



Facility Name & ID Number **BIG MEADOWS**

# **0021394** Report Period Beginning: **1/1/2009** Ending: **12/31/2009**

**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	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	14,115	6,106		20,221	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,115	6,106		20,221	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 56.53%**

**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 11/11/1976

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

YES  Date 09/19/2001 NO

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

YES  NO  If YES, enter number of beds certified \_\_\_\_\_ and days of care provided \_\_\_\_\_

Medicare Intermediary \_\_\_\_\_

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/2009

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

Facility Name &amp; ID Number

BIG MEADOWS

# 0021394

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

## 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	191,797	11,927	8,050	211,774		211,774		211,774		1
2	Food Purchase		137,041		137,041		137,041	(7,557)	129,484		2
3	Housekeeping	51,569	18,552		70,121		70,121		70,121		3
4	Laundry	46,397	10,708		57,105		57,105		57,105		4
5	Heat and Other Utilities			129,718	129,718		129,718	(12,559)	117,159		5
6	Maintenance	55,893	26,208	33,760	115,861		115,861		115,861		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	345,656	204,436	171,528	721,620		721,620	(20,116)	701,504		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			24,000	24,000		24,000		24,000		9
10	Nursing and Medical Records	898,903	69,687	3,342	971,932	(10,153)	961,779		961,779		10
10a	Therapy	23,855	19	2,373	26,247		26,247		26,247		10a
11	Activities	59,725	4,789		64,514		64,514		64,514		11
12	Social Services	42,168			42,168		42,168		42,168		12
13	CNA Training	9,347		2,756	12,103		12,103		12,103		13
14	Program Transportation	31,693	4,267		35,960	(4,267)	31,693		31,693		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,065,691	78,762	32,471	1,176,924	(14,420)	1,162,504		1,162,504		16
	<b>C. General Administration</b>										
17	Administrative	39,550		148,375	187,925		187,925	(43,009)	144,916		17
18	Directors Fees										18
19	Professional Services			25,380	25,380		25,380		25,380		19
20	Dues, Fees, Subscriptions & Promotions			28,080	28,080		28,080	(9,805)	18,275		20
21	Clerical & General Office Expenses	44,855	19,500	13,708	78,063		78,063		78,063		21
22	Employee Benefits & Payroll Taxes			214,723	214,723		214,723		214,723		22
23	Inservice Training & Education			913	913		913		913		23
24	Travel and Seminar			10,859	10,859		10,859	(154)	10,705		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			36,346	36,346		36,346		36,346		26
27	Other (specify):*			752	752		752	(706)	46		27
28	<b>TOTAL General Administration</b>	84,405	19,500	479,136	583,041		583,041	(53,674)	529,367		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,495,752	302,698	683,135	2,481,585	(14,420)	2,467,165	(73,790)	2,393,375		29

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

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

Facility Name &amp; ID Number

BIG MEADOWS

#0021394

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

## 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			22,607	22,607		22,607	102,914	125,521			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			30,482	30,482		30,482	110,450	140,932			32
33	Real Estate Taxes			63,538	63,538		63,538		63,538			33
34	Rent-Facility & Grounds			162,981	162,981		162,981	(162,981)				34
35	Rent-Equipment & Vehicles			6,000	6,000	(6,000)						35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			285,608	285,608	(6,000)	279,608	50,383	329,991			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation					10,267	10,267		10,267			38
39	Ancillary Service Centers					10,153	10,153		10,153			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	20,420	74,075		74,075			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,495,752	302,698	1,022,398	2,820,848		2,820,848	(23,407)	2,797,441			45

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

Big Meadows, Inc. - 0021394  
 Report Period Beginning - 1/1/09  
 Report Period Ending - 12/31/09  
 DETAIL SCHEDULE V-LINE 24

