

		FOR BHF USE				

LL1

**2007**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2007)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

**I. IDPH License ID Number:** 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:** John Smith **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 1/1/07 to 12/31/07 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 # ( ) _____
	<b>MAIL TO: BUREAU OF HEALTH FINANCE</b> <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b> <b>201 S. Grand Avenue East</b> <b>Springfield, IL 62763-0001</b>	

**Phone # (217) 782-1630**

Facility Name & ID Number **BIG MEADOWS**

# **0021394** Report Period Beginning: **1/1/07** Ending: **12/31/07**

**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	21,125	6,620		27,745
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	21,125	6,620		27,745

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.56%

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: 12/31/07 Fiscal Year: 12/31/07

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

**Income Statement**  
**For Period Ending 12/31/2007**

**OPERATIONS**

**Big Meds, Inc. (BMD)**

Account	Description	Number		Cost/Revenue
		06	07	
<b>REVENUE</b>				
4400-00	PHYSICIAN FEE	10,282,071.74	10,282,071.74	100.00
4410-00	PHYSICIAN FEE	861,006.74	861,006.74	100.00
4420-00	PHYSICAL THERAPY	84,300.00	84,300.00	100.00
4430-00	OT/PT/ST	377,766.88	377,766.88	100.00
4440-00	MANAGEMENT FEES, P.A.	60,666.67	60,666.67	42.3
4450-00	MANAGEMENT FEES, P.A.	60,666.67	60,666.67	42.3
<b>Total Revenue</b>		<b>\$11,638,483.00</b>	<b>\$11,638,483.00</b>	
<b>OTHER INCOME</b>				
4300-00	TRANSPORTATION	868.88	868.88	100.00
4310-00	DAY TRAINING/REHABILITATION	\$16,641.50	\$16,641.50	22.3
4320-00	CABLE TV	\$11,162.00	\$11,162.00	11.16
4330-00	RENT	\$2,201.47	\$2,201.47	2.20
4340-00	VENDING MACHINES	\$209.38	\$209.38	2.09
4350-00	INTEREST	\$664.33	\$664.33	6.64
4360-00	EMPLOYEES @ OTHER FACILITY	\$16,218.34	\$16,218.34	16.22
4370-00	MISCELLANEOUS	\$2,000.00	\$2,000.00	2.00
<b>Total Other Income</b>		<b>\$45,967.00</b>	<b>\$45,967.00</b>	
<b>Total Revenue</b>		<b>\$11,684,450.00</b>	<b>\$11,684,450.00</b>	
<b>EXPENSES</b>				
<b>CLINICAL SERVICES</b>				
6800-00	NURSING ADMIN.	866,138.00	866,138.00	10.1
6810-00	NURSING	848,437.14	848,437.14	10.1
6820-00	PHYSICIAN	848,143.28	848,143.28	10.1
6830-00	PHYSICAL THERAPY	116,736.28	116,736.28	10.1
6840-00	REHABILITATION THERAPY	866,766.88	866,766.88	11.1
6850-00	SOCIAL SERVICES	866,666.67	866,666.67	12.1
6860-00	SPEECH THERAPY	\$2,000.00	\$2,000.00	2.00
<b>Total Clinical Services</b>		<b>\$4,137,958.25</b>	<b>\$4,137,958.25</b>	
<b>NON-CLINICAL SERVICES</b>				
2300-00	MEDICAL RECORDS	\$14,238.00	\$14,238.00	10.1
2310-00	DIETARY	\$24,232.67	\$24,232.67	1.1
2320-00	HOUSEKEEPING	\$20,200.75	\$20,200.75	3.1
2330-00	LAUNDRY	\$7,000.00	\$7,000.00	4.1
2340-00	MAINTENANCE	\$64,855.00	\$64,855.00	6.1
2350-00	TRANSPORTATION	\$22,666.67	\$22,666.67	14.1
2360-00	ADMINISTRATION	\$60,666.67	\$60,666.67	21.1
<b>Total Non-Clinical Services</b>		<b>\$202,858.76</b>	<b>\$202,858.76</b>	
<b>EXPENSES</b>				
6200-00	FICA	\$158,765.61	\$158,765.61	22.3
6210-00	WORKERS COMP	\$27,889.61	\$27,889.61	22.3
6220-00	UNEMPLOYMENT	\$17,458.88	\$17,458.88	22.3
6230-00	LIFE INSURANCE	\$4,137.33	\$4,137.33	22.3
6240-00	HEALTH INSURANCE	\$16,160.32	\$16,160.32	22.3
6250-00	DISABILITY INSURANCE	\$8,470.00	\$8,470.00	22.3
6260-00	RETIREMENT	\$16,160.38	\$16,160.38	22.3
6270-00	PROFESSORIAL LICENSE FEES	\$20,000.00	\$20,000.00	22.3
6280-00	OTHER	\$20,000.00	\$20,000.00	22.3
<b>Total Expenses</b>		<b>\$452,817.52</b>	<b>\$452,817.52</b>	
<b>CONTRACT CLINICAL SERVICES</b>				
6300-00	PHYSICIAN	\$17,000.00	\$17,000.00	9.3
6310-00	NURSING	\$6,644.44	\$6,644.44	10.3
6320-00	PHYSICAL THERAPY	\$1,675.75	\$1,675.75	10.3
6330-00	PHARMACY	\$1,680.00	\$1,680.00	10.3
6340-00	LAB	\$208.80	\$208.80	10.3
<b>Total Contract Clinical Services</b>		<b>\$27,214.99</b>	<b>\$27,214.99</b>	
<b>CONTRACT NON-CLINICAL SERVICES</b>				
6400-00	DIETARY	\$7,800.00	\$7,800.00	1.3
6410-00	COMMERCIAL SERVICE	\$18,887.28	\$18,887.28	17.3
6420-00	DATA PROCESSING	\$16,311.08	\$16,311.08	19.3
<b>Total Contract Non-Clinical Services</b>		<b>\$42,998.36</b>	<b>\$42,998.36</b>	
<b>EXPENSES</b>				
7800-00	NURSING	\$71,888.26	\$71,888.26	10.2
7810-00	OT/PT/ST	\$16,888.26	\$16,888.26	10.2
7820-00	REHABILITATION THERAPY	\$7,288.11	\$7,288.11	11.2
7830-00	PT & OT	\$2,848.18	\$2,848.18	11.2
7840-00	MEDICAL SUPPLIES	\$2,848.18	\$2,848.18	11.2
7850-00	PHARMACY	\$8,848.18	\$8,848.18	10.2
7860-00	DIETARY	\$12,848.18	\$12,848.18	1.2
7870-00	FOOD	\$20,848.18	\$20,848.18	2.2
7880-00	HOUSEKEEPING	\$28,848.18	\$28,848.18	3.2
7890-00	LAUNDRY	\$17,848.18	\$17,848.18	4.2
7900-00	MAINTENANCE	\$22,848.18	\$22,848.18	6.2
7910-00	TRANSPORTATION	\$5,748.18	\$5,748.18	14.2
7920-00	OTHER	\$19,848.18	\$19,848.18	21.2
7930-00	COMPUTER SUPPLIES	\$2,848.18	\$2,848.18	21.2
<b>Total Expenses</b>		<b>\$413,558.67</b>	<b>\$413,558.67</b>	
<b>EXPENSES</b>				
8400-00	ELECTRIC & GAS	866,718.26	866,718.26	5.3
8410-00	WATER & SEWER	\$16,718.26	\$16,718.26	5.3
8420-00	TRANSPORTATION	\$2,666.67	\$2,666.67	5.3
8430-00	CABLE TV	\$11,162.00	\$11,162.00	5.3
8440-00	INTEREST	\$1,666.67	\$1,666.67	5.3
8450-00	REPAIRS & MAINTENANCE	\$15,288.61	\$15,288.61	6.3
8460-00	RENT	\$28,166.67	\$28,166.67	24.3
8470-00	RENT - VAN	\$6,000.00	\$6,000.00	35.3
8480-00	RENT - RESIDENTIAL	\$22,666.67	\$22,666.67	35.3
<b>Total Expenses</b>		<b>\$1,037,667.11</b>	<b>\$1,037,667.11</b>	
<b>GENERAL &amp; ADMINISTRATIVE</b>				
8600-00	TELEPHONE	\$8,811.00	\$8,811.00	21.3
8610-00	DUPLICATES & SUBSCRIPTIONS	\$7,666.74	\$7,666.74	20.3
8620-00	INSURANCE	\$14,238.00	\$14,238.00	26.3
8630-00	POSTAGE	\$2,200.00	\$2,200.00	21.3
8640-00	MARKETING	\$2,000.00	\$2,000.00	16.3
8650-00	RECREATION	\$3,333.33	\$3,333.33	20.3
8660-00	ADVERTISING	\$16,766.67	\$16,766.67	20.3
8670-00	TRAVEL & MEALS	\$6,666.67	\$6,666.67	24.3
8680-00	TRAVEL EXPENSES NON-BUSINESS	\$4,166.67	\$4,166.67	24.3
8690-00	TRAVEL EXPENSES NON-BUSINESS	\$2,000.00	\$2,000.00	15.3
8700-00	LICENSES & FEES	\$1,278.27	\$1,278.27	20.3
8710-00	SALARY TAX	\$67,666.67	\$67,666.67	27.3
8720-00	BACKGROUND CHECK	\$7,175.00	\$7,175.00	20.3
8730-00	COMBINATION VOUCHERS	\$1,666.67	\$1,666.67	20.3
<b>Total General &amp; Administrative</b>		<b>\$152,167.11</b>	<b>\$152,167.11</b>	
<b>Total Expenses</b>		<b>\$1,584,484.63</b>	<b>\$1,584,484.63</b>	
<b>NET INCOME FROM OPERATIONS</b>				
<b>Total Revenue</b>		<b>\$11,684,450.00</b>	<b>\$11,684,450.00</b>	
<b>OTHER INCOME AND EXPENSES</b>				
9300-00	INTEREST INCOME	\$15,766.67	\$15,766.67	32.3
9310-00	INTEREST INCOME	\$15,766.67	\$15,766.67	32.3
9320-00	INTEREST INCOME	\$15,766.67	\$15,766.67	32.3
9330-00	INTEREST INCOME	\$15,766.67	\$15,766.67	32.3
<b>Total Other Income and Expenses</b>		<b>\$62,306.68</b>	<b>\$62,306.68</b>	
<b>Income Before Income Taxes</b>		<b>\$11,746,756.68</b>	<b>\$11,746,756.68</b>	
<b>Income Tax Expense</b>		<b>\$2,000.00</b>	<b>\$2,000.00</b>	

