

		FOR BHF USE				

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**2006**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2006)**

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 Facility ID Number:** 0021394

**Facility Name:** BIG MEADOWS

**Address:** 1000 LONGMOOR AVENUE SAVANNA 61074  
 Number City Zip Code

**County:** CARROLL

**Telephone Number:** 815-273-2238 **Fax #** 815-273-7294

**HFS ID Number:** 36-2819435001

**Date of Initial License for Current Owners:** 10/21/76

**Type of Ownership:**

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
<b>IRS Exemption Code</b> _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

**In the event there are further questions about this report, please contact:**  
**Name:** DAVE HECKMAN **Telephone Number:** 815-778-3683

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/06 to 12/31/06 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.

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) <u>JOHN SMITH</u>	
	(Title) <u>CFO</u>	
<b>Paid Preparer</b>	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) ( ) _____ Fax # ( ) _____	

**MAIL TO: BUREAU OF HEALTH FINANCE**  
**ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES**  
 201 S. Grand Avenue East  
 Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number BIG MEADOWS

# 0021394 Report Period Beginning: 1/1/06 Ending: 12/31/06

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	98	Intermediate (ICF)	98	35,770	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	98	TOTALS	98	35,770	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF	21,786	6,678		28,464
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	21,786	6,678		28,464

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.58%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES  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 9/19/01 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

ACCRUAL  MODIFIED CASH\*  CASH\*

Is your fiscal year identical to your tax year? YES  NO

Tax Year: 12/31/06 Fiscal Year: 12/31/06

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



Facility Name & ID Number **BIG MEADOWS** # **0021394** Report Period Beginning: **1/1/06** Ending: **12/31/06**

**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
	<b>A. General Services</b>										
1	Dietary	255,874	16,177	8,160	280,211		280,211		280,211		1
2	Food Purchase		223,092		223,092		223,092	(6,244)	216,848		2
3	Housekeeping	91,754	24,736		116,490		116,490		116,490		3
4	Laundry	75,275	21,694		96,969		96,969		96,969		4
5	Heat and Other Utilities			125,638	125,638		125,638	(10,136)	115,502		5
6	Maintenance	60,627	27,938	16,714	105,279		105,279	360	105,639		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>483,530</b>	<b>313,637</b>	<b>150,512</b>	<b>947,679</b>		<b>947,679</b>	<b>(16,020)</b>	<b>931,659</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			3,000	3,000		3,000		3,000		9
10	Nursing and Medical Records	1,019,490	95,914	22,035	1,137,439	(11,878)	1,125,561		1,125,561		10
10a	Therapy	10,430		1,593	12,023		12,023		12,023		10a
11	Activities	87,695	9,232		96,927		96,927		96,927		11
12	Social Services	57,602			57,602		57,602		57,602		12
13	CNA Training	7,356		4,728	12,084		12,084		12,084		13
14	Program Transportation	20,770	4,998		25,768		25,768		25,768		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>1,203,343</b>	<b>110,144</b>	<b>31,356</b>	<b>1,344,843</b>	<b>(11,878)</b>	<b>1,332,965</b>		<b>1,332,965</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative			155,934	155,934		155,934	(32,590)	123,344		17
18	Directors Fees										18
19	Professional Services			13,108	13,108		13,108	364	13,472		19
20	Dues, Fees, Subscriptions & Promotions			34,505	34,505		34,505	(21,615)	12,890		20
21	Clerical & General Office Expenses	76,901	20,636	13,157	110,694		110,694	2,595	113,289		21
22	Employee Benefits & Payroll Taxes			250,941	250,941	(1,996)	248,945	18,556	267,501		22
23	Inservice Training & Education										23
24	Travel and Seminar			8,364	8,364		8,364	(103)	8,261		24
25	Other Admin. Staff Transportation							1,003	1,003		25
26	Insurance-Prop.Liab.Malpractice			33,713	33,713		33,713	581	34,294		26
27	Other (specify):* <b>SALES TAX</b>			970	970		970	(970)			27
28	<b>TOTAL General Administration</b>	<b>76,901</b>	<b>20,636</b>	<b>510,692</b>	<b>608,229</b>	<b>(1,996)</b>	<b>606,233</b>	<b>(32,179)</b>	<b>574,054</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,763,774</b>	<b>444,417</b>	<b>692,560</b>	<b>2,900,751</b>	<b>(13,874)</b>	<b>2,886,877</b>	<b>(48,199)</b>	<b>2,838,678</b>		<b>29</b>

\*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: 1/1/06 Ending: 12/31/06

## 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	
	<b>D. Ownership</b>											
30	Depreciation			25,392	25,392		25,392	98,266	123,658			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			39,546	39,546		39,546	115,602	155,148			32
33	Real Estate Taxes			43,450	43,450		43,450		43,450			33
34	Rent-Facility & Grounds			224,700	224,700		224,700	(224,700)				34
35	Rent-Equipment & Vehicles			6,000	6,000	(4,998)	1,002		1,002			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			339,088	339,088	(4,998)	334,090	(10,832)	323,258			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation					4,998	4,998		4,998			38
39	Ancillary Service Centers					13,874	13,874		13,874			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			53,655	53,655		53,655		53,655			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			53,655	53,655	18,872	72,527		72,527			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,763,774	444,417	1,085,303	3,293,494		3,293,494	(59,031)	3,234,463			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: **1/1/06**

Ending: **12/31/06**

**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 Programs				3
4	Non-Patient Meals	(6,244)	2		4
5	Telephone, TV & Radio in Resident Rooms	(10,136)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(970)	27		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,100)	20		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	(14,426)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(3,930)	20		28
29	Other-Attach Schedule	(2,550)	VAR		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (39,356)		\$	30

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)	(19,675)	VAR	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (19,675)		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (59,031)		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		\$ 4,998	14	38
39	PA OXYGEN	X		13,874	10	39
40	Gift and Coffee Shops					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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$ 18,872		47

BHF USE ONLY						
48		49		50		51
						52

**BIG MEADOWS**

ID# 0021394  
 Report Period Beginning: 1/1/06  
 Ending: 12/31/06

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	FLOWERS	\$ (1,930)	20	1
2	OUT OF STATE TRAVEL	(103)	24	2
3	ROTARY DUES	(517)	20	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	<b>Total</b>	(2,550)		49

## STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

1/1/06

Ending:

12/31/06

**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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(6,244)	0	0	0	0	0	0	0	0	0	0	(6,244)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(10,136)	0	0	0	0	0	0	0	0	0	0	(10,136)	5
6	Maintenance	0	0	360	0	0	0	0	0	0	0	0	360	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(16,380)</b>	<b>0</b>	<b>360</b>	<b>0</b>	<b>(16,020)</b>	<b>8</b>							
	<b>B. Health Care and Programs</b>													
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	CNA 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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	(32,590)	0	0	0	0	0	0	0	0	(32,590)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	364	0	0	0	0	0	0	0	0	364	19
20	Fees, Subscriptions & Promotions	(21,903)	0	288	0	0	0	0	0	0	0	0	(21,615)	20
21	Clerical & General Office Expenses	0	0	2,595	0	0	0	0	0	0	0	0	2,595	21
22	Employee Benefits & Payroll Taxes	0	0	18,556	0	0	0	0	0	0	0	0	18,556	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(103)	0	0	0	0	0	0	0	0	0	0	(103)	24
25	Other Admin. Staff Transportation	0	0	1,003	0	0	0	0	0	0	0	0	1,003	25
26	Insurance-Prop.Liab.Malpractice	0	0	581	0	0	0	0	0	0	0	0	581	26
27	Other (specify):*	(970)	0	0	0	0	0	0	0	0	0	0	(970)	27
28	<b>TOTAL General Administration</b>	<b>(22,976)</b>	<b>0</b>	<b>(9,203)</b>	<b>0</b>	<b>(32,179)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(39,356)</b>	<b>0</b>	<b>(8,843)</b>	<b>0</b>	<b>(48,199)</b>	<b>29</b>							

