FOR BHF USE

LL1

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.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

I. IDPH License ID Number: 0021394

Facility Name: BIG MEADOWS

Address: 1000 LONGMOOR (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: Samuel S. Card **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 01/01/2014 to 12/31/2014 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)
(Type or Print Name) Samuel S. Card
(Title) CFO

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 # 0021394 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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 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	76	Intermediate (ICF)	83	28,713	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	76	TOTALS	83	28,713	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	15,772	6,701		22,473	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,772	6,701		22,473	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.27%

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 [XX]

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

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

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[XX]	[ ]	[ ]

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

Tax Year: 12/31/2014 Fiscal Year: 12/31/2014

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

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	190,988	11,490	13,450	215,928		215,928		215,928			1
2	Food Purchase		146,208		146,208		146,208	(11,447)	134,761			2
3	Housekeeping	56,618	28,322		84,940		84,940		84,940			3
4	Laundry	48,481	12,587		61,068		61,068		61,068			4
5	Heat and Other Utilities			174,654	174,654		174,654	(10,576)	164,078			5
6	Maintenance	92,538	20,573	25,940	139,051		139,051		139,051			6
7	Other (specify):*											7
8	**TOTAL General Services**	388,625	219,180	214,044	821,849		821,849	(22,023)	799,826			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	1,403,759	100,724	11,839	1,516,322	(18,369)	1,497,953		1,497,953			10
10a	Therapy	51,198	651	124,924	176,773	(109,047)	67,726		67,726			10a
11	Activities	41,174	5,707		46,881		46,881		46,881			11
12	Social Services	69,159		2,519	71,678		71,678		71,678			12
13	CNA Training			4,190	4,190	11,032	15,222		15,222			13
14	Program Transportation		5,699	9,024	14,723	(9,220)	5,503		5,503			14
15	Other (specify):* Equip. Lease			95	95		95		95			15
16	**TOTAL Health Care and Programs**	1,565,290	112,781	176,591	1,854,662	(125,604)	1,729,058		1,729,058			16
	C. General Administration											
17	Administrative			90,000	90,000		90,000	34,598	124,598			17
18	Directors Fees											18
19	Professional Services			16,509	16,509		16,509		16,509			19
20	Dues, Fees, Subscriptions & Promotions			28,230	28,230		28,230	(19,814)	8,416			20
21	Clerical & General Office Expenses	80,699	21,629	11,733	114,061		114,061	4,793	118,854			21
22	Employee Benefits & Payroll Taxes			288,189	288,189		288,189	13,236	301,425			22
23	Inservice Training & Education			4,036	4,036		4,036		4,036			23
24	Travel and Seminar			9,500	9,500	(1,086)	8,414		8,414			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			24,750	24,750		24,750		24,750			26
27	Other (specify):* SALES TAX			748	748		748	(748)				27
28	**TOTAL General Administration**	80,699	21,629	473,695	576,023	(1,086)	574,937	32,065	607,002			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,034,614	353,590	864,330	3,252,534	(126,690)	3,125,844	10,042	3,135,886			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 #0021394 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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			26,021	26,021		26,021	105,348	131,369			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							90,514	90,514			32
33	Real Estate Taxes			41,774	41,774		41,774		41,774			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**			169,795	169,795		169,795	93,862	263,657			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					10,306	10,306		10,306			38
39	Ancillary Service Centers					116,384	116,384		116,384			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			176,023	176,023		176,023		176,023			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			176,023	176,023	126,690	302,713		302,713			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,034,614	353,590	1,210,148	3,598,352		3,598,352	103,904	3,702,256			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 -- 01/01/2014
Report Period Ending -- 12/31/2014

RECLASSIFICATIONS, Pages 3 & 4		Dr.	Cr.	Line #
MEDICALLY NECASSRY	Medically Necessary Transportation	10,306		38
TRANSPORTATION	Program Transportation		10,306	14
TRAVEL & SEMINAR	Program Transportation	1,086		14
FOR NURSING STAFF	Travel and Seminar		1,086	24
REIMBURSED THERAPY	Ancillary Service Center	109,047		39
	Therapy		109,047	10a
NURSE AID TRAINING CLASS	CNA Training	11,032		13
	Nursing and Medical Records		11,032	10
PUBLIC AID OXYGEN	Ancillary Service Center	7,337		39
	Nursing & Medical Records		7,337	10

