FOR BHF USE

LL1

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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

I. IDPH License ID Number: 0021394

Facility Name: BIG MEADOWS INC

Address: 1000 LONGMOOR AVE (Number) SAVANNA (City) 61074 (Zip Code)

County: CARROLL

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

HFS ID Number:

Date of Initial License for Current Owners: 10/21/1976

Type of Ownership:

	VOLUNTARY,NON-PROFIT	XX	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		XX	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: MILT RUE **Telephone Number:** 815-778-3683
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2011 to 12/31/2011 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date) 6/14/2012

(Type or Print Name) MILT RUE

(Title) CHIEF FINANCIAL OFFICER

Paid Preparer

(Signed) (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

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

Facility Name & ID Number BIG MEADOWS INC # 0021394 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	12,279	3,722		16,001	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,279	3,722		16,001	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 44.73%

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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

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 [X] Date 09/19/2001 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2011 Fiscal Year: 12/31/2011

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

Facility Name & ID Number BIG MEADOWS INC # 0021394 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	165,893	11,087	8,325	185,305		185,305		185,305			1
2	Food Purchase		131,551		131,551		131,551	(8,388)	123,163			2
3	Housekeeping	52,982	17,751		70,733		70,733		70,733			3
4	Laundry	47,260	10,677		57,937		57,937		57,937			4
5	Heat and Other Utilities			147,556	147,556		147,556	(8,894)	138,662			5
6	Maintenance	67,483	20,029	27,148	114,660		114,660		114,660			6
7	Other (specify):*											7
8	TOTAL General Services	333,618	191,095	183,029	707,742		707,742	(17,282)	690,460			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	869,038	75,464	1,583	946,085	(13,761)	932,324		932,324			10
10a	Therapy			7,861	7,861	(7,607)	254		254			10a
11	Activities	37,363	3,947		41,310		41,310		41,310			11
12	Social Services	46,148			46,148		46,148		46,148			12
13	CNA Training			1,159	1,159	1,524	2,683		2,683			13
14	Program Transportation		6,583	11,025	17,608	(11,294)	6,314		6,314			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	952,549	85,994	45,628	1,084,171	(31,138)	1,053,033		1,053,033			16
	C. General Administration											
17	Administrative			118,200	118,200		118,200	14,796	132,996			17
18	Directors Fees											18
19	Professional Services			24,068	24,068		24,068		24,068			19
20	Dues, Fees, Subscriptions & Promotions			26,454	26,454		26,454	(15,818)	10,636			20
21	Clerical & General Office Expenses	20,889	18,335	10,412	49,636		49,636	4,995	54,631			21
22	Employee Benefits & Payroll Taxes			206,537	206,537		206,537	19,244	225,781			22
23	Inservice Training & Education			249	249		249		249			23
24	Travel and Seminar			3,121	3,121	(1,032)	2,089	(153)	1,936			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			22,831	22,831		22,831		22,831			26
27	Other (specify):* SALES TAX			506	506		506	(506)				27
28	TOTAL General Administration	20,889	18,335	412,378	451,602	(1,032)	450,570	22,558	473,128			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,307,056	295,424	641,035	2,243,515	(32,170)	2,211,345	5,276	2,216,621			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 & ID Number BIG MEADOWS INC #0021394 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			26,881	26,881		26,881	105,191	132,072			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			15,574	15,574		15,574	106,225	121,799			32
33	Real Estate Taxes			52,334	52,334		52,334		52,334			33
34	Rent-Facility & Grounds			128,928	128,928		128,928	(128,928)				34
35	Rent-Equipment & Vehicles			6,000	6,000	(4,200)	1,800		1,800			35
36	Other (specify):*											36
37	**TOTAL Ownership**			229,717	229,717	(4,200)	225,517	82,488	308,005			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					16,526	16,526		16,526			38
39	Ancillary Service Centers					19,844	19,844		19,844			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			102,804	102,804		102,804		102,804			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			102,804	102,804	36,370	139,174		139,174			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,307,056	295,424	973,556	2,576,036		2,576,036	87,764	2,663,800			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 – 01/01/2011
Report Period Ending – 12/31/2011

