

Facility Name & ID Number BIG MEADOWS# 0021394 Report Period Beginning: 1/1/2008 Ending: 12/31/2008

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		Intermediate (ICF)			3
4	<u>98</u>	Intermediate/DD	<u>98</u>	<u>35,770</u>	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>98</u>	TOTALS	<u>98</u>	<u>35,770</u>	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	<u>16,514</u>	<u>6,753</u>		<u>23,267</u>
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	<u>16,514</u>	<u>6,753</u>		<u>23,267</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.05%

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)

NONEF. 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 11/11/1976

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: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number **BIG MEADOWS** # **0021394** Report Period Beginning: **1/1/2008** Ending: **12/31/2008**

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	211,302	13,715	7,065	232,082		232,082		232,082		1
2	Food Purchase		172,388		172,388		172,388	(6,909)	165,479		2
3	Housekeeping	79,151	21,134		100,285		100,285		100,285		3
4	Laundry	69,755	15,068		84,823		84,823		84,823		4
5	Heat and Other Utilities			109,714	109,714		109,714	(11,349)	98,365		5
6	Maintenance	66,816	28,414	24,977	120,207		120,207		120,207		6
7	Other (specify):*										7
8	TOTAL General Services	427,024	250,719	141,756	819,499		819,499	(18,258)	801,241		8
	B. Health Care and Programs										
9	Medical Director			24,000	24,000		24,000		24,000		9
10	Nursing and Medical Records	988,274	79,411	3,007	1,070,692	(10,567)	1,060,125		1,060,125		10
10a	Therapy	23,937		1,609	25,546		25,546		25,546		10a
11	Activities	60,839	9,248		70,087		70,087		70,087		11
12	Social Services	50,803			50,803		50,803		50,803		12
13	CNA Training	13,746		6,740	20,486		20,486		20,486		13
14	Program Transportation	28,919	5,452		34,371	(5,452)	28,919		28,919		14
15	Other (specify):* OTHER FACILITIES			74,213	74,213		74,213	(74,213)			15
16	TOTAL Health Care and Programs	1,166,518	94,111	109,569	1,370,198	(16,019)	1,354,179	(74,213)	1,279,966		16
	C. General Administration										
17	Administrative	35,387		91,148	126,535		126,535	(3,374)	123,161		17
18	Directors Fees										18
19	Professional Services			18,138	18,138		18,138	1,219	19,357		19
20	Dues, Fees, Subscriptions & Promotions			24,884	24,884		24,884	(9,422)	15,462		20
21	Clerical & General Office Expenses	60,769	22,767	13,523	97,059		97,059	788	97,847		21
22	Employee Benefits & Payroll Taxes			248,511	248,511		248,511	(8,880)	239,631		22
23	Inservice Training & Education			815	815		815		815		23
24	Travel and Seminar			8,183	8,183		8,183	96	8,279		24
25	Other Admin. Staff Transportation							615	615		25
26	Insurance-Prop.Liab.Malpractice			31,520	31,520		31,520		31,520		26
27	Other (specify):* SEE SCHEDULE			34,346	34,346		34,346	(34,346)			27
28	TOTAL General Administration	96,156	22,767	471,068	589,991		589,991	(53,304)	536,687		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,689,698	367,597	722,393	2,779,688	(16,019)	2,763,669	(145,775)	2,617,894		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Big Meadows, Inc. -- 0021394
Report Period Beginning -- 1/1/08
Report Period Ending -- 12/31/08
DETAIL SCHEDULE V -- LINE 27

Sales Tax	846
Fines Paid to State of Illinois	<u>33500</u>
Total Line 27	<u><u>34346</u></u>

Big Meadows, Inc. – 0021394
Report Period Beginning – 1/1/08
Report Period Ending – 12/31/08
DETAIL SCHEDULE V-LINE 24

1		
Names & Titles	Linda Johnson, RN Director of Nursing	
Dates of Seminar	05/6/2008 & 05/7/2008	
Location	Springfield, IL	
Title	Resource for Success	
Sponsor	IHCA	
Cost		\$200.00
2		
Name & Title	Diane Giddings	
Dates of Seminar	2/19/2008	
Location	Chicago, IL	
Title	Healing Touch Seminar	
Sponsor	Life works AHNA	
Cost		\$613.00
3		
Names & Titles	JoEllen McCaskey, Director of Therapeutic Recreation	
Dates of Seminar	03/05/08 - 03/08/08	
Location	Springfield, IL	
Title of Seminar	Review course for Nursing Home Administrators	
Sponsor	IHCA	
Cost		\$681.00
4		
Names & Titles	Hali Bower, Transportation	
Date of Seminar	05/06/08 - 05/07/08	
Location	Glen Ellyn, IL	
Title	First Step Trainer Program	
Sponsor	First Transit	
Cost		\$250.00
5		
Name & Title	Kelly Foley	
Date Travel	8/4/2008	
Location	Springfield, IL	
Title of Seminar	Medical Records seminar	
Sponsor	IHCA	
Total Cost		\$100.00
7		
Names & Titles	Jim Harkness, Intern Administrator Linda Johnson, RD Phylliss Jonkman, DON JoEllen McCaskey, Director TR Lisa Mussman, Dietary Manager Gary Stevens, Maintenance	
Date of Seminar	9/17/08-9/20/08	
Location	Pecoria, IL	
Title	IHCA Annual Conference	
Sponsor	IHCA	
Cost		\$2,879.00
<hr/>		
Total Travel & Semir		\$4,723.00
Less: Out of State		0.00
Total		\$4,723.00
Employee Mileage Re		\$3,460.00
Total - Line 24, Schedu		\$8,183.00