STATE OF ILLINOIS

Facility Name & ID Number **BIG MEADOWS**

# **0021394** Report Period Beginning:

**1/1/06** Ending:

Summary B

**12/31/06**

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	96,973	1,293	0	0	0	0	0	0	0	0	98,266	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	114,469	1,133	0	0	0	0	0	0	0	0	115,602	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(224,700)	0	0	0	0	0	0	0	0	0	(224,700)	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	<b>TOTAL Ownership</b>	<b>0</b>	<b>(13,258)</b>	<b>2,426</b>	<b>0</b>	<b>(10,832)</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(39,356)</b>	<b>(13,258)</b>	<b>(6,417)</b>	<b>0</b>	<b>(59,031)</b>	<b>45</b>							

Facility Name & ID Number BIG MEADOWS

# 0021394

Report Period Beginning:

1/1/06

Ending:

12/31/06

**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	MORRISON			
ALAN GAPINSKI	100%					
	0%	WINNING WHEELS, INC.	PROPHETSTOWN			
	0%	S.T.R.I.V.E.	PROPHETSTOWN			

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	VAR PROFESSIONAL SERVICES	\$ 155,934	AMERICAN HEALTH ENTERPRISES, INC.	100.00%	\$ 149,517	\$ (6,417)	1
2	V	34 RENT	224,700	WINNING WHEELS - 100% BUILDING OWNER			(224,700)	2
3	V	32 INTEREST				114,469	114,469	3
4	V	30 DEPRECIATION				96,973	96,973	4
5	V			SEE ATTACHED PAGE 7				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		\$ 380,634			\$ 360,959	\$ * (19,675)	14

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

Facility Name & ID Number **BIG MEADOWS**# **0021394**Report Period Beginning: **1/1/06**Ending: **12/31/06****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	17 MANAGEMENT FEES	\$ 155,934	AMERICAN HEALTH ENTERPRISES, INC.	100.00%	\$		15
16	V	17 (SEE PAGE 8)		AMERICAN HEALTH ENTERPRISES, INC.	100.00%	123,344	123,344	16
17	V	22		AMERICAN HEALTH ENTERPRISES, INC.	100.00%	18,556	18,556	17
18	V	19		AMERICAN HEALTH ENTERPRISES, INC.	100.00%	364	364	18
19	V	20		AMERICAN HEALTH ENTERPRISES, INC.	100.00%	288	288	19
20	V	21		AMERICAN HEALTH ENTERPRISES, INC.	100.00%	2,595	2,595	20
21	V	25		AMERICAN HEALTH ENTERPRISES, INC.	100.00%	1,003	1,003	21
22	V	26		AMERICAN HEALTH ENTERPRISES, INC.	100.00%	581	581	22
23	V	30		AMERICAN HEALTH ENTERPRISES, INC.	100.00%	1,293	1,293	23
24	V	32		AMERICAN HEALTH ENTERPRISES, INC.	100.00%	1,133	1,133	24
25	V	6		AMERICAN HEALTH ENTERPRISES, INC.	100.00%	360	360	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		\$ 155,934			\$ 149,517	\$ * (6,417)	39

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

Facility Name &amp; ID Number

BIG MEADOWS

#

0021394

Report Period Beginning:

1/1/06

Ending:

12/31/06

## 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			100.00					\$	1
2	Alan Gapinski	President	Direct Management							2
3										3
4	Big Meadows			100.00	36,792	10	28.00	management fees	155,934	4
5	Pleasant View			100.00	26,280	10	28.00	"	130,219	5
6	Winning Wheels			NONE	47,304	18	36.00	"	177,500	6
7	S.T.R.I.V.E.			NONE	13,140	5	10.00	"	109,750	7
8	Other(non cost reporting)			NONE	7,884	3	6.00	"	136,012	8
9										9
10										10
11										11
12										12
13								TOTAL	\$ 709,415	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: **1/1/06**

Ending: **12/31/06**

**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 \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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

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	17	Admin	Direct costs	1	\$ 68,577	\$ 68,577	1	\$ 68,577	1
2	17	Admin	Gross Revenue	12,009,091	5	207,409	3,171,019	54,767	2
3	22	benefits	% Salary	454,180	5	68,329	123,344	18,556	3
4	19	Accounting	Gross Revenue	12,009,091	5	68	3,171,019	18	4
5	19	Data Processing	Gross Revenue	12,009,091	5	1,311	3,171,019	346	5
6	20	Dues fees	Gross Revenue	12,009,091	5	1,090	3,171,019	288	6
7	21	Supplies Phone	Gross Revenue	12,009,091	5	9,828	3,171,019	2,595	7
8									8
9	20	Traing Seminars	Gross Revenue	12,009,091	5	0	3,171,019	0	9
10	25	Admin Transportation	Gross Revenue	12,009,091	5	3,798	3,171,019	1,003	10
11	26	Insurance	Gross Revenue	12,009,091	5	2,199	3,171,019	581	11
12	30	Depreciation, Vehicles	Gross Revenue	12,009,091	5	4,895	3,171,019	1,293	12
13									13
14	32	Interest Vehicle	Gross Revenue	12,009,091	5	1,358	3,171,019	359	14
15	32	Interst Working capital	Gross Revenue	2	2	1,548	1	774	15
16	6	Maintenance	Gross Revenue	12,009,091	5	1,362	3,171,019	360	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 371,772	\$ 68,577		\$ 149,517	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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	AMCORE BANK		X	BUILDING MORTGAGE	\$12,227.35	6/30/04	\$ 1,730,000	\$ 1,659,873	6/30/29	6.9000	\$ 114,469	1								
2	AMCORE BANK		X	CORPORATE VEHICLES	\$1,003.90	10/2005	32,000		9/09	6.5000	359	2								
3	WINNING WHEELS, INC.	X			\$5,000.24	3/2005	300,000	219,831	3/2011	6.2000	15,150	3								
4	CORPORATE ALLOCATION	X		WORKING CAPITAL	NONE	6/2000	25,000		7/2010	5.0000	774	4								
5												5								
<b>Working Capital</b>																				
6	THE NATIONAL BANK		X	WORKING CAPITAL	\$697.58	6/9/04	192,467	44,943	6/9/09	7.0000	1,620	6								
7	THE NATIONAL BANK		X	WORKING CAPITAL	INT. ONLY	4/10/03	175,000	293,462	6/1/07	8.0000	6,984	7								
8	VINCE ARIOSO	X		WORKING CAPITAL	NONE	6/2000	197,389	197,389	DEMAND	9.0000	15,792	8								
9	<b>TOTAL Facility Related</b>				\$18,929.07		\$ 2,651,856	\$ 2,415,498			\$ 155,148	9								
<b>B. Non-Facility Related*</b>																				
10												10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 2,651,856	\$ 2,415,498			\$ 155,148	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ NONE Line # \_\_\_\_\_

\* 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.)



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2006 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 Bureau of Health Finance at (217) 782-1630.

**2005 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME BIG MEADOWS COUNTY CARROLL

FACILITY IDPH LICENSE NUMBER 0021394

CONTACT PERSON REGARDING THIS REPORT DAVE HECKMAN

TELEPHONE 815-778-3683 FAX #: 815-778-4503

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(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>08-000-073-00</u>	<u>77 SAV L73 S3 T24 R3</u>	\$ <u>43,425.32</u>	\$ <u>43,425.32</u>
2. _____	<u>PT 600' X 880' SE. &amp; .28 AC ADJ N S</u>	\$ _____	\$ _____
3. _____	<u>B77 P347</u>	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>43,425.32</u>	\$ <u>43,425.32</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 original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

Facility Name & ID Number BIG MEADOWS

# 0021394 Report Period Beginning:

1/1/06 Ending:

12/31/06

**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 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).

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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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>FACILITY GROUNDS</u>	<u>566,280</u>		<u>\$ 139,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>566,280</b>		<b>\$ 139,000</b>	<b>3</b>

Facility Name & ID Number **BIG MEADOWS**

# **0021394**

Report Period Beginning:

1/1/06

Ending:

12/31/06

**XI. OWNERSHIP COSTS (continued)**

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	98		2001	1968	\$ 2,659,130	\$	39	\$ 68,183	\$ 68,183	\$ 329,556	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		REPLACEMENT FLOOR TILE		2001	1,182	79	15	79		407	9
10		WHIRLPOOL/SHOWER ROOM		2002	12,150	810	15	810		3,915	10
11		FIREDOORS		2002	9,076	454	20	454		2,042	11
12		REMODEL DINING ROOM		2004	4,060	406	10	406		1,015	12
13		ROOF & CUTTERS		2002	244,631		20	12,232	12,232	43,867	13
14		AIR CONDITIONERS		2003	23,038		10	2,304	2,304	8,063	14
15		GARAGE		2003	32,491		20	1,625	1,625	4,874	15
16		BATHROOM REMODELING		2003	4,885		10	489	489	1,221	16
17		ROOF ADDITION		2003	4,500		20	225	225	675	17
18		PAVING		2003	10,115		10	1,012	1,012	2,529	18
19		SMOKE ALARM SYSTEM		2003	28,321		15	1,888	1,888	4,877	19
20		WIRELESS MONITORING SYSTEM		2004	69,820		15	4,655	4,655	11,250	20
21		DINING ROOM		2005	21,857		15	1,457	1,457	1,579	21
22		PAVE SIDEWALK		2005	7,780		20	389	389	421	22
23		CARPET		2005	19,473		5	1,947	1,947	1,947	23
24		HEATING & AC		2005	13,660		20	569	569	569	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

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number **BIG MEADOWS** # **0021394** Report Period Beginning: **1/1/06** Ending: **12/31/06**

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 224,364	\$ 21,763	\$ 21,763	\$	VARIOUS	\$ 157,914	71
72	Current Year Purchases	25,240	1,880	1,880		VARIOUS	1,880	72
73	Fully Depreciated Assets	445,510				VARIOUS	445,510	73
74								74
75	TOTALS	\$ 695,114	\$ 23,643	\$ 23,643	\$		\$ 605,304	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 PLOW/MAINT.	1997 CHEVY TRUCK	1997	\$ 29,205	\$	\$	\$	5	\$ 29,205	76
77	HOME OFFICE ALLOCATION					1,293	1,293	5		77
78										78
79										79
80	TOTALS			\$ 29,205	\$	\$ 1,293	\$ 1,293		\$ 29,205	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,029,488	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 25,392	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 123,658	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 98,266	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,053,317	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-Progress

	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 8.

**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 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>1967/68</u>	<u>98</u>	<u>9/19/2001</u>	\$ <u>224,700</u>	<u>20</u>		3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>		<b>98</b>		\$ <b>224,700</b>			<b>7</b>

10. Effective dates of current rental agreement:

Beginning 9/19/2001

Ending 9/19/2021

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

Fiscal Year Ending                      Annual Rent

12.	<u>12/31/2007</u>	\$ <u>224,700</u>
13.	<u>12/31/2008</u>	\$ <u>224,700</u>
14.	<u>12/31/2009</u>	\$ <u>224,700</u>

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: VARIOUS \*

**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	<u>TRANSPORTATION</u>	<u>2005 FORD VAN</u>	\$ <u>500.00</u>	\$ <u>6,000</u>	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$ <b>500.00</b>	\$ <b>6,000</b>	<b>21</b>

\* 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.)

<p>1. HAVE YOU TRAINED CNAs 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. <u>CLASSROOM PORTION:</u></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 CNA <u>96</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input checked="" type="checkbox"/></p> <p>HOURS PER CNA <u>48</u></p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)		2,688		2,688
4	Clinical Wages (b)		4,668		4,668
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments		4,728		4,728
8	CNA Competency Tests				
9	TOTALS	\$	\$ 12,084	\$	\$ 12,084
10	SUM OF line 9, col. 1 and 2 (e)	\$	12,084		

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	7
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>7</b>

- (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.)**

	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 prescripts							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	<b>TOTAL</b>			\$		\$	\$		\$	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.**

**Balance Sheet**  
**As of 12/31/2028**

**Big Meadows, Inc. (BIM)**

**ASSETS**

**CASH**

1100.00	PETTY CASH	\$350.00	1,1
1110.00	THE NATIONAL BANK	\$336,602.24	1,1
1130.00	PETTY CASH CHECKING	\$998.15	1,1
1150.00	INVESTMENT IN LTG STOCK	\$71,169.00	12,1
	<b>Total CASH:</b>	<u>\$350,100.39</u>	

**ACCOUNTS RECEIVABLE**

1210.00	PUBLIC AID	\$444,960.41	3,1
1230.00	PRIVATE PAY	\$17,108.17	3,1
1240.00	OXYGEN	\$11,250.75	3,1
1260.00	ALLOWANCE	<u>\$63,368.48</u>	3,1
	<b>Total ACCOUNTS RECEIVABLE:</b>	<u>\$419,968.85</u>	

**INVENTORY**

1350.00	NURSING/DIETARY/FOOD/LAUNDRY	\$23,083.31	4,1
1360.00	LINEN	\$15,834.00	4,1
1370.00	HOUSEKEEPING/MAINTENANCE	<u>\$5,368.98</u>	4,1
	<b>Total INVENTORY:</b>	<u>\$44,286.27</u>	

**PREPAID ASSETS**

1420.00	PREPAID DUES	\$5,139.12	7,1
1430.00	PREPAID INSURANCE	\$7,928.79	6,1
1440.00	PREPAID LONG TERM CARE LICENSE FEE	\$414.82	7,1
1450.00	DUE FROM (TO) WINNING WHEELS	<u>\$6,516.41</u>	8,1
	<b>Total PREPAID ASSETS:</b>	<u>\$17,999.84</u>	

**FIXED ASSETS**

1730.00	LEASEHOLD IMPROVEMENTS	\$26,467.53	15,1
1740.00	ACCUM. DEPR. - LEASEHOLD IMPR.	\$7,379.14	17,1
1750.00	FURNITURE AND FIXTURES	\$562,746.76	16,1
1760.00	ACCUM. DEPR. - FURN. & FIXTURE	<u>\$480,252.52</u>	17,1
1770.00	VEHICLES	\$25,205.00	16,1
1780.00	ACCUM. DEPR. - VEHICLES	<u>\$29,265.00</u>	17,1
1810.00	OFFICE EQUIPMENT	\$132,397.10	16,1
1820.00	ACCUM. DEPR. - OFFICE EQUIP.	<u>\$128,051.87</u>	17,1
	<b>Total FIXED ASSETS:</b>	<u>\$108,868.08</u>	

**Total ASSETS:**

\$945,175.41

**LIABILITIES**

**ACCOUNTS PAYABLE AND ACCRUALS**

2110.00	ACCOUNTS PAYABLE	\$131,999.89	
2120.00	ACCOUNTS PAYABLE - UNVOUCHERED	\$26,096.05	
2130.00	DUE TO AHE	\$246,840.82	
2140.00	ACCRUED RENT/WINNING WHEELS	\$12,236.00	
2150.00	ACCRUED WORKMANS COMP	\$18,879.39	
2160.00	ACCRUED UNEMPLOYMENT	\$3,088.00	
2170.00	ACCRUED SALES TAX	\$485.00	
2180.00	ACCRUED ASSESSMENT	<u>\$13,230.00</u>	
	<b>Total ACCOUNTS PAYABLE AND ACCRUALS:</b>	<u>\$552,461.15</u>	

**ACCRUED PAYROLL & WH TAXES**

2250.00	ACCRUED PAYROLL	\$74,268.03	
2260.00	ACCRUED VACATION	\$46,862.75	
2310.00	ACCRUED FICA	<u>\$5,844.21</u>	
	<b>Total ACCRUED PAYROLL &amp; WH TAXES:</b>	<u>\$126,974.99</u>	