BIG MEADOWS

Report Period Beginning: 1/1/07 Ending: 12/31/07

Travel and Seminar Analysis

Acct #

9140-00	TRAVEL & SEMINAR		
	Seminars	\$5,431.74	
	Instate travel	\$740.11	
	Other	\$750.83	6,923
9141-00	TRAVEL EXPENSES-NON SEMINAR		
	Travel..to other facility	\$589.76	
	Instate travel	\$2,670.80	
	Local travel to banks	\$843.90	4,104
	Total		11,027
	Per Schedule V line 24		

Facility Name & ID Number **BIG MEADOWS** # **0021394** Report Period Beginning: **1/1/07** Ending: **12/31/07**

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	244,326	12,920	7,550	264,796		264,796		264,796		1
2	Food Purchase		205,597		205,597		205,597	(5,325)	200,272		2
3	Housekeeping	82,260	24,543		106,803		106,803		106,803		3
4	Laundry	70,051	17,050		87,101		87,101		87,101		4
5	Heat and Other Utilities			129,682	129,682		129,682	(10,552)	119,130		5
6	Maintenance	64,855	22,828	15,300	102,983		102,983	440	103,423		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>461,492</b>	<b>282,938</b>	<b>152,532</b>	<b>896,962</b>		<b>896,962</b>	<b>(15,437)</b>	<b>881,525</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			17,000	17,000		17,000		17,000		9
10	Nursing and Medical Records	979,598	97,512	8,643	1,085,753	(12,767)	1,072,986	(3,131)	1,069,855		10
10a	Therapy	11,059		1,673	12,732		12,732		12,732		10a
11	Activities	85,794	7,191		92,985		92,985		92,985		11
12	Social Services	62,929			62,929		62,929		62,929		12
13	CNA Training	12,852	39	5,385	18,276		18,276		18,276		13
14	Program Transportation	23,656	5,715		29,371	(5,715)	23,656		23,656		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>1,175,888</b>	<b>110,457</b>	<b>32,701</b>	<b>1,319,046</b>	<b>(18,482)</b>	<b>1,300,564</b>	<b>(3,131)</b>	<b>1,297,433</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative			158,867	158,867		158,867	38,223	197,090		17
18	Directors Fees										18
19	Professional Services			18,567	18,567		18,567	14,850	33,417		19
20	Dues, Fees, Subscriptions & Promotions			22,550	22,550		22,550	6,270	28,820		20
21	Clerical & General Office Expenses	60,989	20,412	14,118	95,519		95,519	437	95,956		21
22	Employee Benefits & Payroll Taxes			238,523	238,523		238,523	73,868	312,391		22
23	Inservice Training & Education										23
24	Travel and Seminar			11,027	11,027		11,027	(446)	10,581		24
25	Other Admin. Staff Transportation							172	172		25
26	Insurance-Prop.Liab.Malpractice			34,240	34,240		34,240	1,219	35,459		26
27	Other (specify):* <b>SALES TAX</b>			841	841		841	(841)			27
28	<b>TOTAL General Administration</b>	<b>60,989</b>	<b>20,412</b>	<b>498,733</b>	<b>580,134</b>		<b>580,134</b>	<b>133,752</b>	<b>713,886</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,698,369</b>	<b>413,807</b>	<b>683,966</b>	<b>2,796,142</b>	<b>(18,482)</b>	<b>2,777,660</b>	<b>115,184</b>	<b>2,892,844</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: 1/1/07 Ending: 12/31/07