Big Meadows, Inc. – 0021394
Report Period Beginning – 1/1/08
Report Period Ending – 12/31/08

RECLASSIFICATIONS, Pages 3 & 4

	<u>Dr.</u>	<u>Cr.</u>	<u>Line #</u>
TRANSPORTATION: Medically Necessary Transportation	11,452		38
Program Transportation		5,452	14
Rent-Equipment and Vehicles		6,000	35
PUBLIC AID OXYGEN Ancillary Service Centers	10,567		39
Nursing & Medical Records		10,567	10

	Operating Expenses	Costs Per General Ledger		
		Salary/Wage 1	Supplies 2	Other 3
	A. General Services			
1	Dietary	211,302	13,715	7,065
2	Food Purchase		172,388	
3	Housekeeping	79,151	21,134	
4	Laundry	69,755	15,068	
5	Heat and Other Utilities			109,714
6	Maintenance	66,816	28,414	24,977
7	Other (specify):*			
8	TOTAL General Services	427,024	250,719	141,756
	B. Health Care and Programs			
9	Medical Director			24,000
10	Nursing and Medical Records	1,002,020	79,411	3,007
10a	Therapy	23,937		1,609
11	Activities	60,839	9,248	
12	Social Services	50,803		
13	CNA Training			6,740
14	Program Transportation	28,919	5,452	
15	Other (specify):*			
16	TOTAL Health Care and Programs	1,166,518	94,111	35,356
	C. General Administration			
17	Administrative	35,387		91,148
18	Directors Fees			
19	Professional Services			18,138
20	Dues, Fees, Subscriptions & Promotions			24,884
21	Clerical & General Office Expenses	60,769	22,767	13,523
22	Employee Benefits & Payroll Taxes			248,511
23	Inservice Training & Education			815
24	Travel and Seminar			8,183
25	Other Admin. Staff Transportation			
26	Insurance-Prop.Liab.Malpractice			31,520
27	Other (specify):*			34,346
28	TOTAL General Administration	96,156	22,767	471,068
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,689,698	367,597	648,180

	Capital Expense	Cost Per General Ledger		
		Salary/Wage 1	Supplies 2	Other 3
	D. Ownership			
30	Depreciation			21,543
31	Amortization of Pre-Op. & Org.			
32	Interest			30,919
33	Real Estate Taxes			58,032
34	Rent-Facility & Grounds			224,700
35	Rent-Equipment & Vehicles			6,000
36	Other (specify):*			
37	TOTAL Ownership			341,194
	Ancillary Expense			
	E. Special Cost Centers			
38	Medically Necessary Transportation			
39	Ancillary Service Centers			
40	Barber and Beauty Shops			
41	Coffee and Gift Shops			
42	Provider Participation Fee			53,802
43	Other (specify):*			
44	TOTAL Special Cost Centers	0	0	53,802
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	0	0	0

Income Statement

For The 12 Months Ended 12/31/2008
 OPERATIONS
 Big Meadows, Inc. (BID)