**ACCRUED PAYROLL DEDUCTIONS**

2350.00	CREDIT UNION	\$354.00	
2360.00	ADVANCE/TUTOR	\$827.72	
2370.00	GARNISHMENTS	\$223.84	
2371.00	VOLUNTARY LIFE	\$113.26	
2372.00	DENTAL	\$227.84	
2374.00	VISION	\$323.36	
2375.00	INDIVIDUAL INS	<u>\$2,344.31</u>	
2376.00	AFAC	\$322.40	
2377.00	COBRA	\$1,948.72	
2378.00	BLUE CROSS	<u>\$1,847.31</u>	
2390.00	ANNUITY	<u>\$2,322.68</u>	
	<b>Total ACCRUED PAYROLL DEDUCTIONS:</b>	<u>\$12,009.40</u>	

**ADDITIONAL ACCRUALS**

2430.00	ACCRUED REAL ESTATE TAXES	\$43,425.32	
2450.00	ACCRUED INTEREST	\$27,973.26	
2460.00	DUE TO WINNABLE HEALTHPLAN	<u>\$27,000.00</u>	
	<b>Total ADDITIONAL ACCRUALS:</b>	<u>\$134,398.58</u>	

**LONG TERM LIABILITIES**

2510.00	NOTES PAYABLE-WOV	\$219,831.40	
2520.00	NOTES PAYABLE-TNB	\$38,405.02	
2540.00	NOTES PAYABLE - VINCE	\$19,388.00	
2560.00	PUBLIC AID ADVANCE - D.T.	\$2,135.46	
2570.00	DEFERRED TAXES	\$3,000.00	
2640.00	DUE FROM PLEASANT VIEW	<u>\$70,434.16</u>	
2650.00	RESIDENT S.S.	<u>\$72.00</u>	
	<b>Total LONG TERM LIABILITIES:</b>	<u>\$373,266.16</u>	

**Total LIABILITIES:**

\$674,368.93

**RETAINED EARNINGS**

**CAPITAL**

2810.00	COMMON STOCK	\$1,000.00	
2820.00	PAID-IN CAPITAL	<u>\$1,000.00</u>	
	<b>Total CAPITAL:</b>	<u>\$2,000.00</u>	

**RETAINED EARNINGS**

3200.00	Retained Earnings-Current Year	\$122,481.05	
3200.00	RETAINED EARNINGS- PRIOR	<u>\$362,287.53</u>	
	<b>Total RETAINED EARNINGS:</b>	<u>\$239,806.48</u>	

**Total RETAINED EARNINGS:**

\$271,806.48

**Total LIABILITIES & RETAINED EARNINGS:**

\$945,175.41

Facility Name & ID Number **BIG MEADOWS**# **0021394**Report Period Beginning: **1/1/06**

Ending:

**12/31/06****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/06**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 337,950	\$ 85,949	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>473320-53366</u> )	419,954	840,426	3
4	Supply Inventory (priced at <u>COST</u> )	44,226	78,743	4
5	Short-Term Investments			5
6	Prepaid Insurance	7,929	24,000	6
7	Other Prepaid Expenses	5,554	10,287	7
8	Accounts Receivable (owners or related parties)	4,514	4,514	8
9	Other(specify): <u>OTHER RECEIVABLE</u>	37,000	37,000	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 857,127	\$ 1,080,919	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	17,150	30,100	12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	26,468	430,984	15
16	Equipment, at Historical Cost	724,319	975,895	16
17	Accumulated Depreciation (book methods)	(641,888)	(1,019,097)	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): <u>GOODWILL</u>		55,842	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 126,048	\$ 473,724	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 983,175	\$ 1,554,643	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 275,056	\$ 429,819	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	115,149	206,417	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,217	13,470	31
32	Accrued Real Estate Taxes(Sch.IX-B)	43,425	82,083	32
33	Accrued Interest Payable	27,973	29,944	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>DUE FROM PLEASANT VIEW, INC.</u>	(767,434)		36
37	<u>RESIDENT S.S. PAYABLE</u>	375	1,034	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ (296,239)	\$ 762,768	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	563,378	691,384	39
40	Mortgage Payable	197,389	197,389	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>RENTS PAYABLE-OSO PARTNERS</u>		347,821	43
44	<u>DUE TO AHE, INC.</u>	246,841	347,347	44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 1,007,608	\$ 1,583,942	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 711,369	\$ 2,346,709	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 271,806	\$ (792,066)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 983,175	\$ 1,554,643	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>394,287</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>394,287</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(122,481)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (122,481)	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>271,806</b>	<b>24</b> *