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>D. Ownership</b>										
30	Depreciation			23,639	23,639		23,639	1,788	25,427		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			35,568	35,568		35,568	1,012	36,580		32
33	Real Estate Taxes			53,007	53,007		53,007		53,007		33
34	Rent-Facility & Grounds			224,700	224,700		224,700		224,700		34
35	Rent-Equipment & Vehicles			6,000	6,000	(6,000)					35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			342,914	342,914	(6,000)	336,914	2,800	339,714		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation					11,715	11,715		11,715		38
39	Ancillary Service Centers					12,767	12,767		12,767		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	24,482	78,137		78,137		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,698,369	413,807	1,080,535	3,192,711		3,192,711	117,984	3,310,695		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: **1/1/07**

Ending: **12/31/07**

**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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5,325)	2		4
5	Telephone, TV & Radio in Resident Rooms	(10,552)	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	(841)	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	(500)	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	(8,681)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,506)	20		28
29	Other-Attach Schedule SEE PAGE 5A	(4,087)	VAR		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (31,492)</b>		<b>\$</b>	<b>30</b>

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)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (31,492)</b>		<b>37</b>

\*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.			\$ 11,715	14,35	38
39	P.A. OXYGEN			12,767	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>			<b>\$ 24,482</b>		<b>47</b>

BHF USE ONLY						
48		49		50		51
						52

**BIG MEADOWS**

ID# 0021394  
 Report Period Beginning: 1/1/07  
 Ending: 12/31/07

Sch. V Line  
 Reference

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	FLOWERS	\$ (510)	20	1
2	OUT OF STATE TRAVEL	(446)	24	2
3	EMPLOYEES AT OTHER FACILITIES	(3,131)	10	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>	(4,087)		49

## STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

1/1/07

Ending:

12/31/07

**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	(5,325)	0	0	0	0	0	0	0	0	0	0	(5,325)	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	(10,552)	0	0	0	0	0	0	0	0	0	0	(10,552)	5
6	Maintenance	0	0	440	0	0	0	0	0	0	0	0	440	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(15,877)</b>	<b>0</b>	<b>440</b>	<b>0</b>	<b>(15,437)</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	(3,131)	0	0	0	0	0	0	0	0	0	0	(3,131)	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>(3,131)</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>(3,131)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	38,223	0	0	0	0	0	0	0	0	38,223	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	14,850	0	0	0	0	0	0	0	0	14,850	19
20	Fees, Subscriptions & Promotions	(11,197)	0	17,467	0	0	0	0	0	0	0	0	6,270	20
21	Clerical & General Office Expenses	0	0	437	0	0	0	0	0	0	0	0	437	21
22	Employee Benefits & Payroll Taxes	0	0	73,868	0	0	0	0	0	0	0	0	73,868	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(446)	0	0	0	0	0	0	0	0	0	0	(446)	24
25	Other Admin. Staff Transportation	0	0	172	0	0	0	0	0	0	0	0	172	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,219	0	0	0	0	0	0	0	0	1,219	26
27	Other (specify):*	(841)	0	0	0	0	0	0	0	0	0	0	(841)	27
28	<b>TOTAL General Administration</b>	<b>(12,484)</b>	<b>0</b>	<b>146,236</b>	<b>0</b>	<b>133,752</b>	<b>28</b>							
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(31,492)</b>	<b>0</b>	<b>146,676</b>	<b>0</b>	<b>115,184</b>	<b>29</b>							

STATE OF ILLINOIS

Facility Name & ID Number **BIG MEADOWS**

# **0021394**

Report Period Beginning:

1/1/07

Ending:

Summary B

12/31/07

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	0	1,788	0	0	0	0	0	0	0	0	1,788	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	1,012	0	0	0	0	0	0	0	0	1,012	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	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>0</b>	<b>2,800</b>	<b>0</b>	<b>2,800</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>(31,492)</b>	<b>0</b>	<b>149,476</b>	<b>0</b>	<b>117,984</b>	<b>45</b>							

Facility Name & ID Number BIG MEADOWS

# 0021394

Report Period Beginning:

1/1/07

Ending:

12/31/07

**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%					

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	PROFESSIONAL SERVICES	\$ 158,867	AMERICAN HEALTH ENTERPRISES, INC.	100.00%	\$ 180,106	\$ 21,239	1
2	V	RENT	224,700	WINNING WHEELS, INC. - 100% BUILDING OWNER			(224,700)	2
3	V	INTEREST				114,312	114,312	3
4	V	DEPRECIATION				101,069	101,069	4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 383,567			\$ 395,487	\$ * 11,920	14