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(11,447)	2		4
5	Telephone, TV & Radio in Resident Rooms	(10,576)	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	(748)	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	(17,734)			25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(234)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (40,739)		$	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)	149,021		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 149,021		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 108,282		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.	XX		$ 10,306	14	38
39	MEDICARE THERAPY	XX		109,047	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		7,337	10	44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 126,690		47

BIG MEADOWS

ID# 0021394

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	PUBLIC RELATIONS	$ (1,798)	20	1
2	DEPRECIATION ON ASSETS UNDER $2500	(2,532)	30	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**	(4,330)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BIG MEADOWS # 0021394 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(11,447)	0	0	0	0	0	0	0	0	0	0	(11,447)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(10,576)	0	0	0	0	0	0	0	0	0	0	(10,576)	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**	(22,023)	0	0	0	0	0	0	0	0	0	0	(22,023)	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	34,598	0	0	0	0	0	0	0	0	0	34,598	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	(2,032)	0	0	0	0	0	0	0	0	0	0	(2,032)	20
21	Clerical & General Office Expenses	0	4,793	0	0	0	0	0	0	0	0	0	4,793	21
22	Employee Benefits & Payroll Taxes	0	13,236	0	0	0	0	0	0	0	0	0	13,236	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	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):*	(748)	0	0	0	0	0	0	0	0	0	0	(748)	27
28	**TOTAL General Administration**	(2,780)	52,627	0	0	0	0	0	0	0	0	0	49,847	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(24,803)	52,627	0	0	0	0	0	0	0	0	0	27,824	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BIG MEADOWS **#** 0021394 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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	(2,532)	107,880	0	0	0	0	0	0	0	0	0	105,348	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	90,514	0	0	0	0	0	0	0	0	0	90,514	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	(2,532)	96,394	0	0	0	0	0	0	0	0	0	93,862	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)	(27,335)	149,021	0	0	0	0	0	0	0	0	0	121,686	45

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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. [XX] 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	$ 102,000	WINNING WHEELS - 100% BUILDING OWNER		$	$ (102,000)	1
2	V	30	DEPRECIATION		WINNING WHEELS - 100% BUILDING OWNER		107,880	107,880	2
3	V	32	INTEREST		WINNING WHEELS - 100% BUILDING OWNER		90,514	90,514	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		124,598	124,598	5
6	V	21	HOME OFFICE COSTS		AMERICAN HEALTH ENTERPRISES INC		4,793	4,793	6
7	V	22	HOME OFFICE COSTS		AMERICAN HEALTH ENTERPRISES INC		13,236	13,236	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 192,000			$ 341,021	$ * 149,021	14

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

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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: 01/01/2014 Ending: 12/31/2014

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				218,506						3
4	MANAGEMENT FEES FROM STRIVE				131,133						4
5	MANAGEMENT FEES FROM PINNACLE PLACE				60,167						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: 01/01/2014 Ending: 2/31/2014

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 [XX] NO [ ]

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

Name of Related Organization: AMERICAN HEALTH ENTERPRISES
Street Address: 501 6TH AVENUE 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	9,137,299	4	$ 115,908	$ 115,908	2,920,987	$ 37,053	1
2	17	Administrator Salary	DIRECT COST	1	1	87,545	87,545	1	87,545	2
3	22	Employee Benefits	% OF PAYROLL	487,738	4	51,811	0	124,598	13,236	3
4	21	Office Costs	GROSS REVENUES	9,137,299	4	14,993	0	2,920,987	4,793	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					$ 270,257	$ 203,453		$ 142,627	25

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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 STATES BANK		XX	BUILDING MORTGAGE	$11,642.46	06/2004	$ 1,730,000	$ 1,348,328	6/30/29	6.0000	$ 90,514	1
2												2
3												3
4												4
5												5
	Working Capital											
6	WINNING WHEELS INC	XX		WORKING CAPITAL		10/2009	700,000	635,375	10/2015			6
7												7
8												8
9	TOTAL Facility Related				$11,642.46		$ 2,430,000	$ 1,983,703			$ 90,514	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,430,000	$ 1,983,703			$ 90,514	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 # 0021394 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 38,421	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.)		$ 39,111	2
3. Under or (over) accrual (line 2 minus line 1).		$ 690	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 38,589	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.)**		$ 2,494	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.		$ 41,773	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	57,462	8
	2010	57,180	9
	2011	39,277	10
	2012	38,421	11
	2013	39,111	12

We spent $7,486 to appeal the 2011-2013 real estate tax assessments. The appeal was won and the real estate taxes are lowered. The expense for the appeal will be taken over the 3 years the taxes are paid. The amount on line 5 represents 1/3 of the total appeal cost.