RECLASSIFICATIONS, Pages 3 & 4		Dr.	Cr.	Line #
MEDICALLY NECASSRY TRANSPORTATION	Medically Necessary Transportation	16,526		38
	Program Transportation		12,326	14
	Rent-Equipment and Vehicles		4,200	35
TRAVEL & SEMINAR FOR NURSING STAFF	Program Transportation	1,032		14
	Travel and Seminar		1,032	24
PUBLIC AID OXYGEN	Ancillary Service Center	12,237		39
	Nursing & Medical Records		12,237	10
NURSE AID TRAINING CLASS	CNA Training	1,524		13
	Nursing and Medical Records		1,524	10
MEDICARE REIMBURSED THERAPY	Ancillary Service Center	7,607		39
	Therapy		7,607	10a

Facility Name & ID Number BIG MEADOWS INC # 0021394 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(8,388)	2		4
5	Telephone, TV & Radio in Resident Rooms	(8,894)	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	(506)	27		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,000)	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	(12,392)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,749)	20		28
29	Other-Attach Schedule SEE PAGE 5A	(830)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (33,759)		$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (33,759)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$ 16,526	14, 35	38
39	PUBLIC AID OXYGEN			12,237	10	39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	THERAPY			7,607	10a	44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 36,370		47

BIG MEADOWS INC

ID# 0021394

Report Period Beginning: 01/01/2011

Ending: 12/31/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	OUT OF STATE TRAVEL	$ (153)	24	1
2	PUBLIC RELATIONS	(677)	20	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**	(830)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BIG MEADOWS INC # 0021394 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(8,388)	0	0	0	0	0	0	0	0	0	0	(8,388)	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	(8,894)	0	0	0	0	0	0	0	0	0	0	(8,894)	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**	(17,282)	0	0	0	0	0	0	0	0	0	0	(17,282)	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	14,796	0	0	0	0	0	0	0	0	0	14,796	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	(15,818)	0	0	0	0	0	0	0	0	0	0	(15,818)	20
21	Clerical & General Office Expenses	0	4,995	0	0	0	0	0	0	0	0	0	4,995	21
22	Employee Benefits & Payroll Taxes	0	19,244	0	0	0	0	0	0	0	0	0	19,244	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(153)	0	0	0	0	0	0	0	0	0	0	(153)	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):*	(506)	0	0	0	0	0	0	0	0	0	0	(506)	27
28	**TOTAL General Administration**	(16,477)	39,035	0	0	0	0	0	0	0	0	0	22,558	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(33,759)	39,035	0	0	0	0	0	0	0	0	0	5,276	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BIG MEADOWS INC **#** 0021394 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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

	Capital Expense D. Ownership	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)	
30	Depreciation	0	105,191	0	0	0	0	0	0	0	0	0	105,191	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	106,225	0	0	0	0	0	0	0	0	0	106,225	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(128,928)	0	0	0	0	0	0	0	0	0	(128,928)	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	82,488	0	0	0	0	0	0	0	0	0	82,488	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)**	(33,759)	121,523	0	0	0	0	0	0	0	0	0	87,764	45

Facility Name & ID Number BIG MEADOWS INC # 0021394 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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
AMERICAN HEALTH ENTERPRISES INC	100	WINNING WHEELS (BUILDING OWNER)	PROPHETSTOWN			
ALAN GAPINSKI	100					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	$ 128,928	WINNING WHEELS INC - 100% BUILDING OWNER		$	$ (128,928)	1
2	V	30	DEPRECIATION		WINNING WHEELS INC - 100% BUILDING OWNER		105,191	105,191	2
3	V	32	INTEREST		WINNING WHEELS INC - 100% BUILDING OWNER		106,225	106,225	3
4	V	17	PROFESSIONAL SERVICES	118,200	AMERICAN HEALTH ENTERPRISES INC	100.00%		(118,200)	4
5	V	17	HOME OFFICE COSTS		AMERICAN HEALTH ENTERPRISES INC		132,996	132,996	5
6	V	21	HOME OFFICE COSTS		AMERICAN HEALTH ENTERPRISES INC		4,995	4,995	6
7	V	22	HOME OFFICE COSTS		AMERICAN HEALTH ENTERPRISES INC		19,244	19,244	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 247,128			$ 368,651	$ * 121,523	14

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

Facility Name & ID Number BIG MEADOWS INC # 0021394 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		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				201,000						3
4	MANAGEMENT FEES FROM STRIVE				121,998						4
5	MANAGEMENT FEES FROM PINNACLE PLACE				39,417						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 INC # 0021394 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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 [X] NO [ ]