	Var. to	Cost Report
REVENUE		
4030-00 PUBLIC AID	1,060,079	
4040-00 PHYSIC THERAPY	1,002,236	
4060-00 SUPPLIES	26,267	
4070-00 PHYSICAL THERAPY	126,150	
4100-00 OXYGEN	20,315	
4120-00 ASSESSMENT FEES - P.A.	5,860	42.3
4150-00 BAD DEBTS	6,000	
Total REVENUE:	3,180,807	
OTHER INCOME		
4360-00 TRANSPORTATION	971	
4360-00 CNA TRAINING REIMBURSEMENT	6,008	
4360-00 CHARITY	8,286	
4360-00 MEALS	6,909	
4320-00 TONGING MACHINES	282	
4360-00 INTEREST	567	
4370-00 EMPLOYEES AT OTHER FACILITIES	97,182	
4380-00 MISCELLANEOUS	5,787	
Total OTHER INCOME:	125,572	
Total REVENUE:	3,306,379	
Gross Profit:		
EXPENSES		
CLINICAL SALARIES		
5050-00 NURSING ADMIN	55,804	10.1
5060-00 NURSES	471,114	10.1
5070-00 AIDES	451,236	10.1
5100-00 PHYSICAL THERAPY	23,037	10.1
5120-00 RECREATIONAL THERAPY	40,839	11.1
5140-00 SOCIAL SERVICES	50,803	12.1
5170-00 SPEECH THERAPY	90	
Total CLINICAL SALARIES:	1,123,071	
NON-CLINICAL SALARIES		
5160-00 MEDICAL RECORDS	16,976	10.1
5180-00 DIETARY	21,342	1.1
5190-00 HOUSEKEEPING	70,153	3.1
5200-00 LAUNDRY	49,785	4.1
5220-00 MAINTENANCE	46,816	4.1
5440-00 TRANSPORTATION	28,919	14.1
5460-00 ADMINISTRATION	49,739	21.1
5470-00 ADMINISTRATION	7,211	
Total NON-CLINICAL SALARIES:	328,726	
BENEFITS		
6020-00 FICA	113,143	22.3
6400-00 WORKMENS COMP	40,290	22.3
6600-00 MEDICAL INSURANCE	16,366	22.3
6660-00 LIFE INSURANCE	769	22.3
6670-00 LIFE INSURANCE	4,874	22.3
6680-00 HEALTH INSURANCE	10,028	22.3
6690-00 DENTAL INSURANCE	2,888	22.3
6690-00 RETIREMENT	10,234	22.3
6700-00 PFTV	130	22.3
6730-00 UNIFORMS	1,230	22.3
6750-00 PROFESSIONAL LICENSE FEES	1,419	22.3
6760-00 OTHER	6,039	22.3
Total BENEFITS:	203,571	
CONTRACT CLINICAL SERVICES		
6800-00 PHYSICIAN	24,000	9.3
6860-00 NURSES	1,287	10.3
6300-00 PHYSICAL THERAPY	1,489	10.3
6300-00 PHARMACY	1,800	10.3
Total CONTRACT CLINICAL SERVICES:	28,576	
CONTRACT NON-CLINICAL SERVICES		
6800-00 DIETARY	7,665	1.3
6400-00 ADMINISTRATIVE	91,148	17.3
6470-00 DATA PROCESSING	15,274	10.3
Total CONTRACT NON-CLINICAL SERVICES:	113,087	
SUPPLIES		
7000-00 NURSING	41,324	10.2
7070-00 OXYGEN	11,452	10.2
7120-00 RECREATION THERAPY	9,248	11.2
7200-00 PHARMACY	6,515	10.2
7300-00 DIETARY	13,715	1.2
7360-00 FOOD	172,388	2.2
7380-00 HOUSEKEEPING	21,124	3.2
7390-00 LAUNDRY	15,668	4.2
7420-00 MAINTENANCE	26,411	4.2
7460-00 TRANSPORTATION	5,422	14.2
7460-00 OFFICE	20,711	21.2
7520-00 COMPUTER SUPPLIES	2,056	21.2
Total SUPPLIES:	397,377	
FACILITIES		
8000-00 ELECTRIC & GAS	77,445	5.3
8010-00 WATER & SEWER	12,888	5.3
8040-00 TRASH REMOVAL	6,348	5.3
8050-00 CABLE TV	11,769	5.3
8090-00 INTERNET	1,224	5.3
8100-00 REPAIR & MAINTENANCE	26,797	6.3
8120-00 RENT	224,700	34.3
8170-00 RENT VAX	6,800	36.3
8190-00 REAL ESTATE TAXES	9,023	33.3
Total FACILITIES:	423,427	
GENERAL & ADMINISTRATIVE		
9010-00 TELEPHONE	8,779	21.3
9020-00 NEWS SUBSCRIPTIONS	6,680	20.3
9040-00 INSURANCE	15,520	20.3
9050-00 POSTAGE	4,744	21.3
9100-00 LEGAL & ACCOUNTING	2,864	10.3
9100-00 MARKETING	624	20.3
9120-00 RECRUITMENT	5,276	20.3
9130-00 ADVERTISING	9,478	20.3
9140-00 TRAVEL & SEMINAR	4,723	24.3
9140-00 TRAVEL EXPENSES-NON SEMINAR	1,460	24.3
9150-00 TRAINING	815	21.3
9160-00 MISCELLANEOUS TRAINING	1,400	12.3
9160-00 LICENSE & TAXES	1,823	20.3
9170-00 SALES TAX	896	22.3
9175-00 BACKGROUND CHECK	1,010	20.3
9180-00 OTHER	3,509	22.3
9190-00 COMMUNITY RELATIONS	2,025	20.3
Total GENERAL & ADMINISTRATIVE:	122,477	
Total EXPENSES:	2,096,019	
NET INCOME FROM OPERATIONS:	1,210,360	
OTHER INCOME AND EXPENSE		
0100-00 INTEREST INCOME	15,792	32.3
0110-00 INTEREST W/	8,266	32.3
0460-00 INTEREST FOR	8,862	32.3
0490-00 DEPRECIATION	21,541	30.3
Total OTHER INCOME AND EXPENSE:	53,461	
EARNINGS BEFORE INCOME TAXES:	1,263,821	
Net Income (Loss):	1,263,821	