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BIG MEADOWS COUNTY CARROLL

FACILITY IDPH LICENSE NUMBER 0021394

CONTACT PERSON REGARDING THIS REPORT SAMUEL CARD

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 2013 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 2013.

	(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	$ 39,110.58	$ 39,110.58
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	$ 39,110.58	$ 39,110.58

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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: 01/01/2014 Ending: 12/31/2014

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 [XX] (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? [XX] (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 [XX] 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 # 0021394 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	83		2001	1968	$ 2,659,130	$ 68,183	39	$ 68,183	$	$ 943,201	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	2001 IMPROVEMENTS			2001	1,182	79	15	79		1,038	9
10	2002 IMPROVEMENTS			2002	265,858	12,232	19	12,232		168,756	10
11	2003 IMPROVEMENTS			2003	103,349	4,488	14.17	4,488		82,853	11
12	2004 IMPROVEMENTS			2004	73,880	5,061	12.5	5,061		57,404	12
13	2005 IMPROVEMENTS			2005	62,770	2,529	15	2,529		44,804	13
14	2006 IMPROVEMENTS			2006	4,514	286	17.5	286		2,515	14
15	2008 IMPROVEMENTS			2008	58,716	3,594	16.88	3,594		26,106	15
16	30 TON CHILLER			2010	28,082	2,808	10	2,808		14,041	16
17	HOSPICE ROOM FLOORING			2010	5,335	356	15	356		1,601	17
18	DRAIN TILING AND DRAINAGE DITCH			2010	4,600	460	10	460		2,070	18
19	SMOKE DETECTORS			2011	3,433	229	15	229		916	19
20	FLOORING			2011	3,308	472	7	472		2,126	20
21	ELEVATOR REPAIRS			2011	6,456	922	7	922		4,150	21
22	FIRE RATED DOORS			2011	935	134	7	134		601	22
23	FIRE PANEL ANNUNCIATOR			2011	4,368	291	15	291		1,068	23
24	FIRE RATED DOORS			2011	7,672	1,096	7	1,096		3,836	24
25	FIRE RATED DOORS			2012	2,609	373	7	373		932	25
26	FENCE FOR NEW E&F WING COURTYARD			2013	8,713	581	15	581		871	26
27	FLOORING FOR NEW E&F WING DINING/ACTIVITY AREA			2013	5,601	800	7	800		1,200	27
28	PATH FOR NEW E&F WING COURTYARD			2013	9,750	650	15	650		975	28
29	NEW HALLWAY DOORS FOR E&F WINGS			2013	7,419	742	10	742		1,113	29
30	FIRE SUPPRESSION SYSTEM			2014	335,902	4,479	25	4,479		4,479	30
31	TOILETS FOR E WING			2014	6,043	134	15	134		134	31
32	ELEVATOR REPAIRS			2014	2,449	122	10	122		122	32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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)		$ 3,672,074	$ 111,101		$ 111,101	$	$ 1,366,912	70

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

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	$ 181,285	$ 21,353	$ 21,353	$	8.18	$ 131,773	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	695,561					695,561	73
74								74
75	TOTALS	$ 876,846	$ 21,353	$ 21,353	$		$ 827,334	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)	$ 4,687,920	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 132,454	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 131,369	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)	$ 2,194,246	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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. [XX] 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	83	9/19/01	$ 102,000	20		3
4	Additions							4
5								5
6								6
7	TOTAL		83		$ 102,000 **			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: [XX] 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.	12/31/2015	$ 124,000
13.	12/31/2016	$ 136,000
14.	12/31/2017	$ 148,000

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

15. Is Movable equipment rental included in building rental? [ ] YES [XX] 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.