<b>1</b>			
<b>Names &amp; Titles</b>	Julie Johnson, Social Worker		
<b>Dates of Seminar</b>	6/29/2009		
<b>Location</b>	Naperville, IL		
<b>Title</b>	Alzheimer's and Dementia		
<b>Sponsor</b>	Alzheimer's Assoc		
<b>Cost</b>		\$	214.33
<b>2</b>			
<b>Name &amp; Title</b>	JoEllen McCaskey, Administer Julie Johnson, Social Worker Kelly Foley		
<b>Dates of Seminar</b>	7/29/2009		
<b>Location</b>	Naperville, IL		
<b>Title</b>	Medicare Workshop		
<b>Sponsor</b>	LSN		
<b>Cost</b>		\$	255.00
<b>3</b>			
<b>Names &amp; Titles</b>	Kelly Foley, MDS Coord. Jen Majors, Licensed Nurse		
<b>Dates of Seminar</b>	7/13/09-8/4/09		
<b>Location</b>	West Mont, IL		
<b>Title of Seminar</b>	Rehab Nursing Certification		
<b>Sponsor</b>	Pathway Health Services		
<b>Cost</b>		\$	2,283.78
<b>4</b>			
<b>Name &amp; Title</b>	Lisa Mussman, Dietary Manager Sue Wheelly		
<b>Date Travel</b>	10/18/09-10/19/09		
<b>Location</b>	Waterloo, IA		
<b>Title of Seminar</b>	Martin Brothers Food Show		
<b>Sponsor</b>	Martin Brothers		
<b>Total Cost</b>		\$	154.00
<b>5</b>			
<b>Names &amp; Titles</b>	Hali Bower, Transportation Julie Johnson, Social Worker Phyllis Jonkman, DON JoEllen McCaskey, Administer Lisa Mussman, Dietary Manager Gary Stevens, Maintenance Jamie Barnhart, Recreational Therapist		
<b>Date of Seminar</b>	9/17/09-9/20/09		
<b>Location</b>	Peoria, IL		
<b>Title</b>	IHCA Annual Conference		
<b>Sponsor</b>	IHCA		
<b>Cost</b>		\$	3,041.35
<b>6</b>			
<b>Name &amp; Title</b>	Julie Johnson, Social Worker Linda Grissinger, Administrative Assistant		
<b>Date Travel</b>	11/5/2009		
<b>Location</b>	Davenport, IA		
<b>Title of Seminar</b>	Alzheimer's		
<b>Sponsor</b>	Alzheimer's Assoc		
<b>Total Cost</b>		\$	144.90
<b>7</b>			
<b>Name &amp; Title</b>	JoEllen McCaskey, Administer		
<b>Date Travel</b>	11/25/2009		
<b>Location</b>	Naperville, IL		
<b>Title of Seminar</b>	MDS Hero		
<b>Sponsor</b>	IHCA		
<b>Total Cost</b>		\$	250.95
<b>8</b>			
<b>Name &amp; Title</b>	Phyllis Jonkman, DON Linda Johnson, RN		
<b>Date Travel</b>	5/22/2009		
<b>Location</b>	Dubuque, IA		
<b>Title of Seminar</b>	Nursing Symposium		
<b>Sponsor</b>	Finley Hospital		
<b>Total Cost</b>		\$	150.00
<b>9</b>			
<b>Name &amp; Title</b>	Jamie Barnhart, Recreational Therapist		
<b>Date Travel</b>	8/25/09 - 9/3/09		
<b>Location</b>	Palatine, IL		
<b>Title of Seminar</b>	Activity Director Course		
<b>Sponsor</b>	Harper College		
<b>Total Cost</b>		\$	1,211.33
<b>10</b>			
<b>Name &amp; Title</b>	Julie Johnson, Social Worker		
<b>Date Travel</b>	6/29/2009		
<b>Location</b>	Naperville, IL		
<b>Title of Seminar</b>	Certified Dementia Practitioner		
<b>Sponsor</b>	May Field Healthcare Seminars		
<b>Total Cost</b>		\$	199.00
<b>Total Travel &amp; Seminars</b>		\$	7,904.64
<b>Less: Out of State</b>		\$	(154.00)
<b>Total</b>		\$	7,750.64
<b>Employee Mileage Reimbursements</b>		\$	2,954.08
<b>Total - Line 24, Schedule V</b>		\$	<u>10,704.72</u>