Facility Name & ID Number **BIG MEADOWS** #0021394 Report Period Beginning: 1/1/2008 Ending: 12/31/2008

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
	D. Ownership										
30	Depreciation			21,543	21,543		21,543	100,209	121,752		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			30,919	30,919		30,919	113,053	143,972		32
33	Real Estate Taxes			58,032	58,032		58,032		58,032		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	TOTAL Ownership			341,194	341,194	(6,000)	335,194	(11,438)	323,756		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation					11,452	11,452		11,452		38
39	Ancillary Service Centers					10,567	10,567		10,567		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			53,802	53,802		53,802		53,802		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers			53,802	53,802	22,019	75,821		75,821		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,689,698	367,597	1,117,389	3,174,684		3,174,684	(157,213)	3,017,471		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: **1/1/2008**

Ending: **12/31/2008**

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	(6,909)	2		4
5	Telephone, TV & Radio in Resident Rooms	(11,349)	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	(367)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(846)	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	(33,500)	27		18
19	Entertainment				19
20	Contributions	(618)	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	(8,719)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(757)	20		28
29	Other-Attach Schedule SEE PAGE 5A	(86,752)	MULT		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (149,817)		\$	30

BHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	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)	(7,396)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (7,396)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (157,213)		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.			\$ 11,452	14,35	38
39	P.A. OXYGEN			10,567	10	39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 22,019		47

BIG MEADOWS

ID# 0021394
 Report Period Beginning: 1/1/2008
 Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	FLOWERS	\$ (1,407)	20	1
2	EMPLOYEES AT OTHER FACILITES	(74,213)	15	2
3	Benefits for Employees at Other Facilities	(11,132)	22	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
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36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(86,752)		49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(6,909)	0	0	0	0	0	0	0	0	0	0	(6,909)	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	(11,349)	0	0	0	0	0	0	0	0	0	0	(11,349)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(18,258)	0	0	0	0	0	0	0	0	0	0	(18,258)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	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):*	(74,213)	0	0	0	0	0	0	0	0	0	0	(74,213)	15
16	TOTAL Health Care and Programs	(74,213)	0	0	0	0	0	0	0	0	0	0	(74,213)	16
	C. General Administration													
17	Administrative	0	(3,374)	0	0	0	0	0	0	0	0	0	(3,374)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,219	0	0	0	0	0	0	0	0	0	1,219	19
20	Fees, Subscriptions & Promotions	(11,501)	2,079	0	0	0	0	0	0	0	0	0	(9,422)	20
21	Clerical & General Office Expenses	0	788	0	0	0	0	0	0	0	0	0	788	21
22	Employee Benefits & Payroll Taxes	(11,132)	2,252	0	0	0	0	0	0	0	0	0	(8,880)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	96	0	0	0	0	0	0	0	0	0	96	24
25	Other Admin. Staff Transportation	0	615	0	0	0	0	0	0	0	0	0	615	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(34,346)	0	0	0	0	0	0	0	0	0	0	(34,346)	27
28	TOTAL General Administration	(56,979)	3,675	0	(53,304)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(149,450)	3,675	0	(145,775)	29								

STATE OF ILLINOIS

Facility Name & ID Number **BIG MEADOWS**

0021394 Report Period Beginning:

1/1/2008 Ending:

Summary B

12/31/2008

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	100,209	0	0	0	0	0	0	0	0	0	100,209	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(367)	113,420	0	0	0	0	0	0	0	0	0	113,053	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	TOTAL Ownership	(367)	(11,071)	0	(11,438)	37								
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(149,817)	(7,396)	0	(157,213)	45								

Facility Name & ID Number BIG MEADOWS

0021394

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

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 (not associated after @10/01/08)	MORRISON			
ALAN GAPINSKI	100					
	0	WINNING WHEELS (Building Owner)	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	17 PROFESSIONAL SERVICES	\$ 91,148	AMERICAN HEALTH ENTERPRISES INC	100.00%	\$ 96,073	\$	4,925 1
2	V	34 RENT	224,700	WINNING WHEELS - 100% BUILDING OWNER				(224,700) 2
3	V	32		WINNING WHEELS - 100% BUILDING OWNER		112,170		112,170 3
4	V	30		WINNING WHEELS - 100% BUILDING OWNER		100,209		100,209 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		\$ 315,848			\$ 308,452	\$ *	(7,396) 14