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

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

	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	17	Admin. Home Office Salaries	GROSS REVENUES	8,119,596	4	$ 193,232	$ 193,232	2,335,460	$ 55,580	1
2	17	Administrator Salary	DIRECT COST	1	1	77,416	77,416	1	77,416	2
3	22	Employee Benefits	% OF PAYROLL	471,518	4	68,228	0	132,996	19,244	3
4	21	Office costs	GROSS REVENUES	8,119,596	4	17,365	0	2,335,460	4,995	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					$ 356,241	$ 270,648		$ 157,235	25

Facility Name & ID Number BIG MEADOWS INC # 0021394 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	MIDLAND BANK		X	BUILDING MORTGAGE	$12,058.57	06/2004	$ 1,730,000	$ 1,482,139	06/30/29	6.9000	$ 106,225	1
2												2
3												3
4												4
5												5
	Working Capital											
6	WINNING WHEELS INC	X		WORKING CAPITAL	PAID OFF	03/2005	300,000		03/2011	6.2000	77	6
7	WINNING WHEELS INC	X		WORKING CAPITAL	INT. ONLY	10/2009	750,000	642,000	10/2014	5.0000	15,497	7
8												8
9	TOTAL Facility Related				$12,058.57		$ 2,780,000	$ 2,124,139			$ 121,799	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,780,000	$ 2,124,139			$ 121,799	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.)**

Facility Name & ID Number BIG MEADOWS INC # 0021394 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 58,000	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.)		$ 57,608	2
3. Under or (over) accrual (line 2 minus line 1).		$ (392)	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 52,725	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.		$ 52,334	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	48,216	8
	2007	56,248	9
	2008	56,539	10
	2009	57,462	11
	2010	57,180	12

4. 2011 ACCRUAL BASED ON TAX BILL HISTORY AND A CHANGE IN THE BUILDING VALUE

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BIG MEADOWS INC 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 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-07-03-400-003	77 SAV L73 S3 T24 R3 PT	$ 57,179.60	$ 57,179.60
2.		660' X 880' SE. & .28 AC ADJ	$	$
3.		N SIDE B77 P347 08-000-073-00	$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 57,179.60	$ 57,179.60

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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

CARROLL COUNTY PROPERTY TAX BILL
2010 PAYABLE 2011

PLEASE READ the instructions on the back of this bill regarding when to pay 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 Collector 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.

LEGAL DESC:
77 SAV L73 S3 T24 R3 PT 660' X 880' SE.&
.28 AC ADJ N SIDE B77 P347

08-000-073-00

PROPERTY INDEX NUMBER (PIN)	08-07-03-400-003
PROPERTY CLASS	0050
FIRST DUE DATE	07/01/2011
FIRST INSTALLMENT	$28,589.80
SECOND DUE DATE	09/01/2011
SECOND INSTALLMENT	$28,589.80
PRIOR TAX SOLD	
FORFEITED	

NAME: WINNING WHEELS INC
%GAPINSKI AL
701 E 3RD ST
PROPHETSTOWN, IL 61277-1334

TAX CODE	CARROLL COUNTY ITEMIZED STATEMENT	TOWNSHIP
08003		Savanna Township

Taxing Body		Prior Year Rate	Prior Year Amount	Current Rate	Current Amount	% of Total
TRI-TWP MUNICIPAL AIRPRT		0.05516	$317.91	0.05767	$322.40	0.56
CARROLL COUNTY		0.65489	$3,774.35	0.68398	$3,823.74	6.69
CARROLL COUNTY	PENSION	0.15345	$884.38	0.16227	$907.16	1.59
HIGHLAND JC 519		0.46865	$2,700.98	0.47662	$2,664.51	4.66
HIGHLAND JC 519	PENSION	0.00834	$48.07	0.00848	$47.41	0.08
SAVANNA LIBRARY DIST		0.20849	$1,201.60	0.21344	$1,193.22	2.09
SAVANNA LIBRARY DIST	PENSION	0.03212	$185.11	0.03495	$195.39	0.34
SAVANNA PARK DIST		0.60982	$3,514.59	0.63330	$3,540.42	6.19
SAVANNA PARK DIST	PENSION	0.06787	$391.16	0.06339	$354.38	0.62
SAVANNA TWP		0.17159	$988.93	0.17420	$973.85	1.70
SAVANNA R&B		0.14480	$834.53	0.14699	$821.74	1.44
SAVANNA U300 BOND		0.00000	$0.00	0.00000	$0.00	0.00
WEST CARROLL U314		5.13076	$29,570.25	5.26641	$29,441.52	51.49
WEST CARROLL U314	PENSION	0.47963	$2,764.28	0.40313	$2,253.65	3.94
SAVANNA CORP		1.18053	$6,803.79	1.28374	$7,176.66	12.55
SAVANNA CORP	PENSION	0.60425	$3,482.49	0.61955	$3,463.55	6.06
Totals		9.97035	$57,462.42	10.22812	$57,179.60	

LOCATION: 1000 LONGMOOR
SAVANNA, IL

Owner Name: WINNING WHEELS INC

PLEASE SEE REVERSE SIDE FOR PAYMENT INFORMATION

1977 EQUALIZED	0
SAF BASE	0
FAIR CASH VALUE	1,677,129
TOTAL ACRES	13.33
TIF BASE	0
LAND VALUE	46,879
+ BUILDING VALUE	512,164
+ FARM BUILDING	0
+ FARM LAND	0
+HOME IMPROVEMENT	0
- DISABLE VET EXEMPT	0
ASSESSED VALUE	559,043
x STATE MULTIPLIER	1.0000
= EQUALIZED VALUE	559,043
- OWNER OCCUPIED	0
- SENIOR EXMPT	0
- FREEZE EXEMPTIONS	0
- RT VETERAN EXEMPT	0
- DISABLE VET EXEMPT	0
- DISABLE PER EXEMPT	0
= NET TAXABLE VAL.	559,043
x TAX RATE	10.22812
= CURRENT TAX	$57,179.60
- ENTERPRISE ZONE	$0.00
+ FORFEITURE BAL.	$0.00
= TOTAL TAX DUE	$57,179.60

RETURN THIS PORTION WITH PAYMENT

FOR THE YEAR 2010	FORFEITED TAXES OR YEARS	
PROPERTY INDEX NUMBER(PIN) 08-07-03-400-003	FIRST INSTALLMENT $28,589.80	
	DUE DATE 07/01/2011	
PAID BY	PENALTY	COSTS
TOTAL TAX DUE $57,179.60	AMOUNT PAID	

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

RETURN THIS PORTION WITH PAYMENT

FOR THE YEAR 2010	FORFEITED TAXES OR YEARS	
PROPERTY INDEX NUMBER(PIN) 08-07-03-400-003	SECOND INSTALLMENT $28,589.80	
	DUE DATE 09/01/2011	
PAID BY	PENALTY	COSTS
TOTAL TAX DUE $57,179.60	AMOUNT PAID	

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

Facility Name & ID Number BIG MEADOWS INC # 0021394 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

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

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

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

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY GROUNDS	580,800	2001	$ 139,000	1
2					2
3	TOTALS	580,800		$ 139,000	3

Facility Name & ID Number BIG MEADOWS INC # 0021394 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	98		2001	1968	$ 2,659,130	$ 68,183	39	$ 68,183	$	$ 670,470	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	2001 IMPROVEMENTS			2001	1,182	79	15	79		801	9
10	2002 IMPROVEMENTS			2002	265,857	13,495	18	13,495		117,301	10
11	2003 IMPROVEMENTS			2003	103,350	7,541	14	7,541		59,946	11
12	2004 IMPROVEMENTS			2004	73,880	5,061	13	5,061		37,567	12
13	2005 IMPROVEMENTS			2005	62,770	4,476	15	4,476		34,688	13
14	2006 IMPROVEMENTS			2006	4,514	287	18	287		1,371	14
15	OUTSIDE LIGHT FIXTURES			2008	2,813	141	20	141		445	15
16	KITCHEN AREA HORN			2008	854	57	15	57		180	16
17	HOME FREE SYSTEM			2008	23,201	1,160	20	1,160		3,674	17
18	ORNAMENTAL FENCE			2008	3,836	192	20	192		591	18
19	FIRE DAMPERS			2008	5,487	274	20	274		846	19
20	FIRE DOORS			2008	9,647	482	20	482		1,487	20
21	SEALCOAT PARKING LOTS			2008	6,324	632	10	632		2,213	21
22	CCTV EQUIPMENT INSTALLATION			2008	6,554	655	10	655		2,294	22
23	30 TON CHILLER			2010	28,082	2,808	10	2,808		4,212	23
24	DRAIN TILING AND DRAINAGE DITCH			2010	4,600	460	10	460		690	24
25	HOSPICE ROOM FLOORING			2010	5,335	356	15	356		534	25
26	FLOORING			2011	3,308	236	7	236		236	26
27	ELEVATOR REPAIRS			2011	6,456	461	7	461		461	27
28	FIRE RATED DOORS			2011	935	67	7	67		67	28
29	FIRE RATED DOORS			2011	7,672	192	20	192		192	29
30	SMOKE DETECTORS			2011	3,433	229	15	229		229	30
31	FIRE PANEL ANNUNCIATOR			2011	4,368	194	15	194		194	31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number BIG MEADOWS INC # 0021394 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,293,588	$ 107,718		$ 107,718	$	$ 940,689	70

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

Facility Name & ID Number BIG MEADOWS INC # 0021394 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	$ 170,525	$ 21,550	$ 21,550	$	VARIOUS	$ 113,276	71
72	Current Year Purchases	39,258	2,804	2,804		VARIOUS	2,804	72
73	Fully Depreciated Assets	595,585					595,585	73
74								74
75	TOTALS	$ 805,368	$ 24,354	$ 24,354	$		$ 711,665	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	TRANSPORTATION	1997 CHEVY VAN	1997	$ 29,205	$	$	$	5	$ 29,205	76
77										77
78										78
79										79
80	TOTALS			$ 29,205	$	$	$		$ 29,205	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,267,161	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 132,072	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 132,072	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)	$ 1,681,559	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number BIG MEADOWS INC # 0021394 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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. [X] 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:	1968	98	9/19/01	$ 128,928	20		3
4	Additions							4
5								5
6								6
7	TOTAL		98		$ 128,928 **			7

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: [X] YES [ ] NO Terms: VARIOUS *

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.	12/31/2012	$ 132,386
13.	12/31/2013	$ 161,805
14.	12/31/2014	$ 191,224

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] 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	TRANSPORTATION	2005 FORD VAN	$ 500.00	$ 6,000	17
18					18
19					19
20					20
21	TOTAL		$ 500.00	$ 6,000	21

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

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

Facility Name & ID Number BIG MEADOWS INC # 0021394 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [X]
- COMMUNITY COLLEGE [ ]
- HOURS PER CNA 96

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [X]
- HOURS PER CNA 48

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies	50	75		125
3	Classroom Wages (a)	493	523		1,016
4	Clinical Wages (b)		508		508
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments	320	639		959
8	CNA Competency Tests		75		75
9	TOTALS	$ 863	$ 1,820	$	$ 2,683
10	SUM OF line 9, col. 1 and 2 (e)	$ 2,683			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number BIG MEADOWS INC # 0021394 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a.3	hrs	$	1	$ 86	$	1	$ 86	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs		32	1,575		32	1,575	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$	33	$ 1,661	$	33	$ 1,661	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.

STATE OF ILLINOIS

Facility Name & ID Number BIG MEADOWS INC # 0021394 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2011 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 11,158	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 6,708)	763,554		3
4	Supply Inventory (priced at COST)	31,062		4
5	Short-Term Investments			5
6	Prepaid Insurance	5,320		6
7	Other Prepaid Expenses	3,319		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 814,413	$	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	39,604		15
16	Equipment, at Historical Cost	834,573		16
17	Accumulated Depreciation (book methods)	(757,948)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 133,379	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 947,792	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 154,745	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	63,734		30
31	Accrued Taxes Payable (excluding real estate taxes)	20,230		31
32	Accrued Real Estate Taxes(Sch.IX-B)	52,725		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	PROVIDER TAX ASSESSMENT	49,149		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 340,583	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,139,881		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	DUE TO AHE INC.	107,728		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,247,609	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,588,192	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (640,400)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 947,792	$	48

***(See instructions.)**

Facility Name & ID Number BIG MEADOWS INC # 0021394 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 143,699	1
2	Restatements (describe):		2
3	WRITE OFF DUE FROM OTHER FACILTIES	(572,868)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (429,169)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(211,231)	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)**	$ (211,231)	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)**	$ (640,400)	24 *