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

Facility Name & ID Number **BIG MEADOWS**# **0021394**Report Period Beginning: **1/1/07**Ending: **12/31/07****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	\$ 30,000	AMERICAN HEALTH ENTERPRISES, INC.	100.00%	\$	(30,000)	15
16	V	17 (SEE PAGE 8)		AMERICAN HEALTH ENTERPRISES, INC.	100.00%	68,223	68,223	16
17	V	22		AMERICAN HEALTH ENTERPRISES, INC.	100.00%	73,868	73,868	17
18	V	19		AMERICAN HEALTH ENTERPRISES, INC.	100.00%	14,850	14,850	18
19	V	20		AMERICAN HEALTH ENTERPRISES, INC.	100.00%	17,467	17,467	19
20	V	21		AMERICAN HEALTH ENTERPRISES, INC.	100.00%	437	437	20
21	V	25		AMERICAN HEALTH ENTERPRISES, INC.	100.00%	172	172	21
22	V	26		AMERICAN HEALTH ENTERPRISES, INC.	100.00%	1,219	1,219	22
23	V	30		AMERICAN HEALTH ENTERPRISES, INC.	100.00%	1,788	1,788	23
24	V	32		AMERICAN HEALTH ENTERPRISES, INC.	100.00%	1,012	1,012	24
25	V	6		AMERICAN HEALTH ENTERPRISES, INC.	100.00%	440	440	25
26	V			AMERICAN HEALTH ENTERPRISES, INC.	100.00%	336	336	26
27	V			AMERICAN HEALTH ENTERPRISES, INC.	100.00%	22	22	27
28	V			AMERICAN HEALTH ENTERPRISES, INC.	100.00%	0		28
29	V			AMERICAN HEALTH ENTERPRISES, INC.	100.00%	272	272	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		\$ 30,000			\$ 180,106	\$ * 150,106	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:

1/1/07

Ending:

12/31/07

## 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				MANAGE FEES	158,867	4
5	PLEASANT VIEW			100.00				MANAGE FEES	30,000	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$ 188,867	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: **1/1/07**

Ending: **12/31/07**

**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	1	\$ 68,223	\$ 68,223	1	\$ 68,223	1
2	17	ADMIN.	GROSS REVENUE	12,018,660	5	274,460	3,234,691	73,868	2
3	22	BENEFITS	Payroll	314,319	5	54,473	85,690	14,850	3
4	19	ACCOUNTING	GROSS REVENUE	12,018,660	5	64,901	64,901	17,467	4
5	19	DATA PROCESSING	GROSS REVENUE	12,018,660	5	1,625	3,234,691	437	5
6	20	DUES, FEES	GROSS REVENUE	12,018,660	5	640	3,234,691	172	6
7	21	SUPPLIES, TELEPHONE	GROSS REVENUE	12,018,660	5	4,531	3,234,691	1,219	7
8	20	TRAINING, SEMINARS	GROSS REVENUE	12,018,660	5	6,642	3,234,691	1,788	8
9	25	ADMIN. TRANSPORTATION	GROSS REVENUE	12,018,660	5	3,761	3,234,691	1,012	9
10	26	INSURANCE	GROSS REVENUE	12,018,660	5	1,635	3,234,691	440	10
11	30	DEPRECIATION VEHICLES	GROSS REVENUE	12,018,660	5	1,250	3,234,691	336	11
12	32	INTEREST VEHICLES	GROSS REVENUE	12,018,660	5	81	3,234,691	22	12
13	32	INTEREST WORKING CAPITAL	GROSS REVENUE	12,018,660	5		3,234,691	0	13
14	6	MAINTENANCE	GROSS REVENUE	12,018,660	5	1,011	3,234,691	272	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 483,233	\$ 133,124		\$ 180,106	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	\$	6/30/29	6.9000	\$	1								
2	AMCORE BANK		X	CORPORATE VEHICLES	\$1,003.90	10/2005	32,000		9/09	6.5000		2								
3	WINNING WHEELS, INC.	X			\$5,000.24	3/2005	300,000	172,117	3/2011	6.2000	12,289	3								
4	CORPORATE ALLOCATION	X		WORKING CAPITAL	NONE	6/2000	25,000		7/2010	5.0000		4								
5												5								
<b>Working Capital</b>																				
6	THE NATIONAL BANK		X	WORKING CAPITAL	\$697.58	6/9/04	192,467	37,697	6/9/09	7.0000	1,135	6								
7	THE NATIONAL BANK		X	WORKING CAPITAL	INT. ONLY	4/10/03	175,000	259,473	6/1/07	8.0000	6,352	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	\$ 666,676			\$ 35,568	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	\$ 666,676			\$ 35,568	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.)