**Big Meadows, Inc. – 0021394**  
**Report Period Beginning – 1/1/09**  
**Report Period Ending – 12/31/09**

**RECLASSIFICATIONS, Pages 3 & 4**

	<u>Dr.</u>	<u>Cr.</u>	<u>Line #</u>
TRANSPORTATION: Medically Necessary Transportation	10,267		38
Program Transportation		4,267	14
Rent-Equipment and Vehicles		6,000	35
PUBLIC AID OXYGEN Ancillary Service Centers	10,153		39
Nursing & Medical Records		10,153	10

**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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(7,557)	2		4
5	Telephone, TV & Radio in Resident Rooms	(12,559)	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	(73)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(706)	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	(550)	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	(8,626)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(629)	20		28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (30,700)		\$	30

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

		1	2	
		<b>Amount</b>	<b>Reference</b>	
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>	\$		36
37	<b>TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)</b>	\$ (30,700)		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	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
38	Medically Necessary Transport.			\$ 10,267	14, 35	38
39	<u>P.A. OXYGEN</u>			10,153	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	<u>Other-Attach Schedule</u>					45
46	<u>Other-Attach Schedule</u>					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$ 20,420		47

<b>BHF USE ONLY</b>							
48		49		50		51	

BIG MEADOWS

ID# 0021394

Report Period Beginning: 1/1/2009

Ending: 12/31/2009

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount Reference

1	OUT OF STATE TRAVEL	\$ (154)	24	1
2				2
3				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>	(154)		49

## STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

## 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	(7,557)	0	0	0	0	0	0	0	0	0	0	(7,557)	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	(12,559)	0	0	0	0	0	0	0	0	0	0	(12,559)	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	<b>TOTAL General Services</b>	<b>(20,116)</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>(20,116)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(43,009)	0	0	0	0	0	0	0	0	0	(43,009)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(9,805)	0	0	0	0	0	0	0	0	0	0	(9,805)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(154)	0	0	0	0	0	0	0	0	0	0	(154)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(706)	0	0	0	0	0	0	0	0	0	0	(706)	27
28	<b>TOTAL General Administration</b>	<b>(10,665)</b>	<b>(43,009)</b>	<b>0</b>	<b>(53,674)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(30,781)</b>	<b>(43,009)</b>	<b>0</b>	<b>(73,790)</b>	<b>29</b>								

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number BIG MEADOWS# 0021394

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	0	102,914	0	0	0	0	0	0	0	0	0	102,914	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(73)	110,523	0	0	0	0	0	0	0	0	0	110,450	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(162,981)	0	0	0	0	0	0	0	0	0	(162,981)	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>	(73)	50,456	0	0	0	0	0	0	0	0	0	50,383	37
	<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>	0	0	0	0	0	0	0	0	0	0	0	0	44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	(30,854)	7,447	0	0	0	0	0	0	0	0	0	(23,407)	45

Facility Name & ID Number **BIG MEADOWS**

# **0021394**

Report Period Beginning: **1/1/2009** Ending: **12/31/2009**

**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
<b>AMERICAN HEALTH ENTERPRISES INC 100</b>		<b>WINNING WHEELS (BUILDING OWNER)</b>	<b>PROPHETSTOWN</b>			
<b>ALAN GAPINSKI</b>	<b>100</b>					
		<b>S.T.R.I.V.E.</b>	<b>PROPHETSTOWN</b>			

**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)	
1	V	17 PROFESSIONAL SERVICES	\$ 148,375	AMERICAN HEALTH ENTERPRISES INC	100.00%	\$ 105,366	\$ (43,009)	1
2	V	34 RENT	162,981	WINNING WHEELS INC - 100% BUILDING OWNER			(162,981)	2
3	V	32 INTEREST		WINNING WHEELS INC - 100% BUILDING OWNER		110,523	110,523	3
4	V	30 DEPRECIATION		WINNING WHEELS INC - 100% BUILDING OWNER		102,914	102,914	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		\$ 311,356			\$ 318,803	\$ * 7,447	14

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

Facility Name &amp; ID Number

BIG MEADOWS

#

0021394

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

## 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									\$		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: **1/1/2009**

Ending: **2/31/2009**

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( \_\_\_\_\_  
 Fax Number ( \_\_\_\_\_

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number **BIG MEADOWS**

# **0021394**

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

**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										
										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		X	BUILDING MORTGAGE	\$12,227.35	06/30/04	\$ 1,730,000	\$ 1,561,325	6/30/29	6.9000	\$ 110,523	1								
2											2								
3		X		\$5,000.24	03/2005	300,000	67,896	03/2011	6.2000	6,540	3								
4											4								
5											5								
<b>Working Capital</b>																			
6	X		WORKING CAPITAL	INT. ONLY	10/5/09	200,000	200,000	10/5/14	5.0000	2,417	6								
7		X	WORKING CAPITAL	INT. ONLY	4/10/03	175,000	224,080	6/1/07	8.0000	10,997	7								
8		X	WORKING CAPITAL	NONE	06/2000	197,389	197,389	DEMAND	9.0000	10,528	8								
9			<b>TOTAL Facility Related</b>	\$17,227.59		\$ 2,602,389	\$ 2,250,690			\$ 141,005	9								
<b>B. Non-Facility Related*</b>																			
10											10								
11											11								
12										(73)	12								
13											13								
14			<b>TOTAL Non-Facility Related</b>			\$	\$			\$ (73)	14								
15			<b>TOTALS (line 9+line14)</b>			\$ 2,602,389	\$ 2,250,690			\$ 140,932	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ 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

1. Real Estate Tax accrual used on 2008 report.		\$	<b>50,000</b>	<b>1</b>
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.)		\$	<b>56,539</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>6,539</b>	<b>3</b>
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>56,999</b>	<b>4</b>
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>		\$		<b>5</b>
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>		\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>63,538</b>	<b>7</b>

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2004	<b>43,401</b>	<b>8</b>
	2005	<b>46,021</b>	<b>9</b>
	2006	<b>48,216</b>	<b>10</b>
	2007	<b>56,248</b>	<b>11</b>
	2008	<b>56,539</b>	<b>12</b>

	<b>FOR BHF USE ONLY</b>		
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2008	\$	<b>13</b>
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**4. 2009 ACCRUAL BASED ON 2007 AND 2008.**

**NOTES:**

- Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
- 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:** 2008 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 2008 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2008.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2008 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 2009 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.

**2008 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME BIG MEADOWS COUNTY CARROLL

FACILITY IDPH LICENSE NUMBER 0021394

CONTACT PERSON REGARDING THIS REPORT Milt Rue

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 2008 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 2008.

(A)	(B)	(C)	(D) <u>Tax Applicable to Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>08-07-03-400-003</u>	<u>77 SAV L73 S3 T24 R3 PT 660' X</u>	\$ <u>56,538.50</u>	\$ <u>56,538.50</u>
2. _____	<u>880' SE. &amp; .28 AC ADJ N SIDE</u>	\$ _____	\$ _____
3. _____	<u>B77 P347 08-000-073-00</u>	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>56,538.50</u>	\$ <u>56,538.50</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 and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the original 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

**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

# 2008 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  
 2008 CARROLL COUNTY REAL ESTATE TAX  
 PAY TO: CARROLL COUNTY TREASURER

FORMULA FOR TAX CALCULATION - 2008	
TIF BASE	0
LAND	48,339
STRUCTURES/BLDGS	520,004
FARM BLDG	0
FARM LAND	0
80% OF REVIEW EQUALIZED VALUE	= 576,333
HOME IMPROVEMENT EXEMPTION	- 0
DISABLED VETERANS' EXEMPTION	- 0
VALUE PRIOR TO STATE EQUALIZE	= 576,333
STATE EQUALIZATION ADJUSTMENT	- 1,000
STATE EQUALIZED VALUE	= 575,333
OWNER OCCUPIED EXEMPTION	- 0
SENIOR HOMESTEAD EXEMPTION	- 0
SENIOR ASSESSMENT FRELIE	- 0
DISABLED PERSONS' EXEMPTION	- 0
RETURNING VETERANS' EXEMPTION	- 0
DISABLED VETERANS' EXEMPTION	- 0
MISC EXEMPTION	- 0
TAXABLE VALUE	= 576,333
TAX RATE	X 9.51004
TOTAL TAX	= \$54,838.50

****NOT TO BE USED FOR FARM LAND AND FARM BUILDINGS	
INTEREST 1% PER MONTH	TOTAL TAX DUE
	\$56,538.50
1077 EQUALIZED VALUE	PAID MARKET VALUE
0	1,728,989

PROPERTY DESCRIPTION		PARCEL NUMBER				
77 SAW L73 S3 T24 R3 PT 660' X 880' SE 1/4 .28 AC ADJ N SIDC D77 P847 08-000-073-00		08-07-03-400-003				
LOCATION OF PROPERTY 1000 LONGMEOR SAVANNA, IL		ADDRESS 13.33	TAXABLE VALUE 576,333			
		CLASS CODE 0050	TAX CODE 00003			
		TOWNSHIP Savanna Township				
TAXING BODY	PRIOR RATE	PRIOR AMOUNT	CURRENT RATE	CURRENT AMOUNT	% OF TOTAL	
TRI-TWP MUNICIPAL ARPT	0.05038	\$293.41	0.05310	\$306.29	0.54	
CARROLL COUNTY	0.21408	\$2,562.81	0.22744	\$3,073.76	5.53	
CARROLL COUNTY PENSION	0.12084	\$748.32	0.14155	\$816.90	1.45	
HIGHLAND JC 519	0.48000	\$2,655.17	0.47715	\$2,746.97	4.89	
HIGHLAND JC 519 PENSION	0.00218	\$47.14	0.00254	\$44.03	0.08	
SAVANNA LIBRARY DIST	0.21000	\$1,211.34	0.21329	\$1,228.74	2.19	
SAVANNA LIBRARY DIST PENSION	0.00811	\$268.11	0.00155	\$181.89	0.32	
SAVANNA PARK DIST	0.00201	\$8,584.84	0.00182	\$3,427.31	6.16	
SAVANNA PARK DIST PENSION	0.00418	\$369.78	0.00554	\$380.04	0.68	
SAVANNA TWP	0.17432	\$1,007.56	0.18102	\$862.59	1.71	
SAVANNA RSB	0.14751	\$890.15	0.14063	\$812.23	1.44	
SAVANNA UNDEVELOPED	0.20855	\$1,203.90	0.00000	\$0.00	0.00	
WEST CARROLL U014	4.91000	\$28,303.29	5.63216	\$29,180.76	51.88	
WEST CARROLL U014 PENSION	0.49975	\$2,890.30	0.48903	\$2,795.29	4.97	
SAVANNA CORP	1.05137	\$6,096.39	1.14366	\$6,521.28	11.72	
SAVANNA CORP PENSION	0.07000	\$2,002.13	0.08102	\$1,346.32	2.33	
<b>Totals</b>		<b>9.75958</b>	<b>\$56,247.69</b>	<b>9.81004</b>	<b>\$56,538.50</b>	

JUN 10 REC'D

FIRST INSTALLMENT	07/10/2009	AMOUNT	\$28,269.25	SECOND INSTALLMENT	09/10/2009	AMOUNT	\$28,269.25
DUE DATE:				DUE DATE:			

Facility Name & ID Number **BIG MEADOWS**

# **0021394**

Report Period Beginning:

**1/1/2009**

Ending:

**12/31/2009**

**X. BUILDING AND GENERAL INFORMATION:**

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

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

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

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

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

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

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

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

Nature of Costs: \_\_\_\_\_  
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

	1	2	3	4	
A. Land.	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**# **0021394**

Report Period Beginning:

**1/1/2009**

Ending:

**12/31/2009****XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	98		2001	1968	\$ 2,659,130	\$ 68,183	39	\$ 68,183		\$ 534,104	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		REPLACEMENT FLOOR TILE	2001		1,182	79	15	79		644	9
10		WHIRLPOOL/SHOWER ROOM	2002		12,150	810	15	810		6,345	10
11		FIREDOORS	2002		9,076	454	20	454		3,404	11
12		ROOF AND GUTTERS	2002		244,631	12,232	20	12,232		80,562	12
13		AIR CONDITIONERS	2003		23,038	2,304	10	2,304		14,975	13
14		GARAGE	2003		32,491	1,625	20	1,625		9,747	14
15		BATHROOM REMODELING	2003		4,885	488	10	488		2,687	15
16		ROOF ADDITION	2003		4,500	225	20	225		1,350	16
17		PAVING	2003		10,115	1,011	10	1,011		5,563	17
18		SMOKE ALARM SYSTEM	2003		28,321	1,888	15	1,888		10,542	18
19		REMODEL DINING ROOM	2004		4,060	406	10	406		2,233	19
20		WIRELESS MONITORING SYSTEM	2004		69,821	4,655	15	4,655		25,213	20
21		DINING ROOM	2005		21,857	1,457	15	1,457		5,950	21
22		PAVE SIDE WALK	2005		7,780	389	20	389		1,588	22
23		CARPET	2005		19,473	3,895	5	3,895		13,631	23
24		HEATING AND A/C	2005		13,660	683	20	683		2,618	24
25		DOOR	2006		1,043	52	20	52		156	25
26		BOILER REGISTER	2006		876	44	20	44		131	26
27		FANS	2006		1,386	69	20	69		208	27
28		WALLPAPER	2006		1,209	121	10	121		302	28
29		OUTSIDE LIGHT FIXTURES	2008		2,813	141	20	141		164	29
30		KITCHEN AREA HORN	2008		854	57	15	57		66	30
31		HOME FREE SYSTEM	2008		23,201	1,160	20	1,160		1,353	31
32		ORNAMENTAL FENCE	2008		3,837	192	20	192		208	32
33		FIRE DAMPERS	2008		5,487	274	20	274		297	33
34		FIRE DOORS	2008		9,647	482	20	482		523	34
35		SEALCOAT PARKING LOTS	2008		6,324	632	10	632		949	35
36		CCTV EQUIPMENT	2008		6,554	655	10	655		983	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:

**1/1/2009**

Ending:

**12/31/2009**

**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>3,229,401</b>	\$	<b>104,663</b>	\$	<b>104,663</b>	\$	<b>726,496</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:

1/1/2009

Ending:

12/31/2009

**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	\$ 185,862	\$ 19,156	\$ 19,156	\$	VARIOUS	\$ 140,559	71
72	Current Year Purchases	22,901	1,702	1,702		VARIOUS	1,702	72
73	Fully Depreciated Assets	525,586					525,586	73
74								74
75	<b>TOTALS</b>	\$ 734,348	\$ 20,858	\$ 20,858	\$		\$ 667,847	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	<b>TOTALS</b>			\$ 29,205	\$	\$	\$		\$ 29,205	80

**E. Summary of Care-Related Assets**

	1	2		
	Reference	Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,131,954	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 125,521	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 125,521	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,423,548	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	<b>TOTALS</b>	\$	\$	\$	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:

**1/1/2009**

Ending: **12/31/2009**

**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:	<b>1967/68</b>	<b>98</b>	<b>9/19/01</b>	\$ <b>162,981</b>	<b>20</b>		<b>3</b>
4	Additions							<b>4</b>
5								<b>5</b>
6								<b>6</b>
7	<b>TOTAL</b>		<b>98</b>		\$ <b>162,981</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.	<b>12/31/2010</b>	\$ <b>176,514</b>
13.	<b>12/31/2011</b>	\$ <b>191,224</b>
14.	<b>12/31/2012</b>	\$ <b>205,933</b>