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

Facility Name & ID Number BIG MEADOWS INC # 0021394 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,335,460	1
2	Discounts and Allowances for all Levels	(12,000)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,323,460	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	7,607	6
7	Oxygen	12,237	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 19,844	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	4,128	11
12	Gift and Coffee Shop	699	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	8,388	14
15	Telephone, Television and Radio	6,815	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)**	$ 20,030	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	TRANSPORTATION	967	28
28a	SNOW PLOWING FOR OTHER FACILITIES	503	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,470	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,364,805	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	707,742	31
32	Health Care	1,084,171	32
33	General Administration	451,602	33
	B. Capital Expense		
34	Ownership	229,717	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	102,804	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,576,036	40
41	**Income before Income Taxes (line 30 minus line 40)****	(211,231)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (211,231)	43

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

****** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

******* **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number BIG MEADOWS INC # 0021394 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,972	2,108	$ 63,371	$ 30.06	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,872	8,062	181,350	22.49	3
4	Licensed Practical Nurses	8,867	9,335	188,191	20.16	4
5	CNAs & Orderlies	37,478	39,636	414,116	10.45	5
6	CNA Trainees	169	169	1,524	9.02	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,929	2,135	27,711	12.98	9
10	Activity Assistants	994	1,032	9,652	9.35	10
11	Social Service Workers	1,927	2,093	46,148	22.05	11
12	Dietician					12
13	Food Service Supervisor	1,935	2,139	36,737	17.17	13
14	Head Cook	3,637	4,027	41,353	10.27	14
15	Cook Helpers/Assistants	9,299	10,110	87,803	8.68	15
16	Dishwashers					16
17	Maintenance Workers	4,985	5,320	67,483	12.68	17
18	Housekeepers	5,350	5,857	52,982	9.05	18
19	Laundry	4,463	4,820	47,260	9.80	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,820	1,883	19,281	10.24	23
24	Clerical	170	187	1,608	8.60	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	1,686	1,820	20,487	11.26	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	94,553	100,733	$ 1,307,057 *	$ 12.98	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	167	$ 8,325	1.3	35
36	Medical Director	120	24,000	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	40	1,583	10.3	39
40	Physical Therapy Consultant	32	1,575	10a.3	40
41	Occupational Therapy Consultant	1	86	10a.3	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	Physical Therapy Aide Consultant	124	6,200	10a.3	47
48					48
49	TOTAL (lines 35 - 48)	483	$ 41,769		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

Facility Name & ID Number BIG MEADOWS INC # 0021394 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
PAT BOOMGARDEN	ADMINISTRATOR	0	$ 77,416
(Included in AMERICAN HEALTH ENTERPRISES Fee in B below)			(77,416)
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
AMERICAN HEALTH ENTERPRISES	$ 118,200
TOTAL (agree to Schedule V, line 17, col. 3)	$ 118,200
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
MDI ACHIEVE	SOFTWARE MAINTENAN	$ 10,770
JOHN PYSE CONSULTING	COMPUTER CONSULTING	4,551
MIDWEST AUTOMATED TIME	TIME CLOCK MAINTENANC	650
NURSING HOME QUALITY	QIS SOFTWARE MAINTENAN	2,280
WARD, MURRAY, PACE, & JOHN	LEGAL SERVICES	5,817
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 24,068

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 52,008
Unemployment Compensation Insurance	18,153
FICA Taxes	96,566
Employee Health Insurance	20,138
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
LIFE INSURANCE	2,850
DENTAL INSURANCE	1,810
RETIREMENT	7,886
PHYSICALS	1,242
PROFESSIONAL LICENSING	205
EMPLOYEE RECOGNITION	5,679
HOME OFFICE ALLOCATION	19,244
TOTAL (agree to Schedule V, line 22, col.8)	$ 225,781

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,741
Advertising: Employee Recruitment	2,089
Health Care Worker Background Check	717
(Indicate # of checks performed 24)	
Patient Background Checks 47	470
Newspapers/magazines for residents	480
COMMUNITY RELATIONS	677
IL HEALTH CARE ASSOCIATION DUES	5,139
ADVERTISING	12,118
MARKETING	2,023
Less: Public Relations Expense	(677)
Non-allowable advertising	(12,392)
Yellow page advertising	(1,749)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,636