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

Facility Name & ID Number **BIG MEADOWS**

0021394

Report Period Beginning: **1/1/2008**

Ending: **12/31/2008**

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	\$	American Health Enterprises, Inc.	100.00%	\$	\$	15
16	V	17			See page 8				16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

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

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 1/1/2008 Ending: 12/31/2008

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	Alan Gapinski	President	Admin.	100.00	0	4	8.00	0	\$ 0	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number BIG MEADOWS

0021394 Report Period Beginning: 1/1/2008

Ending: 2/31/2008

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization American Health Enterprises, Inc.
 Street Address 501 6th Ave. W.
 City / State / Zip Code Lyndon, IL 61261
 Phone Number (815-778-3683
 Fax Number (815-778-4503

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

1	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	Administration	Direct	1	\$ 13,492	\$ 13,492	1	\$ 13,492	1
2	17	Administration	Gross Revenue	5	311,858		2,971,268	74,282	2
3	22	Benefits	Payroll	5	32,527		13,492	2,252	3
4	19	Accounting	Gross Revenues	5	2,590		2,971,268	617	4
5	19	Data Processing	Gross Revenues	5	2,529		2,971,268	602	5
6	20	Dues and Fees	Gross Revenues	5	832		2,971,268	198	6
7	21	Supplies, Telephone	Gross Revenues	5	3,308		2,971,268	788	7
8	20	Training Seminars	Gross Revenues	5	401		2,971,268	96	8
9	25	Admin. Transportation	Gross Revenues	5	2,582		2,971,268	615	9
10	32	Interest	Direct	2	2,500		1	1,250	10
11	20	Recruitment	Gross Revenues	5	7,899		2,971,268	1,881	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 380,518	\$ 13,492		\$ 96,073	25

Facility Name & ID Number

BIG MEADOWS

0021394

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
		A. Directly Facility Related										
Long-Term												
1	AMCORE BANK		X	BUILDING MORTGAGE	\$12,227.35	6/30/04	\$ 1,730,000	\$ 1,594,688	6/30/29	6.9000	\$ 112,170	1
2												2
3	WINNING WHEELS, INC.	X			\$5,000.24	3/2005	300,000	121,360	3/2011	6.2000	9,245	3
4	CORPORATE ALLOCATION	X		WORKING CAPITAL	NONE	6/2000	25,000	25,000	7/2010	5.0000	1,250	4
5												5
Working Capital												
6	THE NATIONAL BANK		X	Equipment Loan	\$697.58	6/9/04	192,467	22,475	6/9/09	7.0000	3,264	6
7	THE NATIONAL BANK		X	WORKING CAPITAL	INT. ONLY	4/10/03	175,000	224,080	6/1/07	8.0000	2,618	7
8	VINCE ARIOSO		X	WORKING CAPITAL	NONE	6/2000	197,389	197,389	DEMAND	9.0000	15,792	8
9	TOTAL Facility Related				\$17,925.17		\$ 2,619,856	\$ 2,184,992			\$ 144,339	9
B. Non-Facility Related*												
10												10
11												11
12	Interest Income Offset										(367)	12
13												13
14	TOTAL Non-Facility Related						\$	\$			(367)	14
15	TOTALS (line 9+line14)						\$ 2,619,856	\$ 2,184,992			\$ 143,972	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.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2007 report.		\$	48,216	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.)		\$	56,248	2
3. Under or (over) accrual (line 2 minus line 1).		\$	8,032	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	50,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	58,032	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	40,474	8
	2004	43,401	9
	2005	46,021	10
	2006	48,216	11
	2007	56,248	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2007	\$	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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BIG MEADOWS COUNTY CARROLL

FACILITY IDPH LICENSE NUMBER 0021394

CONTACT PERSON REGARDING THIS REPORT Al Gapinski

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 2007 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 2007.

(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>56,247.68</u>	\$ <u>56,247.68</u>
2. _____	<u>PT 660'X880' SE& 28AC ADJ</u>	\$ _____	\$ _____
3. _____	<u>N SIDE B77 P347 08-000-073-00</u>	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>56,247.68</u>	\$ <u>56,247.68</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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.

CARROLL COUNTY
 DIANE L. POWERS, COUNTY TREASURER
 P.O. BOX 198
 MOUNT CARROLL, IL 61053-0198

2007 REAL ESTATE TAX BILL

PLEASE READ the instructions on the back of this bill regarding when and where to pay your taxes. Additional information is provided for changing your mailing address and tax exemptions in which you might be entitled.