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	<b>TRANSPORTATION</b>	<b>2005 FORD VAN</b>	\$ <b>500.00</b>	\$ <b>6,000</b>	<b>17</b>
18					<b>18</b>
19					<b>19</b>
20					<b>20</b>
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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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		42		42
3	Classroom Wages (a)	1,074	5,333		6,407
4	Clinical Wages (b)		2,940		2,940
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments	495	2,219		2,714
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$ 1,569	\$ 10,534	\$	\$ 12,103
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$ 12,103			

**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	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5					
					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	<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: **1/1/2009**

Ending:

**12/31/2009****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2009**

(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	\$ 173,614	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>325284 - 41399</u> )	283,885		3
4	Supply Inventory (priced at <u>COST</u> )	34,330		4
5	Short-Term Investments			5
6	Prepaid Insurance	7,473		6
7	Other Prepaid Expenses	7,534		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>DUE FROM OTHER FACILITI</u>	1,296,854		9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,803,690	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	17,150		12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	26,467		15
16	Equipment, at Historical Cost	734,348		16
17	Accumulated Depreciation (book methods)	(680,472)		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	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 97,493	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 1,901,183	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 109,625	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	56,805		30
31	Accrued Taxes Payable (excluding real estate taxes)	25,885		31
32	Accrued Real Estate Taxes(Sch.IX-B)	57,000		32
33	Accrued Interest Payable	33,214		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>RESIDENT S.S. PAYABLE</u>	1,017		36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 283,546	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	858,108		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>DUE TO AHE, INC.</u>	491,912		43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 1,350,020	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 1,633,566	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 267,617	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 1,901,183	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>314,920</b>	<b>1</b>
<b>2</b>	Restatements (describe):	(209)	<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>314,711</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(47,094)	<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>	\$ (47,094)	<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>267,617</b>	<b>24</b> *

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

**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	\$ 2,692,565	1
2	Discounts and Allowances for all Levels	(6,000)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 2,686,565</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	15,680	6
7	Oxygen	14,810	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 30,490</b>	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	18,023	11
12	Gift and Coffee Shop	929	12
13	Barber and Beauty Care	744	13
14	Non-Patient Meals	7,557	14
15	Telephone, Television and Radio	7,428	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 34,681</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	73	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 73</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>TRANSPORTATION</b>	<b>2,064</b>	28
28a	<b>EMPLOYEES AT OTHER FACILITIES</b>	<b>19,881</b>	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 21,945</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 2,773,754</b>	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	721,620	31
32	Health Care	1,176,924	32
33	General Administration	583,041	33
<b>B. Capital Expense</b>			
34	Ownership	285,608	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	53,655	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 2,820,848</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(47,094)</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (47,094)</b>	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? \_\_\_\_\_ 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:

1/1/2009

Ending:

12/31/2009

**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	1,720	1,923	\$ 51,465	\$ 26.76	1
2	Assistant Director of Nursing	1,140	1,250	30,585	24.47	2
3	Registered Nurses	6,702	7,210	150,117	20.82	3
4	Licensed Practical Nurses	11,699	12,519	238,852	19.08	4
5	CNAs & Orderlies	39,105	40,959	401,246	9.80	5
6	CNA Trainees	1,064	1,064	9,347	8.78	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,943	2,138	23,864	11.16	8
9	Activity Director	505	559	12,936	23.14	9
10	Activity Assistants	3,719	4,111	43,225	10.51	10
11	Social Service Workers	1,871	2,081	41,872	20.12	11
12	Dietician					12
13	Food Service Supervisor	1,727	2,010	31,534	15.69	13
14	Head Cook	2,075	2,262	22,255	9.84	14
15	Cook Helpers/Assistants	15,174	16,411	143,113	8.72	15
16	Dishwashers					16
17	Maintenance Workers	4,215	4,539	55,466	12.22	17
18	Housekeepers	5,764	6,162	51,718	8.39	18
19	Laundry	5,169	5,653	50,685	8.97	19
20	Administrator	1,370	1,570	39,550	25.19	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,035	2,177	27,410	12.59	23
24	Clerical	1,971	2,083	19,547	9.38	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	1,874	1,987	19,531	9.83	31
32	Other Health Care(specify)					32
33	Other(specify) <u>TRANSPORTATI</u>	2,260	2,421	31,434	12.98	33
34	TOTAL (lines 1 - 33)	113,102	121,089	\$ 1,495,752 *	\$ 12.35	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	161	\$ 8,050	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	37	2,373	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>	31	1,542	10,3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	385	\$ 37,765		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				52
53	TOTAL (lines 50 - 52)		\$		53

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	Amount		
JOELLEN MCCASKEY	ADMINISTRATOR	0	\$ 39,550	Workers' Compensation Insurance	\$ 52,236	IDPH License Fee	\$ 995			
				Unemployment Compensation Insurance	14,083	Advertising: Employee Recruitment	6,476			
				FICA Taxes	112,870	Health Care Worker Background Check				
				Employee Health Insurance	8,867	(Indicate # of checks performed <u>15</u> )	230			
				Employee Meals		Patient Background Checks	31	310		
				Illinois Municipal Retirement Fund (IMRF)*		<b>DUES &amp; SUBSCRIPTIONS</b>		7,994		
				LIFE INSURANCE	3,260	ADVERTISING		9,255		
				RETIREMENT	9,637	MARKETING		1,006		
				PHYSICALS	475	COMMUNITY RELATIONS		1,814		
				EMPLOYEE RECOGNITION	10,601					
				TUITION ASSISTANCE	2,166	Less: Public Relations Expense		(1,764)		
				PROFESSIONAL LICENSE FEES	528	Non-allowable advertising		(7,412)		
						Yellow page advertising		(629)		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						TOTAL (agree to Sch. V, line 20, col. 8)				
			\$ 39,550		\$ 214,723			\$ 18,275		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
Description			Amount	Description	Line #	Amount	Description	Amount		
AMERICAN HEALTH ENTERPRISES, INC			\$ 148,375				Out-of-State Travel	\$ (154)		
							In-State Travel	2,954		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)										
			\$ 148,375				Seminar Expense	7,905		
C. Professional Services										
Vendor/Payee	Type		Amount							
JOHN PYSE CONSULTING	COMPUTER CONSULT		\$ 2,961							
MDI ACHIEVE	SOFTWARE MAINTENANCE		6,316							
MIDWEST AUTOMATED TIME	TIMECLOCK MAINTENANCE		650							
T6 BROADBAND	INTERNET/EMAIL SERVICES		616							
ROBERT SYSCO, INC	SOFTWARE MAINTENANCE		240							
WARD MURRAY PACE JOHNSON	LEGAL		9,097							
INTEGRA REALTY RESOURCES	APPRAISAL SERVICES		5,500							
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				TOTAL				Entertainment Expense (agree to Sch. V, line 24, col. 8)		
			\$ 25,380			\$			\$ 10,705	

\* Attach copy of IMRF notifications

\*\*See instructions.

Facility Name & ID Number **BIG MEADOWS**

Report Period Beginning: 1/1/2009 Ending:

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).**  
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

**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 - \$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
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 6,083 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. \$ 53,655  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? YES 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. \$ 7,557
- (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: \_\_\_\_\_
- (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? YES  
Attach invoices and a summary of services for all architect and appraisal fees.

**Big Meadows, Inc. – 0021394**  
**Report Period Beginning – 1/1/09**  
**Report Period Ending – 12/31/09**  
**PAGE 23 EXPLANATIONS**

**#12 - EMPLOYEES IN MORE THAN ONE CATEGORY**

JoEllen McCaskey	Started year as Activity Director and was moved to the Administrator mid year	
	Activity Director	\$ 12,936.00
	Administrator	\$ 39,550.00

**#19 - LEGAL AND APPRAISAL FEES**

Ward, Murray, Pace, and Johnson	Legal advice and assistance in collecting outstanding accounts receivable balances	\$ 7,317.83
Ward, Murray, Pace, and Johnson	Legal advice and assistance in defense of an intellectual property claim	\$ 1,778.75
Integra Realty Resources	Market Value Appraisal	<u>\$ 5,500.00</u>
	Total Legal and Appraisal Fees	\$ 14,596.58