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ (153)
In-State Travel	1,507
Seminar Expense	1,614
LESS: NURSING TRAVEL & SEMINARS	(1,032)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,936

* Attach copy of IMRF notifications

**See instructions.

Big Meadows, Inc. – 0021394
Report Period Beginning – 01/01/2011
Report Period Ending – 12/31/2011
DETAIL PAGE 21, SCHEDULE XIX, SECTION G

		Total Cost	Nursing	General & Administrative
1				
Name & Title	Lisa Johnson, Medical Records			
Date Travel	2/16/2011			
Location	Rockford, IL			
Title of Seminar	Records Retention			
Sponsor	Fred Pryor Seminars			
Total Cost		$ 228.05		$ 228.05
2				
Names & Titles	Jan Majors, LPN Dawn Herrington, CNA Tonya Edwards, CNA			
Dates of Seminar	2/16/2011			
Location	Westmont, IL			
Title	Restorative Refresher Seminar			
Sponsor	Pathway Health Services			
Cost		$ 507.00	$ 507.00	
3				
Name & Title	Lisa Mussman, Dietary Manager			
Dates of Seminar	2/23/2011			
Location	Bettendorf, IA (5 miles from border)			
Title	Martin Brothers Taste and Educate			
Sponsor	Martin Brothers			
Cost		$ 39.00		$ 39.00
4				
Names & Titles	Gary Stephens, Director of Maintenance			
Dates of Seminar	5/23/11 - 5/26/11			
Location	Lisle, IL			
Title of Seminar	NFPA Seminar			
Sponsor	IDPH			
Cost		$ 442.48		$ 442.48
5				
Names & Titles	Lisa Johnson, Medical Records Julie Johnson, Social Worker			
Date of Seminar	8/18/2011			
Location	Clinton, IA (5 miles from border)			
Title	Alzheimers Awareness Day			
Sponsor	Clinton Community College			
Cost		$ 29.97		$ 29.97
6				
Name & Title	Jaime Barnhart, Activities Director			
Date Travel	9/8/2011			
Location	Webinar			
Title of Seminar	F-tags seminar			
Sponsor	Activity Directors Network			
Total Cost		$ 59.95		$ 59.95
7				
Name & Title	Lisa Mussman, Dietary Manager			
Date Travel	10/16/2011			
Location	Waterloo, IA (out-of-state)			
Title of Seminar	Martin Brothers Food Show			
Sponsor	Martin Brothers			
Total Cost		$ 152.63		$ 152.63
8				
Name & Title	Joan Anderson, DON			
Date Travel	11/1/2011			
Location	Rockford, IL			
Title of Seminar	IL Nursing Law & Documentation			
Sponsor	Healthcare Enrichment Institute			
Total Cost		$ 154.92	$ 154.92	
Total Travel & Seminars		$ 1,614.00	$ 661.92	$ 952.08
Less: Out of State		$ (152.63)		$ (152.63)
Total		$ 1,461.37	$ 661.92	$ 799.45
Employee Mileage Reimbursements		$ 1,506.83	$ 370.04	$ 1,136.79
Total - Schedule V, Line 14			**$ 1,031.96**	
Total - Schedule V, Line 24		**$ 2,968.20**		**$ 1,936.24**

Facility Name & ID Number BIG MEADOWS INC # 0021394 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number BIG MEADOWS INC # 0021394 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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. **IHCA - $5,139**

(3) Did the nursing home make political contributions or payments to a politica
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? **9 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **19,591** 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 fo
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 Departmen
during this cost report period. $ **102,804**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
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. $ **8,388**

(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 fo
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 othe
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. $

(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
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 – 01/01/2011
Report Period Ending – 12/31/2011

Page 23, XX 19 **Summary of Legal Invoices**

Ward, Murray, Pace, and Johnson

1/6/2011	ALL LEGAL FEES IN 2011 ARE TO DEFEND	$	403
2/8/2011	AGAINST AN EMPLOYMENT LAWSUIT	$	65
3/2/2011		$	1,055
4/4/2011		$	415
5/3/2011		$	22
6/8/2011		$	43
7/1/2011		$	151
8/2/2011		$	65
9/8/2011		$	2,910
10/4/2011		$	434
11/2/2011		$	129
12/2/2011		$	129
		$	**5,817**