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

Facility Name & ID Number **BIG MEADOWS**# **0021394**Report Period Beginning: **1/1/06**Ending: **12/31/06****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	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,126,099	1
2	Discounts and Allowances for all Levels	(6,000)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 3,120,099</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,999	6
7	Oxygen	23,253	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 27,252</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	1,800	11
12	Gift and Coffee Shop	261	12
13	Barber and Beauty Care	2,160	13
14	Non-Patient Meals	6,244	14
15	Telephone, Television and Radio	11,753	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 22,218</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>TRANSPORTATION</b>	1,082	28
28a	<b>GAIN ON SALE</b>	362	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 1,444</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 3,171,013</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	947,679	31
32	Health Care	1,344,843	32
33	General Administration	608,229	33
<b>B. Capital Expense</b>			
34	Ownership	339,088	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	53,655	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 3,293,494</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(122,481)</b>	<b>41</b>
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (122,481)</b>	<b>43</b>

\* 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:

1/1/06

Ending:

12/31/06

**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	2,016	2,236	\$ 63,704	\$ 28.49	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,220	7,791	163,188	20.95	3
4	Licensed Practical Nurses	13,998	14,918	265,694	17.81	4
5	CNAs & Orderlies	53,954	57,644	510,145	8.85	5
6	CNA Trainees	918	918	7,356	8.01	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	845	920	10,430	11.34	8
9	Activity Director	1,852	2,080	38,827	18.67	9
10	Activity Assistants	5,081	5,472	48,868	8.93	10
11	Social Service Workers	3,405	3,805	57,602	15.14	11
12	Dietician					12
13	Food Service Supervisor	1,925	2,135	30,548	14.31	13
14	Head Cook	3,606	3,969	34,791	8.77	14
15	Cook Helpers/Assistants	22,840	24,585	190,535	7.75	15
16	Dishwashers					16
17	Maintenance Workers	5,636	6,180	60,627	9.81	17
18	Housekeepers	11,075	11,994	91,754	7.65	18
19	Laundry	8,708	9,577	75,275	7.86	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	1,531	1,625	20,196	12.43	22
23	Office Manager	1,796	2,044	29,282	14.33	23
24	Clerical	2,977	3,181	27,423	8.62	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	1,410	1,559	16,759	10.75	31
32	Other Health Care(specify)					32
33	Other(specify) <u>TRANSPORTATI</u>	1,976	2,217	20,770	9.37	33
34	TOTAL (lines 1 - 33)	152,769	164,850	\$ 1,763,774 *	\$ 10.70	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	181	\$ 8,160	1,3	35
36	Medical Director	30	3,000	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	36	1,800	10,3	39
40	Physical Therapy Consultant	32	1,593	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) <u>LAB</u>	27	1,068	10,3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	306	\$ 15,621		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	80	\$ 2,117	10,3	50
51	Licensed Practical Nurses	221	3,969	10,3	51
52	Certified Nurse Assistants/Aides	609	13,081	10,3	52
53	TOTAL (lines 50 - 52)	910	\$ 19,167		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 - \$5,139
- (3) Did the nursing home make political contributions or payments to a political action 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 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 12,884 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? \_\_\_\_\_  
If YES, give effective date of lease. NO
- (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 during this cost report period. \$ 53,655  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ NONE Has any meal income been offset against related costs? YES Indicate the amount. \$ 6,244
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
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.