXES	3,006	3,006	43
44	OTHER (SEE ATTACHED)	2,135	131,883	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 330,908	\$ 874,415	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 498,496	\$ 1,540,613	46
47	TOTAL EQUITY(page 18, line 24)	\$ 52,484	\$ (200,572)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 550,980	\$ 1,340,041	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 222,521	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 222,521	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(170,037)	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 Owner:	()	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)	\$ (170,037)	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)	\$ 52,484	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number BIG MEADOWS

0021394

Report Period Beginning: 01/01/01

Ending: 12/31/01

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 expenses

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,699,781	1
2	Discounts and Allowances for all Level	(12,000)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,687,781	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,114	6
7	Oxygen	22,547	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 27,661	8
C. Other Operating Revenue			
9	Payments for Educator		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursement	11,339	11
12	Gift and Coffee Shop	558	12
13	Barber and Beauty Care	2,923	13
14	Non-Patient Meals	5,180	14
15	Telephone, Television and Radio	7,755	15
16	Rental of Facility Space	595	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patient		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	5,630	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 33,980	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income**		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	TRANSPORTATION	4,322	28
28a	MAINTENANCE	3,969	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 8,291	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,757,713	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	789,432	31
32	Health Care	1,133,052	32
33	General Administrator	481,597	33
B. Capital Expense			
34	Ownership	448,879	34
C. Ancillary Expense			
35	Special Cost Centers	7,995	35
36	Provider Participation Fee	66,795	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,927,750	40
41	Income before Income Taxes (line 30 minus line 40)**	(170,037)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (170,037)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? YES 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.

Facility Name & ID Number **BIG MEADOWS**

0021394

Report Period Beginning: 01/01/01

Ending:

12/31/01

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	1,981	2,256	\$ 54,270	\$ 24.06	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,593	7,332	127,306	17.36	3
4	Licensed Practical Nurses	13,034	14,201	210,830	14.85	4
5	Nurse Aides & Orderlies	56,926	60,699	458,286	7.55	5
6	Nurse Aide Trainees	2,640	2,640	20,592	7.80	6
7	Licensed Therapist	1,089	1,189	11,389	9.58	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,932	2,158	31,332	14.52	9
10	Activity Assistants	3,513	3,945	26,857	6.81	10
11	Social Service Worker	3,855	4,381	52,914	12.08	11
12	Dietician					12
13	Food Service Supervisor	2,059	2,136	23,846	11.16	13
14	Head Cook	2,017	2,168	17,956	8.28	14
15	Cook Helpers/Assistants	23,486	25,165	158,929	6.32	15
16	Dishwashers					16
17	Maintenance Worker	5,831	6,299	54,467	8.65	17
18	Housekeepers	9,052	9,863	61,179	6.20	18
19	Laundry	9,180	9,913	60,806	6.13	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,957	2,389	23,872	9.99	23
24	Clerical	4,992	5,428	48,004	8.84	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	2,219	2,439	20,108	8.24	31
32	Other Health Care(specify)					32
33	Other(specify) TRANSPORT	1,948	2,194	16,614	7.57	33
34	TOTAL (lines 1 - 33)	154,304	166,795	\$ 1,479,557 *	\$ 8.87	34

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

** See instructions.

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	188	\$ 9,375	1/3	35
36	Medical Director	32	3,250	9/3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	27	1,350	10/3	39
40	Physical Therapy Consultant	44	2,212	10a/3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	291	\$ 16,187		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses				50
51	Licensed Practical Nurses	195	5,847	10/3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	195	\$ 5,847		53

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 ASSOC. \$6229
- (3) Did the nursing home make political contributions or payments to a political organization? NO If YES, have these costs been properly adjusted out of the cost report _____
- (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? _____
- (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? 7
- (6) Indicate the total amount of both disposable and non-disposable diaper expenses and the location of this expense on Sch. V. 12,636 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation _____
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease _____
- (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 _____
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. 66,795
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 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 of Public Aid, 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 if 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. \$ NONE Has any meal income been offset against related costs? YES Indicate the amount \$ 5,180
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? YES
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 program during this reporting period. _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? _____
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 \$ NONE
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees _____