

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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

<p>I. IDPH License ID Number: <u>0021394</u></p> <p>Facility Name: <u>BIG MEADOWS</u></p> <p>Address: <u>1000 LONGMOOR</u> <u>SAVANNA</u> <u>61074</u> Number City Zip Code</p> <p>County: <u>CARROLL</u></p> <p>Telephone Number: <u>815-273-2238</u> Fax # <u>815-273-7294</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>10/21/1976</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>ROBIN JACKSON</u> Telephone Number: <u>815-778-3683</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2016</u> to <u>12/31/2016</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) <u>ROBIN JACKSON</u> (Title) <u>CFO</u></td> </tr> <tr> <td style="width:15%; padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____</td> </tr> </table> <p align="right">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>ROBIN JACKSON</u> (Title) <u>CFO</u>	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>ROBIN JACKSON</u> (Title) <u>CFO</u>							
Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____							

Facility Name & ID Number **BIG MEADOWS**

0021394 Report Period Beginning: **01/01/2016** Ending: **12/31/2016**

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 08/15/2014

	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	83	Intermediate (ICF)	83	30,378	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	83	TOTALS	83	30,378	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	17,934	7,689		25,623	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,934	7,689		25,623	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.35%

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: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number **BIG MEADOWS** # **0021394** Report Period Beginning: **01/01/2016** Ending: **12/31/2016**

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

	Operating Expenses	Costs Per General Ledger				Reclassification 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	200,560	11,503	11,676	223,739		223,739		223,739		1
2	Food Purchase		161,686		161,686		161,686	(9,654)	152,032		2
3	Housekeeping	57,930	22,831		80,761		80,761		80,761		3
4	Laundry	66,860	7,586		74,446		74,446		74,446		4
5	Heat and Other Utilities			153,306	153,306		153,306	(9,748)	143,558		5
6	Maintenance	91,563	16,052	39,705	147,320		147,320		147,320		6
7	Other (specify):*										7
8	TOTAL General Services	416,913	219,658	204,687	841,258		841,258	(19,402)	821,856		8
	B. Health Care and Programs										
9	Medical Director			27,671	27,671		27,671		27,671		9
10	Nursing and Medical Records	1,459,570	110,245	170,576	1,740,391	(6,076)	1,734,315		1,734,315		10
10a	Therapy	49,714	592	112,546	162,852	(115,488)	47,364		47,364		10a
11	Activities	41,597	3,849		45,446		45,446		45,446		11
12	Social Services	62,679			62,679		62,679		62,679		12
13	CNA Training		315	8,556	8,871		8,871		8,871		13
14	Program Transportation		2,803	4,592	7,395	(1,596)	5,799		5,799		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,613,560	117,804	323,941	2,055,305	(123,160)	1,932,145		1,932,145		16
	C. General Administration										
17	Administrative			93,798	93,798		93,798	44,563	138,361		17
18	Directors Fees										18
19	Professional Services			28,493	28,493		28,493		28,493		19
20	Dues, Fees, Subscriptions & Promotions			15,308	15,308		15,308	(5,817)	9,491		20
21	Clerical & General Office Expenses	84,242	20,499	19,630	124,371		124,371	4,494	128,865		21
22	Employee Benefits & Payroll Taxes			316,664	316,664		316,664	15,137	331,801		22
23	Inservice Training & Education			2,769	2,769		2,769		2,769		23
24	Travel and Seminar			3,326	3,326		3,326	(144)	3,182		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			21,281	21,281		21,281		21,281		26
27	Other (specify):*			870	870		870	(870)			27
28	TOTAL General Administration	84,242	20,499	502,139	606,880		606,880	57,363	664,243		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,114,715	357,961	1,030,767	3,503,443	(123,160)	3,380,283	37,961	3,418,244		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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			25,235	25,235		25,235	127,108	152,343		30
31	Amortization of Pre-Op. & Org.										31
32	Interest							78,189	78,189		32
33	Real Estate Taxes			39,277	39,277		39,277		39,277		33
34	Rent-Facility & Grounds			102,000	102,000		102,000	(102,000)			34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	TOTAL Ownership			166,512	166,512		166,512	103,297	269,809		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation					1,596	1,596		1,596		38
39	Ancillary Service Centers					121,564	121,564		121,564		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			229,694	229,694		229,694		229,694		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers			229,694	229,694	123,160	352,854		352,854		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,114,715	357,961	1,426,973	3,899,649		3,899,649	141,258	4,040,907		45

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

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	(9,654)	2		4
5	Telephone, TV & Radio in Resident Rooms	(9,748)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(870)	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				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	(5,817)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule OUT OF STATE TRAVEL	(144)	24		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (26,233)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	167,491		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 167,491		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 141,258		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.	xx		\$ 1,596	14	38
39	Medicare Therapy	xx		115,488	10a	39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	PUBLIC AID OXYGEN	xx		6,076	10	44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 123,160		47

BHF USE ONLY							
48		49		50		51	52

BIG MEADOWS

ID# 0021394

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
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			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BIG MEADOWS

0021394

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(9,654)	0	0	0	0	0	0	0	0	0	0	(9,654)	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	(9,748)	0	0	0	0	0	0	0	0	0	0	(9,748)	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	(19,402)	0	0	0	0	0	0	0	0	0	0	(19,402)	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):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	44,563	0	0	0	0	0	0	0	0	0	44,563	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	(5,817)	0	0	0	0	0	0	0	0	0	0	(5,817)	20
21	Clerical & General Office Expenses	0	4,494	0	0	0	0	0	0	0	0	0	4,494	21
22	Employee Benefits & Payroll Taxes	0	15,137	0	0	0	0	0	0	0	0	0	15,137	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(144)	0	0	0	0	0	0	0	0	0	0	(144)	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):*	(870)	0	0	0	0	0	0	0	0	0	0	(870)	27
28	TOTAL General Administration	(6,831)	64,194	0	57,363	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(26,233)	64,194	0	37,961	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number **BIG MEADOWS**

0021394

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	127,108	0	0	0	0	0	0	0	0	0	127,108	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	78,189	0	0	0	0	0	0	0	0	0	78,189	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(102,000)	0	0	0	0	0	0	0	0	0	(102,000)	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	0	103,297	0	103,297	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)	(26,233)	167,491	0	141,258	45								

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
WINNING WHEELS, INC	100	BUILDING OWNERS	PROPHETSTOWN			
AMERICAN HEALTH ENTERPRISE INC	100					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 RENT	\$ 102,000	WINNING WHEELS - 100% BUILDING OWNER		\$	(102,000)	1
2	V	30 DEPRECIATION		WINNING WHEELS - 100% BUILDING OWNER		127,108	127,108	2
3	V	32 INTEREST		WINNING WHEELS - 100% BUILDING OWNER		78,189	78,189	3
4	V	17 PROFESSIONAL SERVICES	90,000	AMERICAN HEALTH ENTERPRISES, INC			(90,000)	4
5	V	17 HOME OFFICE COSTS		AMERICAN HEALTH ENTERPRISES, INC		134,563	134,563	5
6	V	21 HOME OFFICE COSTS		AMERICAN HEALTH ENTERPRISES, INC		4,494	4,494	6
7	V	22 HOME OFFICE COSTS		AMERICAN HEALTH ENTERPRISES, INC		15,137	15,137	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 192,000			\$ 359,491	\$ * 167,491	14

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

Facility Name & ID Number

BIG MEADOWS

0021394

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
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								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number

BIG MEADOWS

0021394

Report Period Beginning:

01/01/2016

Ending:

12/31/2016

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		100.00		2	4.00		\$ NONE	1
2	AMERICAN HEALTH ENTERPRISES INC									2
3	MANAGEMENT FEES FROM WINNING WHEELS				222,588					3
4	MANAGEMENT FEES FROM STRIVE				126,333					4
5	MANAGEMENT FEES FROM PINNACLE PLACE				75,250					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: 01/01/2016

Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	ADMIN HOME OFFICE SALAR	GROSS REVENUES	10,545,452	4	\$ 129,307	\$ 129,307	3,685,604	\$ 45,192	1
2	17	ADMINISTRATOR SALARY	DIRECT COST	1	1	89,371	89,371	1	89,371	2
3	22	EMPLOYEE BENEFITS	% OF PAYROLL	505,571	4	56,872	0	134,563	15,137	3
4	21	OFFICE COSTS	GROSS REVENUES	10,545,452	4	12,859	0	3,685,604	4,494	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	TOTALS					\$ 288,409	\$ 218,678		\$ 154,194	25

American Health Enterprises, Inc. (AHE)
For The 12 Periods Ended 12/31/2016
Expense Statement

	2016 Total from G/L	Winning Wheels	Big Meadows	STRIVE	Pinnacle Place	Home Office Allocation	AHE Corp	Total	
Expenses									
SALARIES									
5340 ADMINISTRATORS	\$ 318,706	\$ 90,902	\$ 89,371	\$ 80,440	\$ 57,992			\$ 318,705	\$ (1)
5360 FINANCE	\$ 90,934					\$ 90,934	\$ -	\$ 90,934	\$ -
5460 CORPORATE	\$ 95,931	\$ 57,559	\$ -	\$ -	\$ -	\$ 38,372	\$ -	\$ 95,931	\$ -
Total SALARIES:	\$ 505,571	\$ 148,461	\$ 89,371	\$ 80,440	\$ 57,992	\$ 129,306	\$ -	\$ 505,570	\$ (1)
BENEFITS									
5620 FICA	\$ 37,911					\$ 37,911		\$ 37,911	\$ -
5640 WORKMENS COMP	\$ 1,932					\$ 1,932		\$ 1,932	\$ -
5650 UNEMPLOYMENT	\$ 983					\$ 983		\$ 983	\$ -
5660 DISABILITY	\$ -					\$ -		\$ -	\$ -
5690 401K	\$ -					\$ -		\$ -	\$ -
5750 OTHER	\$ 6,118					\$ 6,118		\$ 6,118	\$ -
Total BENEFITS:	\$ 46,944	\$ -	\$ -	\$ -	\$ -	\$ 46,944	\$ -	\$ 46,944	\$ -
CONTRACT SERVICES									
6460 ADMINISTRATION	\$ -					\$ -		\$ -	\$ -
6470 DATA PROCESSING	\$ 16,602						\$ 16,602	\$ 16,602	\$ -
Total CONTRACT SERVICES:	\$ 16,602	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 16,602	\$ 16,602	\$ -
SUPPLIES									
7420 MAINTENANCE	\$ -					\$ -	\$ -	\$ -	\$ -
7440 TRANSPORTATION	\$ -					\$ -	\$ -	\$ -	\$ -
7460 OFFICE	\$ 1,860					\$ 1,860	\$ -	\$ 1,860	\$ -
7470 COMPUTER SUPPLIES	\$ -					\$ -	\$ -	\$ -	\$ -
Total SUPPLIES:	\$ 1,860	\$ -	\$ -	\$ -	\$ -	\$ 1,860	\$ -	\$ 1,860	\$ -
GENERAL & ADMIN.									
8080 CABLE TV	\$ -					\$ -		\$ -	\$ -
9010 TELEPHONE	\$ 9,928					\$ 9,928		\$ 9,928	\$ -
9020 DUES & SUBSCRIPTIONS	\$ -					\$ -	\$ -	\$ -	\$ -
9040 INSURANCE	\$ 8,400					\$ 8,400		\$ 8,400	\$ -
9080 POSTAGE	\$ 76					\$ 76		\$ 76	\$ -
9100 LEGAL & ACCOUNTING	\$ -					\$ -	\$ -	\$ -	\$ -
9120 RECRUITMENT	\$ -					\$ -		\$ -	\$ -
9140 TRAVEL & SEMINAR	\$ 659					\$ 659		\$ 659	\$ -
9160 LICENSE & TAXES	\$ 364					\$ 364		\$ 364	\$ -
9170 DONATIONS	\$ 1,500					\$ 1,500		\$ 1,500	\$ -
9180 OTHER	\$ -					\$ -	\$ -	\$ -	\$ -
9190 COMMUNITY RELATIONS	\$ -					\$ -		\$ -	\$ -
Total GENERAL & ADMIN.:	\$ 20,927	\$ -	\$ -	\$ -	\$ -	\$ 20,927	\$ -	\$ 20,927	\$ -
INTEREST									
9340 INTEREST - AUTOS	\$ -					\$ -		\$ -	\$ -
Total INTEREST:	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total Expenses:	\$ 591,904	\$ 148,461	\$ 89,371	\$ 80,440	\$ 57,992	\$ 199,037	\$ 16,602	\$ 591,903	

Reimbursed by the facilities

Reimbursed by the facilities

Allocation to the Cost Reports		Winning Wheels	Big Meadows	STRIVE	Pinnacle Place	
Revenues	\$ 10,545,452	\$ 5,196,506	\$ 3,685,604	\$ 1,077,459	\$ 585,883	
		49.28%	34.95%	10.22%	5.56%	
Total Salary for benefit %	\$ 505,571	\$ 212,180	\$ 134,563	\$ 93,652	\$ 65,176	
		41.97%	26.62%	18.52%	12.89%	
Employee Benefits	\$ 56,871	\$ 23,867	\$ 15,137	\$ 10,535	\$ 7,332	\$ 56,872
Home Office Costs	\$ 12,859	\$ 6,337	\$ 4,494	\$ 1,314	\$ 714	\$ 12,859
Administrator	\$ 376,264	\$ 148,461	\$ 89,371	\$ 80,440	\$ 57,992	
Home Office Salaries	\$ 129,307	\$ 63,719	\$ 45,192	\$ 13,212	\$ 7,184	\$ 129,306
	\$ 575,301	\$ 242,384	\$ 154,194	\$ 105,501	\$ 73,222	\$ 199,037

Allocated to the facility cost reports

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 2015 report.		\$	41,500	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.)		\$	40,709	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(1,432)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	40,709	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.		\$	39,277	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2011	39,277	8	
	2012	38,421	9	
	2013	39,111	10	
	2014	38,078	11	
	2015	40,709	12	
				FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2015	\$	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:

- 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.**

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BIG MEADOWS COUNTY CARROLL

FACILITY IDPH LICENSE NUMBER 0021394

CONTACT PERSON REGARDING THIS REPORT ROBIN JACKSON

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 2015 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 2015.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>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 SAVL73 S3 R24 R3 PT</u>	\$ <u> </u>	\$ <u>40,709.00</u>
2. <u> </u>	<u>660' X 880' SE. & .28 AC ADJ</u>	\$ <u> </u>	\$ <u> </u>
3. <u> </u>	<u>N SIDE B77 P347 08-000-073-00</u>	\$ <u> </u>	\$ <u> </u>
4. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
TOTALS		\$ <u> </u>	\$ <u>40,709.00</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 XX 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

Facility Name & ID Number BIG MEADOWS

0021394

Report Period Beginning:

01/01/2016 Ending:

12/31/2016

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).

Empty lines for listing other business entities.

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.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Row 1: FACILITY GROUNDS, 580,800, 2001, \$ 139,000, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, 580,800, (blank), \$ 139,000, 3.

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

Report Period Beginning:

01/01/2016 Ending:

12/31/2016

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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	83	2001	1968	\$ 2,659,130	\$ 68,183	39	\$ 68,183	\$ (0)	\$ 1,079,567	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	2001 IMPROVEMENTS	2001	2001	1,182	65	15	65		1,182	9
10	2002 IMPROVEMENTS	2002	2002	265,858	13,496	19	13,496		197,009	10
11	2003 IMPROVEMENTS	2003	2003	103,349	3,738	14.17	3,738		89,578	11
12	2004 IMPROVEMENTS	2004	2004	73,880	4,655	12.5	4,655		66,510	12
13	2005 IMPROVEMENTS	2005	2005	62,770	2,529	15	2,529		49,862	13
14	2006 IMPROVEMENTS	2006	2006	4,514	225	17.5	225		3,028	14
15	2008 IMPROVEMENTS	2008	2008	58,716	3,594	16.88	3,594	0	33,294	15
16	30 TON CHILLER	2010	2010	28,082	2,808	10	2,808		19,658	16
17	HOSPICE ROOM FLOORING	2010	2010	5,335	356	15	356		2,312	17
18	DRAIN TILING AND DRAINAGE DITCH	2010	2010	4,600	460	10	460		2,990	18
19	SMOKE DETECTORS	2011	2011	3,433	229	15	229		1,373	19
20	FLOORING	2011	2011	3,308	473	7	473		3,072	20
21	ELEVATOR REPAIRS	2011	2011	6,456	922	7	922		5,995	21
22	FIRE RATED DOORS	2011	2011	935	134	7	134		868	22
23	FIRE PANEL ANNUCIATOR	2011	2011	4,368	291	15	291		1,650	23
24	FIRE RATED DOORS	2011	2011	7,672	1,096	7	1,096		6,028	24
25	FIRE RATED DOORS	2012	2012	2,609	373	7	373		1,677	25
26	FENCE FOR NEW E&F WING COURTYARD	2013	2013	8,713	1,089	7	1,089		5,991	26
27	FLOORING FOR NEW E&F WING DINING ACTIVITY AREA	2013	2013	5,601	800	7	800		2,801	27
28	PATH FOR NEW E&F WING COURTYARD	2013	2013	9,750	1,218	7	1,218		6,704	28
29	NEW HALLWAY DOORS FOR E&F WINGS	2013	2013	7,419	927	7	927		5,101	29
30	FIRE SUPPRESSION SYSTEM	2014	2014	335,902	13,436	25	13,436		44,786	30
31	TOILETS FOR E WINGS	2014	2014	6,043	403	15	403		1,343	31
32	ELEVATOR REPAIRS	2014	2014	2,449	245	10	245		857	32
33	INSTALL DOOR RESTRICTOR TO AD EDGE	2014	2014	2,449	350	7	350		875	33
34	NEW FLOORING	2014	2014	3,490	499	7	499		1,247	34
35	REMODEL DINING ROOM	2014	2014	2,117	302	7	302		756	35
36										36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	2014	\$ 7,300	\$ 730	10	\$ 730		\$ 1,095	37	
38	2015	2,249	321	7	321		803	38	
39	2015	8,532	853	10	853		2,133	39	
40	2015	836	167	5	167		418	40	
41	2015	23,700	1,580	15	1,580		2,765	41	
42	2016	3,926	280	7	561	281	841	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)		\$ 3,726,673	\$ 126,827		\$ 127,108	\$ 281	\$ 1,644,169	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 165,554	\$ 25,235	\$ 25,235	\$		\$ 122,591	71
72	Current Year Purchases	6,188	599	599			599	72
73	Fully Depreciated Assets	735,386					735,327	73
74								74
75	TOTALS	\$ 907,128	\$ 25,834	\$ 25,834	\$		\$ 858,517	75

D. Vehicle Costs. (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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 4,772,801	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 152,661	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 152,942	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 281	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,502,686	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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:	198	83	9/19/2001	\$ 102,000	20		3
4	Additions							4
5								5
6								6
7	TOTAL		83		\$ 102,000			7

10. Effective dates of current rental agreement:

Beginning 9/19/2001

Ending 9/19/2021

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

Fiscal Year Ending Annual Rent

12.	<u>12/31/2016</u>	\$ <u>102,000</u>
13.	<u>12/31/2017</u>	\$ <u>102,000</u>
14.	<u>12/31/2018</u>	\$ <u>102,000</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			\$ _____	\$ _____	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ _____	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?</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>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input checked="" type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input checked="" type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$ 4,855	\$ 4,855
2	Books and Supplies				
3	Classroom Wages (a)		5,148		5,148
4	Clinical Wages (b)		1,560		1,560
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 6,708	\$ 4,855	\$ 11,563
10	SUM OF line 9, col. 1 and 2 (e)	\$	6,708		

C. CONTRACTUAL INCOME

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

\$ 10,445

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	9
2. From other facilities (f)	7
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	16

- (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	Emp. Name	Regular Class End Date	Completed Y or N	Paid Hours	Paid Rate	Total Pay	Classroom Pay	Clinical Pay	SIUC/TUITI ON
Wheels	Boutwell, Katherine	4/14/2016	Y	0	\$ -	\$ -	\$ -	\$ -	\$ 65.00
Wheels	Frederick, Jolynn	4/14/2016	Y	0	\$ -	\$ -	\$ -	\$ -	\$ 65.00
Wheels	Perez, Yvonny	4/14/2016	Y	0	\$ -	\$ -	\$ -	\$ -	\$ 65.00
Wheels	Donovan, Destiney	9/29/2016	Y	121.75	\$ 8.25	#####	\$792.00	\$212.44	\$ 65.00
Wheels	Friedmann, Jolene	9/29/2016	Y	125.75	\$ 8.25	#####	\$792.00	\$245.44	\$ 65.00
Wheels	Lang, Samantha	9/29/2016	Y	133.33	\$ 8.25	#####	\$792.00	\$307.97	\$ 65.00
Wheels	Underwood, Maria	9/29/2016	Y	132.58	\$ 8.25	#####	\$792.00	\$301.79	\$ 65.00
Wheels	Smith, Annette	12/8/2016	Y	122.92	\$ 8.25	#####	\$792.00	\$222.09	\$ 65.00
Wheels	Wilson, EmmaLee	12/8/2016	Y	128.8	\$ 8.25	#####	\$792.00	\$270.60	\$ 65.00
Other	Sumner, Destiney	12/15/2016	Y	24	\$ 8.25	\$ 198.00	\$198.00	\$ -	\$ 610.00
Other	Brubacher, Cheyan	12/15/2016	Y	24	\$ 8.25	\$ 198.00	\$198.00	\$ -	\$ 610.00
Other	Pettera, Sabrina	4/15/2016	Y	0	\$ 8.25	\$ -	\$ -	\$ -	\$ 610.00
Other	Suprimido, Julius	5/20/2016	Y	0	\$ 8.25	\$ -	\$ -	\$ -	\$ 610.00
Other	Allred, Delton	6/3/2016	Y	0	\$ 8.25	\$ -	\$ -	\$ -	\$ 610.00
Other	Carter, Krista	6/3/2016	Y	0	\$ 8.25	\$ -	\$ -	\$ -	\$ 610.00
Other	Soto, Cindy	2/5/2016	Y	0	\$ 8.25	\$ -	\$ -	\$ -	\$ 610.00
				813.13		#####	#####	#####	#####

Completed Wheels	9	765.13	6,312.32	#####	#####	585.00
Completed Other	7	48	396	396	0	4270
Drop-Out Wheels	0	-	\$ -	\$ -	\$ -	
Drop-Out Other	0	0				
Total	16	813.13				

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10A.3	hrs			99	\$ 2,121		99	\$ 2,121	1
2	Licensed Speech and Language Development Therapist	10A.3	hrs								2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	10A.3	hrs			92	1,833		92	1,833	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): MEDICARE THERAPY					5,042	115,488		5,042	115,488	12
13	Other (specify): OXYGEN							22,258		22,258	13
14	TOTAL				\$	5,233	\$ 119,441	\$ 22,258	5,233	\$ 141,699	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2016**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (22,167)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>69,482</u>)	1,097,184		3
4	Supply Inventory (priced at <u>COST</u>)	20,593		4
5	Short-Term Investments			5
6	Prepaid Insurance	19,247		6
7	Other Prepaid Expenses	20,964		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,135,820	\$	10
	B. Long-Term Assets			
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	45,205		15
16	Equipment, at Historical Cost	907,128		16
17	Accumulated Depreciation (book methods)	(890,490)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>CONSTRUCTION IN PRO</u>	8,265		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 87,258	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,223,078	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 434,778	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	187,923		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,566		31
32	Accrued Real Estate Taxes(Sch.IX-B)	40,069		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>PROVIDER TAX ASSESSMENT</u>	90,978		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 756,314	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,319,115		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,319,115	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,075,429	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (852,351)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,223,078	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (849,904)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (849,904)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,447)	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)	\$ (2,447)	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)	\$ (852,351)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number BIG MEADOWS

0021394

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

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	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,720,679	1
2	Discounts and Allowances for all Levels	(24,000)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,696,679	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	188,449	6
7	Oxygen	6,076	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 194,525	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	10,445	11
12	Gift and Coffee Shop	1,762	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	9,654	14
15	Telephone, Television and Radio		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)	\$ 21,861	23
D. Non-Operating Revenue			
24	Contributions	638	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 638	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>TRANSPORTATION</u>	1,596	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,596	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,915,300	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	821,856	31
32	Health Care	1,932,145	32
33	General Administration	664,243	33
B. Capital Expense			
34	Ownership	269,809	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	229,694	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,917,747	40
41	Income before Income Taxes (line 30 minus line 40)**	(2,447)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (2,447)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,332,375	44
45	Private Pay - Net Inpatient Revenue	1,374,467	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) <u>SUPPLIES</u>	13,837	47
48	Other-(specify) <u>ALLOWANCES</u>	(24,000)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,696,679	49

* 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: 01/01/2016

Ending:

12/31/2016

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	1,940	2,224	\$ 80,313	\$ 36.11	1
2	Assistant Director of Nursing					2
3	Registered Nurses	14,095	15,902	425,212	26.74	3
4	Licensed Practical Nurses	1,246	13,206	289,069	21.89	4
5	CNAs & Orderlies	47,283	50,269	575,477	11.45	5
6	CNA Trainees	7,183	7,251	66,125	9.12	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,061	4,459	49,714	11.15	8
9	Activity Director	2,601	2,698	41,597	15.42	9
10	Activity Assistants					10
11	Social Service Workers	2,859	3,074	62,679	20.39	11
12	Dietician					12
13	Food Service Supervisor	1,975	2,103	35,810	17.03	13
14	Head Cook	4,605	4,853	57,253	11.80	14
15	Cook Helpers/Assistants	11,415	11,918	107,497	9.02	15
16	Dishwashers					16
17	Maintenance Workers	6,031	6,558	91,563	13.96	17
18	Housekeepers	5,546	5,834	57,930	9.93	18
19	Laundry	5,932	6,437	66,860	10.39	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	2,156	2,308	61,875	26.81	22
23	Office Manager	1,869	2,064	22,367	10.84	23
24	Clerical					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	1,869	2,064	23,374	11.32	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	122,666	143,222	\$ 2,114,715 *	\$ 14.77	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	233	\$ 11,676	1.3	35
36	Medical Director	125	27,671	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	428	5,155	10.3	39
40	Physical Therapy Consultant				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)	786	\$ 44,502		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	89	\$ 3,920	10.3	50
51	Licensed Practical Nurses	108	3,798	10.3	51
52	Certified Nurse Assistants/Aides	4,572	145,183	10.3	52
53	TOTAL (lines 50 - 52)	4,769	\$ 152,901		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount	
<u>PAT BOOMGARDEN</u>		<u>0</u>	\$ <u>89,371</u>	<u>Workers' Compensation Insurance</u>	\$ <u>50,536</u>	<u>IDPH License Fee</u>	\$	
<u>(INCLUDED IN AHE FEE BELOW)</u>				<u>Unemployment Compensation Insurance</u>	<u>18,551</u>	<u>Advertising: Employee Recruitment</u>	<u>2,921</u>	
				<u>FICA Taxes</u>	<u>164,094</u>	<u>Health Care Worker Background Check</u>		
				<u>Employee Health Insurance</u>	<u>55,760</u>	<u>(Indicate # of checks performed <u>57</u>)</u>	<u>1,130</u>	
				<u>Employee Meals</u>		<u>Patient Background Checks <u>25</u></u>	<u>500</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>DUES AND SUBSCRIPTIONS</u>	<u>1,388</u>	
				<u>LIFE/VISION/SUPP INS</u>	<u>7,669</u>	<u>PUBLIC RELATIONS</u>	<u>909</u>	
				<u>DENTAL INS</u>	<u>5,142</u>	<u>LICENSE</u>	<u>3,552</u>	
				<u>RETIREMENT</u>	<u>10,361</u>	<u>ADVERTISING / MARKETING</u>	<u>4,908</u>	
				<u>PHYSICALS</u>	<u>377</u>			
				<u>PROFESSIONAL LICENSES / TUITION</u>	<u>490</u>	<u>Less: Public Relations Expense</u>	<u>(909)</u>	
				<u>EMPLOYEE RECOGNITIONS</u>	<u>3,684</u>	<u>Non-allowable advertising</u>	<u>(4,908)</u>	
				<u>HOME OFFICE ALLOCATION</u>	<u>15,137</u>	<u>Yellow page advertising</u>	<u>()</u>	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ <u>89,371</u>	TOTAL (agree to Schedule V,	\$ <u>331,801</u>	TOTAL (agree to Sch. V,	\$ <u>9,491</u>	
(List each licensed administrator separately.)				line 22, col.8)		line 20, col. 8)		
B. Administrative - Other			Amount	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
Description			Amount	Description	Line #	Amount		
<u>AMERICAN HEALTH ENTERPRISES INC</u>			\$ <u>93,798</u>			\$		
TOTAL (agree to Schedule V, line 17, col. 3)			\$ <u>93,798</u>					
(Attach a copy of any management service agreement)								
C. Professional Services			Amount	G. Schedule of Travel and Seminar**				
Vendor/Payee	Type		Amount <th style="text-align: left;">Description</th> <td></td> <th style="text-align: right;">Amount</th> <td></td>	Description		Amount		
<u>RELIAS</u>	<u>TRAINING SOFTWARE</u>		\$ <u>3,125</u>	<u>Out-of-State Travel</u>		\$ <u>(144)</u>		
<u>JOHN PYSE CONSULTING</u>	<u>COMPUTER CONSULT</u>		<u>7,257</u>					
<u>MIDWEST AUTOMATED TIME</u>	<u>TIMECLOCK MAINT</u>		<u>1,011</u>	<u>In-State Travel</u>		<u>2,640</u>		
<u>CAREVOYANT</u>	<u>SOFTWARE MAINT</u>		<u>1,441</u>					
<u>MEDIPROCITY</u>	<u>SOFTWARE MAINT</u>		<u>2,490</u>	<u>Seminar Expense</u>		<u>632</u>		
<u>WARD MURRAY PACE JOHN</u>	<u>ATTORNEY</u>		<u>12,959</u>					
<u>AATRIX SOFTWARE</u>	<u>GO TO MY PC SOFTWARE</u>		<u>210</u>	<u>Entertainment Expense</u>		<u>()</u>		
TOTAL (agree to Schedule V, line 19, column 3)			\$ <u>28,493</u>	TOTAL		\$ <u>3,128</u>		
(For legal fee disclosure, see page 39 of instructions)								

* Attach copy of IMRF notifications

**See instructions.

BIG MEADOWS - 0021394
Report Period Beginning 01/01/15
Report Period Ending 12/31/2015

Total Cost

1	Name & Title	Pat Boomgarden, Administrator Joan Anderson, Director of Nursing	
	Date Traveled	3/10/2015	
	Location	DeKalb, IL	
	Title	NHRMA	
	Sponsor	NHRMA	
	Total Cost	\$103.50	103.50
2	Name & Title	Julie Johnson, Social Services Dani Wilcox, Unit Director Trinity Solomon, Unit Activity Director	
	Date Traveled	3/6/2015	
	Location	Mt. Morris, IL	
	Title	Demented	
	Sponsor	Mt. Morris Community College	
	Total Cost	\$49.84	49.84
3	Name & Title	Dani Wilcox, Unit Director Trinity Solomon, Unit Activity Director	
	Date Traveled	3/12/2015	
	Location	Fennimore, WI	
	Title	Alzheimers & Dementia	
	Sponsor	Alzheimers & Dementia Alliance	
	Total Cost	\$143.50	143.50
4	Name & Title	Julie Johnson, Social Services Dani Wilcox, Unit Director	
	Date Traveled	9/16/2015	
	Location	Peoria, IL	
	Title	National Council of Dementia	
	Sponsor	National Council of Dementia Practitioners	
	Total Cost	\$297.60	297.60
5	Name & Title	Julie Johnson, Social Services Dani Wilcox, Unit Director Joan Anderson, Director of Nursing	
	Date Traveled	11/13/2015	
	Location	Mt. Morris, IL	
	Title	Regional Pioneer Coalition of IL	
	Sponsor	Pinecrest Community	
	Total Cost	\$37.43	37.43

Total Seminars	\$632.00
Mileage	\$3,975.00
	<u>\$4,607.00</u>

Total - Schedule V, Line 24 - Other	\$4,607.00
Total - Schedule V, Line 24 - Adjustments	\$0.00
Total - Schedule V, Line 24 - 8	<u>\$4,607.00</u>

Facility Name & ID Number **BIG MEADOWS**# **0021394**Report Period Beginning: **01/01/2016**Ending: **12/31/2016****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? NO
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 7 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 35,020 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 XX NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO XX 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. \$ 229,694
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. \$ 9,654
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? YES
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such 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? YES
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. \$ _____
- (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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. YES
Attach invoices and a summary of services for all architect and appraisal fees