The County Treasurer only collects your taxes and is not responsible for the amount of your assessment or the amount of your tax bill. We will be happy to assist you or direct you to the proper authority regarding questions about your tax bill.

THIS IS THE ONLY NOTICE YOU WILL RECEIVE FOR BOTH INSTALLMENTS.

ASSESSED TO: WINNING WHEELS INC

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


RECEIPT PORTION - KEEP FOR YOUR RECORDS
 2007 CARROLL COUNTY REAL ESTATE TAX
 PAY TO: CARROLL COUNTY TREASURER

FORMULA FOR TAX CALCULATION - 2007	
TIP BASE	0
LAND	48,329
STRUCTURES/BLDGS	528,004
FARM BLDG.	0
FARM LAJD	0
50 OF REVIEW EQUALIZED VALUE	576,333
HOME IMPROVEMENT EXEMPTION	0
DISABLED VETERANS' EXEMPTION	0
VALUE PRIOR TO STATE EQUALIZE	576,333
STATE EQUALIZATION FACTOR***	1.0000
STATE EQUALIZED VALUE	576,333
OWNER OCCUPIED EXEMPTION	0
SENIOR HOMESTEAD EXEMPTION	0
SENIOR ASSESSMENT FREEZE	0
DISABLED PERSONS' EXEMPTION	0
RETURNING VETERANS' EXEMPTION	0
DISABLED VETERANS' EXEMPTION	0
MISC. EXEMPTION	0
TAXABLE VALUE	576,333
TAX RATE	9.75956
TOTAL TAX	\$56,247.68

***NOT TO BE USED FOR FARM LAND AND FARM BUILDINGS	
INTEREST 1% PER MONTH	TOTAL TAX DUE
0	\$56,247.68
T877 EQUALIZED VALUE	FAIR MARKET VALUE
0	1,728,999

PROPERTY DESCRIPTION		PARCEL NUMBER				
77 SAV L73 S3 T24 R3 PT 660' X 880' SE & .28 AC ADJ N SIDE B77 P347 08-000-073-00		08-07-03-400-003				
1000 LONGMOOR SAVANNA, IL		ACRES	TAXABLE VALUE			
		13.33	576,333			
		CLASS CODE	TAX CODE			
		0050	08003			
		TOWNSHIP	Savanna Township			
TAXING BODY	PRIOR RATE	PRIOR AMOUNT	CURRENT RATE	CURRENT AMOUNT	% OF TOTAL	
TRI-TWP MUNICIPAL AIRPRT	0.04985	\$246.36	0.05039	\$290.41	0.52	
CARROLL COUNTY	0.55850	\$3,472.64	0.51408	\$2,962.81	5.31	
CARROLL COUNTY PENSION	0.13850	\$0.00	0.12984	\$748.32	1.34	
HIGHLAND JC 519	0.45755	\$2,325.52	0.46070	\$2,655.17	4.76	
HIGHLAND JC 519 PENSION	0.00881	\$0.00	0.00818	\$47.14	0.08	
SAVANNA LIBRARY DIST	0.21530	\$1,245.86	0.21018	\$1,211.34	2.17	
SAVANNA LIBRARY DIST PENSION	0.03476	\$0.00	0.03611	\$208.11	0.37	
SAVANNA PARK DIST	0.64723	\$3,524.26	0.62201	\$3,584.84	6.43	
SAVANNA PARK DIST PENSION	0.06013	\$0.00	0.06416	\$369.78	0.66	
SAVANNA TWP	0.34066	\$1,704.54	0.17482	\$1,007.55	1.81	
SAVANNA TWP PENSION	0.00144	\$0.00	0.00000	\$0.00	0.00	
SAVANNA R&B	0.00000	\$0.00	0.14751	\$850.15	1.52	
SAVANNA US300 BOND	0.69540	\$3,464.68	0.20889	\$1,203.90	2.16	
WEST CARROLL U314	4.16635	\$23,181.10	4.91093	\$28,303.29	50.75	
WEST CARROLL U314 PENSION	0.48636	\$0.00	0.49976	\$2,880.30	5.16	
SAVANNA CORP	1.10736	\$9,048.92	1.05137	\$6,059.39	10.86	
SAVANNA CORP PENSION	0.70886	\$0.00	0.67065	\$3,865.18	6.93	
Totals		9.87748	\$48,215.88	0.79958	\$56,247.68	

FIRST INSTALLMENT	SECOND INSTALLMENT
DUE DATE: 07/25/2008	DUE DATE: 09/05/2008
AMOUNT: \$28,123.84	AMOUNT: \$28,123.84



PARCEL NUMBER	FORFEITED TAXES OR YEARS
08-07-03-400-003	
DUE DATE	CURRENT TAX DUE
07/25/2008	\$28,123.84
	TAX PAYMENT - 1ST INST.
	INTEREST
	COSTS
TOTAL TAX	TOTAL PAID
\$56,247.68	