Facility Name & ID Number **BIG MEADOWS**

# **0021394** Report Period Beginning: **1/1/07**

Ending: **12/31/07**

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

**B. Real Estate Taxes**

<p><b>Important</b>, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2006 report.		\$ 43,425	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.)		\$ 48,216	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 4,791	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 48,216	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 53,007	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2002	40,171	8
	2003	40,474	9
	2004	43,401	10
	2005	46,021	11
	2006	48,216	12
	<b>FOR BHF USE ONLY</b>		
	13	FROM R. E. TAX STATEMENT FOR 2006 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

**2006 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME BIG MEADOWS COUNTY CARROLL

FACILITY IDPH LICENSE NUMBER 0021394

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

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 2006 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 2006.

(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>48,215.88</u>	\$ <u>48,215.88</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>48,215.88</u>	\$ <u>48,215.88</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        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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

**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:

1/1/07 Ending:

12/31/07

**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).

---

---

---

---

---

---

---

---

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>2001</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

**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	\$ 397,838	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		REPLACEMENT FLOOR TILE		2001	1,182	79	15	79		486	9
10		WHIRLPOOL/SHOWER ROOM		2002	12,150	810	15	810		4,725	10
11		FIREDOORS		2002	9,076	454	20	454		2,496	11
12		REMODEL DINING ROOM		2004	4,060	406	10	406		1,421	12
13		ROOF & CUTTERS		2002	244,631		20	12,232	12,232	56,099	13
14		AIR CONDITIONERS		2003	23,038		10	2,304	2,304	10,367	14
15		GARAGE		2003	32,491		20	1,625	1,625	6,498	15
16		BATHROOM REMODELING		2003	4,885		10	489	489	1,710	16
17		ROOF ADDITION		2003	4,500		20	225	225	900	17
18		PAVING		2003	10,115		10	1,012	1,012	3,540	18
19		SMOKE ALARM SYSTEM		2003	28,321		15	1,888	1,888	6,765	19
20		WIRELESS MONITORING SYSTEM		2004	69,820		15	4,655	4,655	15,904	20
21		DINING ROOM		2005	21,857		15	1,457	1,457	3,036	21
22		PAVE SIDEWALK		2005	7,780		20	389	389	810	22
23		CARPET		2005	19,473		5	3,895	3,895	5,842	23
24		HEATING & AC		2005	13,660		20	683	683	1,252	24
25		DOOR		2006	1,043		20	52	52	52	25
26		BOILER REGISTER		2006	876		20	44	44	44	26
27		FANS		2006	1,386		20	69	69	69	27
28		WALLPAPER		2006	1,209		10	60	60	60	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:

**1/1/07**

Ending:

**12/31/07**

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9					
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation					
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								49				
50								50				
51								51				
52								52				
53								53				
54								54				
55								55				
56								56				
57								57				
58								58				
59								59				
60								60				
61								61				
62								62				
63								63				
64								64				
65								65				
66								66				
67								67				
68								68				
69								69				
70	<b>TOTAL (lines 4 thru 69)</b>	\$	<b>3,170,683</b>	\$	<b>1,749</b>	\$	<b>101,008</b>	\$	<b>99,260</b>	\$	<b>519,915</b>	70

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

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 1/1/07 Ending: 12/31/07

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	\$ 229,766	\$ 21,204	\$ 21,204	\$	VARIOUS	\$ 161,160	71
72	Current Year Purchases	7,717	687	687		VARIOUS	687	72
73	Fully Depreciated Assets	465,348				VARIOUS	465,348	73
74								74
75	TOTALS	\$ 702,830	\$ 21,891	\$ 21,891	\$		\$ 627,195	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	TRANSPORTATION	1997 CHEVY VAN	1997	\$ 29,205	\$	\$	\$	5	\$ 29,205	76
77										77
78										78
79										79
80	TOTALS			\$ 29,205	\$	\$	\$		\$ 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)	\$ 4,041,718	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 23,639	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 122,899	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 99,260	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,176,315	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>12/31/2008</u>	\$ <u>224,700</u>
13.	<u>12/31/2009</u>	\$ <u>224,700</u>
14.	<u>12/31/2010</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. 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 CNA <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 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		39		39
3	Classroom Wages (a)		4,284		4,284
4	Clinical Wages (b)		8,568		8,568
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments	1,077	4,308		5,385
8	CNA Competency Tests				
9	TOTALS	\$ 1,077	\$ 17,199	\$	\$ 18,276
10	SUM OF line 9, col. 1 and 2 (e)	\$ 18,276			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$ NONE

D. NUMBER OF CNAs TRAINED

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

Facility Name & ID Number **BIG MEADOWS**# **0021394**Report Period Beginning: **1/1/07**

Ending:

**12/31/07****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/07**

(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	\$ 468,229	\$ 121,360	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>428444-66176</u> )	362,268	685,793	3
4	Supply Inventory (priced at <u>COST</u> )	36,679	76,184	4
5	Short-Term Investments			5
6	Prepaid Insurance	5,962	10,577	6
7	Other Prepaid Expenses	1,990	3,483	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>OTHER RECEIVABLE</u>	40,393	40,393	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 915,520	\$ 937,789	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	433,958	15
16	Equipment, at Historical Cost	732,035	988,705	16
17	Accumulated Depreciation (book methods)	(665,528)	(1,088,809)	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>		44,526	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 110,125	\$ 408,480	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,025,645	\$ 1,346,269	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 283,614	\$ 443,564	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	112,539	214,296	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,764	15,779	31
32	Accrued Real Estate Taxes(Sch.IX-B)	48,216	86,058	32
33	Accrued Interest Payable	27,728	28,456	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>	(822,359)	0	36
37	<u>RESIDENT S.S. PAYABLE</u>	175	1,943	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ (339,323)	\$ 790,096	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	474,430	558,228	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>		309,048	43
44	<u>DUE TO AHE, INC.</u>	325,708	401,215	44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 997,527	\$ 1,465,880	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 658,204	\$ 2,255,976	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 367,441	\$ (909,707)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,025,645	\$ 1,346,269	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>271,806</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>271,806</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>95,635</b>	<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>	\$ <b>95,635</b>	<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>367,441</b>	<b>24</b> *

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

Facility Name & ID Number **BIG MEADOWS**# **0021394**Report Period Beginning: **1/1/07**Ending: **12/31/07****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	\$ 3,207,539	1
2	Discounts and Allowances for all Levels	(6,000)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,201,539	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	6,120	6
7	Oxygen	27,799	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 33,919	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	15,444	11
12	Gift and Coffee Shop	310	12
13	Barber and Beauty Care	620	13
14	Non-Patient Meals	5,325	14
15	Telephone, Television and Radio	11,145	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>	\$ 32,844	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	57	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 57	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>TRANSPORTATION</b>	669	28
28a	<b>EMPLOYEES AT OTHER FACILITIES</b>	19,318	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 19,987	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,288,346	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	896,962	31
32	Health Care	1,319,046	32
33	General Administration	580,134	33
<b>B. Capital Expense</b>			
34	Ownership	342,914	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>	\$ 3,192,711	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	95,635	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 95,635	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:

1/1/07

Ending:

12/31/07

**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	1,732	2,050	\$ 60,130	\$ 29.33	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,657	9,285	198,203	21.35	3
4	Licensed Practical Nurses	13,884	14,892	265,234	17.81	4
5	CNAs & Orderlies	45,711	48,682	441,290	9.06	5
6	CNA Trainees	1,577	1,577	12,852	8.15	6
7	Licensed Therapist	9	9	333	37.00	7
8	Rehab/Therapy Aides	845	916	10,726	11.71	8
9	Activity Director	1,804	2,080	40,200	19.33	9
10	Activity Assistants	4,421	4,820	45,594	9.46	10
11	Social Service Workers	3,662	4,078	62,929	15.43	11
12	Dietician					12
13	Food Service Supervisor	1,521	1,723	25,375	14.73	13
14	Head Cook	1,995	2,216	20,298	9.16	14
15	Cook Helpers/Assistants	23,060	24,578	198,653	8.08	15
16	Dishwashers					16
17	Maintenance Workers	5,920	6,415	64,856	10.11	17
18	Housekeepers	9,354	10,131	82,260	8.12	18
19	Laundry	7,635	8,440	70,051	8.30	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,850	2,058	30,576	14.86	23
24	Clerical	3,067	3,225	30,413	9.43	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	1,193	1,302	14,740	11.32	31
32	Other Health Care(specify)					32
33	Other(specify) <u>TRANSPORTATI</u>	2,055	2,242	23,656	10.55	33
34	TOTAL (lines 1 - 33)	139,952	150,719	\$ 1,698,369 *	\$ 11.27	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	151	\$ 7,550	1,3	35
36	Medical Director		17,000	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		1,674	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>		199	10,3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	187	\$ 28,223		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				51
52	Certified Nurse Assistants/Aides	333	6,644	10,3	52
53	TOTAL (lines 50 - 52)	333	\$ 6,644		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. \$ 12,863 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 during this cost report period. \$ \_\_\_\_\_  
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. \$ \_\_\_\_\_
- (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 \$5,000, 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.

CARROLL COUNTY  
 DIANE POWERS  
 COUNTY COLLECTOR BOX 198  
 MT CARROLL, IL 61053-0198

**JUN 18 REC'D**

PROPERTY NUMBER	CLASS	CODE	NUMBER	TAX
08-07-03-400-003	0050	08003	392	NOTICE
77 SAV L73 S3 T24 R3 PT 660' X 880' SE. & .28 AC ADJ N SIDE B77 P347				
08-000-073-00				
LAND/LOT ASSESSED	FARM LAND ASSESSED	FARM BLDG ASSESSED	BUILDING ASSESSED	TOTAL ASSESSED
46923			451305	498228
LAND/LOT B.O.R. MULT.	FARM LAND B.O.R. MULT.	FARM BLDG. B.O.R. MULT.	BUILDING B.O.R. MULT.	DEPARTMENT MULTIFLIER
				1.00000
IMPROVEMENT EXEMPTION	DEPARTMENT EQUALIZER	OWNER OCCUPIED	HOMESTEAD VET/AN	TAXABLE VALUE
	498228			498228
SCAFHE	1ST INSTALLMENT		2ND INSTALLMENT	
	07/20/2007	<b>DUE DATE</b>	09/06/2007	
	24,107.94	INSTALLMENT	24,107.94	
		PENALTY/COST		
		<b>TOTAL</b>		

TOWNSHIP	LENDING CODE	LAND/LOT ACRES	FARM LAND ACRES	FORFEITED TAX
SAVANNA TOWNSHIP		13.33		

WINNING WHEELS INC  
 %GAPINSKI AL  
 701 E THIRD ST  
 PROPHETSTOWN IL 61277-0000

PROPERTY OWNER IF OTHER THAN ABOVE  
 WINNING WHEELS INC  
 GAPINSKI AL  
 1000 LONGMOOR  
 SAVANNA IL 61074-0000

YOU MAY PAY AT ANY CARROLL COUNTY BANK  
 1-1/2% PENALTY PER MONTH AFTER DUE DATE

TOTAL TAX: 48,215.88

PROPERTY NUMBER	CLASS	NUMBER	TOWNSHIP			
08-07-03-400-003	0050	392	SAVANNA TOWNSHIP			
2005 RATE	2005 TAX	TAXING DISTRICT	2006 RATE	PERCENT	2006 TAX	PENSION
.75200	3,369.76	COUNTY TAX	.89700	7.2	3,472.84	690.05
.35210	1,754.26	TOWNSHIP TAX	.34212	3.5	1,704.54	7.17
.83500	3,741.70	SAVANNA BOND U300	.69540	7.2	3,464.68	
.46640	2,323.74	HIGHLAND JC 519	.46676	4.8	2,325.62	43.89
.69390	3,109.42	SAVANNA PK DIST	.70736	7.3	3,524.26	299.59
.24420	1,094.28	SAVANNA LIB. DIST.	.25006	2.6	1,245.86	173.19
1.76170	7,894.30	SAVANNA CORP	1.81622	18.8	9,048.92	3,531.74
.04900	244.14	TRI-TWP MUN AIRPRT	.04985	.5	248.36	
4.43950	19,893.72	WEST CARROLL US14	4.65271	48.1	23,181.10	2,423.18
9.59380	43,425.32	<b>TOTAL TAX</b>	9.67748	100.0	48,215.88	

YOU MAY BE ELIGIBLE FOR THE SENIOR CITIZENS EXEMPTION AND/OR DISABLED PERSONS PROPERTY TAX RELIEF AND/OR PHARMACEUTICAL ASSISTANCE. APPLICATIONS ARE AVAILABLE FROM THE ILLINOIS DEPARTMENT OF REVENUE. FOR QUESTIONS, CALL: 1-800-824-2459. FOR FORMS, CALL: 1-800-356-6302.

BANK	CHECK	MONEY ORDER	DRAFT	CASH	MAIL
<input type="checkbox"/>					
<b>PROPERTY NUMBER</b>	<b>CODE</b>	<b>NUMBER</b>			
08-07-03-400-003	08003	392			

**RETURN STUB WITH PAYMENT**

<b>1</b>	1ST INSTALLMENT	
	<b>DUE DATE</b>	07/20/2007
	INSTALLMENT	24,107.94
	<b>TOTAL</b>	



08.00392.2006

BANK	CHECK	MONEY ORDER	DRAFT	CASH	MAIL
<input type="checkbox"/>					
<b>PROPERTY NUMBER</b>	<b>CODE</b>	<b>NUMBER</b>			
08-07-03-400-003	08003	392			

**RETURN STUB WITH PAYMENT**

<b>2</b>	2ND INSTALLMENT	
	<b>DUE DATE</b>	09/06/2007
	INSTALLMENT	24,107.94
	<b>TOTAL</b>	



08.00392.2006

TOTAL TAX: 48,215.88