PARCEL NUMBER	FORFEITED TAXES OR YEARS
08-07-03-400-003	
DUE DATE	CURRENT TAX DUE
09/05/2008	\$28,123.84
	TAX PAYMENT - 2ND INST.
	INTEREST
	COSTS
TOTAL TAX	TOTAL PAID
\$56,247.68	

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


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


Facility Name & ID Number BIG MEADOWS

0021394 Report Period Beginning:

1/1/2008 Ending:

12/31/2008

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	TOTALS	566,280		\$ 139,000	3

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

Report Period Beginning:

1/1/2008

Ending:

12/31/2008**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	\$ 465,921	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		REPLACEMENT FLOOR TILE		2001	1,182	79	15	79		565	9
10		WHIRLPOOL/SHOWER ROOM		2002	12,150	810	15	810		5,535	10
11		FIREDOORS		2002	9,076	454	20	454		2,950	11
12		REMODEL DINING ROOM		2004	4,060	406	10	406		1,827	12
13		ROOF & GUTTERS		2002	244,631		20	12,232	12,232	68,330	13
14		AIR CONDITIONERS		2003	23,038		10	2,304	2,304	12,671	14
15		GARAGE		2003	32,491		20	1,625	1,625	8,123	15
16		BATHROOM REMODELING		2003	4,885		10	489	489	2,198	16
17		ROOF ADDITION		2003	4,500		20	225	225	1,125	17
18		PAVING		2003	10,115		10	1,012	1,012	4,552	18
19		SMOKE ALARM SYSTEM		2003	28,321		15	1,888	1,888	8,654	19
20		WIRELESS MONITORING SYSTEM		2004	69,820		15	4,655	4,655	20,558	20
21		DINING ROOM		2005	21,857		15	1,457	1,457	4,493	21
22		PAVE SIDEWALK		2005	7,780		20	389	389	1,199	22
23		CARPET		2005	19,473		5	3,895	3,895	9,736	23
24		HEATING & AC		2005	13,660		20	683	683	1,935	24
25		DOOR		2006	1,043		20	52	52	104	25
26		BOILER REGISTER		2006	876		20	44	44	88	26
27		FANS		2006	1,386		20	69	69	139	27
28		WALLPAPER		2006	1,209		10	60	60	181	28
29		OUTSIDE LIGHT FIXTURES		2008	2,813		20	23	23	23	29
30		KITCHEN AREA HORN		2008	854		15	9	9	9	30
31		HOME FREE SYSTEM		2008	23,201		20	193	193	193	31
32		ORNAMENTAL FENCE		2008	3,837		20	16	16	16	32
33		FIRE DAMPERS		2008	5,487		20	23	23	23	33
34		FIRE DOORS		2008	9,647		20	40	40	40	34
35		SEALCOAT PARKING LOTS		2008	6,325		10	316	316	316	35
36		CCTV EQUIPMENT		2008	6,554		10	328	328	328	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:

1/1/2008

Ending:

12/31/2008

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	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70
		3,229,401	1,749		101,958	100,209	621,833	

**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: **1/1/2008** Ending: **12/31/2008**

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	\$ 175,043	\$ 19,136	\$ 19,136	\$ (0)	VARIOUS	\$ 127,160	71
72	Current Year Purchases	8,617	658	658		VARIOUS	658	72
73	Fully Depreciated Assets	519,171					519,171	73
74								74
75	TOTALS	\$ 702,830	\$ 19,794	\$ 19,794	\$ (0)		\$ 646,989	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)	\$ 4,100,436	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 21,543	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 121,752	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 100,209	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,298,027	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.

Facility Name & ID Number BIG MEADOWS

0021394

Report Period Beginning: 1/1/2008

Ending: 12/31/2008

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>9/19/01</u>	\$ <u>224,700</u>	<u>20</u>		3
4	Additions							4
5								5
6								6
7	TOTAL		98		\$ 224,700			7

10. Effective dates of current rental agreement:

Beginning 9/19/01

Ending 9/19/01

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

Fiscal Year Ending Annual Rent

12.	<u>12/31/2009</u>	\$ <u>224,700</u>
13.	<u>12/31/2010</u>	\$ <u>224,700</u>
14.	<u>12/31/2011</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	TOTAL		\$ 500.00	\$ 6,000	21

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

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

XIII. EXPENSES RELATING TO 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)		10,398		10,398
4	Clinical Wages (b)		3,348		3,348
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments		6,740		6,740
8	CNA Competency Tests				
9	TOTALS	\$	\$ 20,486	\$	\$ 20,486
10	SUM OF line 9, col. 1 and 2 (e)	\$	20,486		

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)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

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	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed 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: **1/1/2008**

Ending:

12/31/2008**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2008**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 526,108	\$ 526,108	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>439739-71711</u>)	368,028	368,028	3
4	Supply Inventory (priced at <u>COST</u>)	35,504	35,504	4
5	Short-Term Investments			5
6	Prepaid Insurance	4,591	4,591	6
7	Other Prepaid Expenses	1,268	1,268	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>OTHER RECEIVABLE</u>	11,442	11,442	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 946,942	\$ 946,941	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	17,150	17,150	12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	26,468	26,468	15
16	Equipment, at Historical Cost	711,447	711,447	16
17	Accumulated Depreciation (book methods)	(657,865)	(657,865)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 97,200	\$ 97,200	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,044,141	\$ 1,044,141	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 483,172	\$ 483,172	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	118,420	118,420	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,198	4,198	31
32	Accrued Real Estate Taxes(Sch.IX-B)	50,000	50,000	32
33	Accrued Interest Payable	33,214	33,214	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>DUE FROM PLEASANT VIEW</u>	(878,660)	(878,660)	36
37	<u>RESIDENT S.S. PAYABLE</u>	707	707	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ (188,949)	\$ (188,949)	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	575,112	575,112	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>DUE TO AHE, INC.</u>	343,058	343,058	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 918,170	\$ 918,170	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 729,221	\$ 729,221	46
47	TOTAL EQUITY(page 18, line 24)	\$ 314,920	\$ 314,920	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,044,141	\$ 1,044,141	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 367,442	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 367,442	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(52,522)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (52,522)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 314,920	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **BIG MEADOWS**# **0021394**Report Period Beginning: **1/1/2008**Ending: **12/31/2008****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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,967,583	1
2	Discounts and Allowances for all Levels	(6,000)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,961,583	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	15,983	6
7	Oxygen	20,315	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 36,298	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	6,608	11
12	Gift and Coffee Shop	282	12
13	Barber and Beauty Care	3,677	13
14	Non-Patient Meals	6,909	14
15	Telephone, Television and Radio	8,286	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	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 25,762	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	367	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 367	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	TRANSPORTATION	971	28
28a	EMPLOYEES AT OTHER FACILITIES	97,182	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 98,153	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,122,162	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	819,499	31
32	Health Care	1,370,198	32
33	General Administration	589,991	33
B. Capital Expense			
34	Ownership	341,194	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	53,802	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,174,684	40
41	Income before Income Taxes (line 30 minus line 40)**	(52,522)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (52,522)	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: **1/1/2008**

Ending:

12/31/2008

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	1,934	2,024	\$ 48,301	\$ 23.86	1
2	Assistant Director of Nursing	2,007	2,111	54,258	25.70	2
3	Registered Nurses	8,192	8,675	190,208	21.93	3
4	Licensed Practical Nurses	12,485	13,278	249,917	18.82	4
5	CNAs & Orderlies	42,401	45,777	428,667	9.36	5
6	CNA Trainees	1,575	1,575	13,746	8.73	6
7	Licensed Therapist	4	4	126	31.50	7
8	Rehab/Therapy Aides	1,971	2,175	23,811	10.95	8
9	Activity Director	320	408	9,955	24.40	9
10	Activity Assistants	4,292	4,734	50,884	10.75	10
11	Social Service Workers	2,799	3,100	50,803	16.39	11
12	Dietician					12
13	Food Service Supervisor	1,802	1,990	27,508	13.82	13
14	Head Cook	2,122	2,344	19,518	8.33	14
15	Cook Helpers/Assistants	18,862	20,149	164,276	8.15	15
16	Dishwashers					16
17	Maintenance Workers	5,393	6,141	66,816	10.88	17
18	Housekeepers	8,417	9,164	79,151	8.64	18
19	Laundry	7,633	8,325	69,755	8.38	19
20	Administrator	586	720	15,489	21.51	20
21	Assistant Administrator	920	960	19,898	20.73	21
22	Other Administrative					22
23	Office Manager	1,918	2,201	34,273	15.57	23
24	Clerical	2,094	2,158	26,496	12.28	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	1,420	1,579	16,924	10.72	31
32	Other Health Care(specify)					32
33	Other(specify) TRANSPORTATI	2,211	2,453	28,918	11.79	33
34	TOTAL (lines 1 - 33)	131,358	142,045	\$ 1,689,698 *	\$ 11.90	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	\$ 7,065	1,3	35
36	Medical Director	120	24,000	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	25	1,609	10a,3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	332	\$ 34,474		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	56	1,207	10,3	52
53	TOTAL (lines 50 - 52)	56	\$ 1,207		53

Facility Name & ID Number BIG MEADOWS

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. IL HEALTHCARE - \$5410
- (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 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 11,033 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. \$ 53,802
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. \$ 6,909
- (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? N/A
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.