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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? [XX] 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 [XX]
- COMMUNITY COLLEGE [ ]
- HOURS PER CNA 96

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [XX]
- 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		232		232
3	Classroom Wages (a)		7,144		7,144
4	Clinical Wages (b)		3,888		3,888
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments		3,893		3,893
8	CNA Competency Tests		65		65
9	TOTALS	$	$ 15,222	$	$ 15,222
10	SUM OF line 9, col. 1 and 2 (e)	$ 15,222			

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

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

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

	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	$	306	$ 7,362	$	306	$ 7,362	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		85	4,393		85	4,393	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs		178	4,122		178	4,122	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): MEDICARE THERAP	39			4,372	109,047		4,372	109,047	12
13	Other (specify): PUBLIC AID OXYGE	39					7,337		7,337	13
14	TOTAL			$	4,941	$ 124,924	$ 7,337	4,941	$ 132,261	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 # 0021394 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2014 (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	$ 101,170	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	958,389		3
4	Supply Inventory (priced at)	20,593		4
5	Short-Term Investments			5
6	Prepaid Insurance	5,229		6
7	Other Prepaid Expenses	4,809		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,090,190	$	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	892,830		16
17	Accumulated Depreciation (book methods)	(839,705)		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): Construction in Progress	8,265		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 123,745	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,213,935	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 373,159	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	127,474		30
31	Accrued Taxes Payable (excluding real estate taxes)	35,313		31
32	Accrued Real Estate Taxes(Sch.IX-B)	40,300		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	32,650		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 608,896	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,392,890		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)**	$ 1,392,890	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,001,786	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (787,851)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,213,935	$	48

***(See instructions.)**

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (788,327)	1	
2	Restatements (describe):		2	
3	ADJUSTMENT PRIOR YEAR BALANCE		3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (788,327)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	476	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)**	$ 476	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)**	$ (787,851)	24	*

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

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,424,795	1
2	Discounts and Allowances for all Levels	(24,000)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,400,795	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	163,900	6
7	Oxygen	7,337	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 171,237	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	11,739	11
12	Gift and Coffee Shop	1,359	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	11,447	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)**	$ 24,545	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	759	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 759	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation	1,492	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,492	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,598,828	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	821,849	31
32	Health Care	1,854,662	32
33	General Administration	576,023	33
	B. Capital Expense		
34	Ownership	169,795	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	176,023	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,598,352	40
41	**Income before Income Taxes (line 30 minus line 40)****	476	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 476	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,288,497	44
45	Private Pay - Net Inpatient Revenue	1,112,298	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,400,795	49

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

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

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

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

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	1,877	2,093	$ 76,653	$ 36.62	1
2	Assistant Director of Nursing					2
3	Registered Nurses	12,955	13,571	344,613	25.39	3
4	Licensed Practical Nurses	10,560	11,242	244,369	21.74	4
5	CNAs & Orderlies	63,602	66,563	705,990	10.61	5
6	CNA Trainees	1,226	1,226	11,032	9.00	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,988	4,243	51,198	12.07	8
9	Activity Director	2,510	2,780	41,174	14.81	9
10	Activity Assistants					10
11	Social Service Workers	3,539	3,818	69,159	18.11	11
12	Dietician					12
13	Food Service Supervisor	2,041	2,148	35,212	16.39	13
14	Head Cook	4,196	4,497	48,396	10.76	14
15	Cook Helpers/Assistants	11,127	11,714	107,379	9.17	15
16	Dishwashers					16
17	Maintenance Workers	6,817	7,285	92,538	12.70	17
18	Housekeepers	6,117	6,534	56,618	8.67	18
19	Laundry	4,150	4,390	48,481	11.04	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	2,078	2,256	52,719	23.37	22
23	Office Manager	2,694	2,769	27,980	10.10	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	1,434	1,609	21,103	13.12	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	140,911	148,738	$ 2,034,614 *	$ 13.68	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	269	$ 13,450	1.3	35
36	Medical Director	120	24,000	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	118	4,758	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	32	2,519	12.3	45
46	Other(specify) LAB	0	(150)	10.3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	539	$ 44,577		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	25	$ 1,426	10.3	50
51	Licensed Practical Nurses	150	5,655	10.3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	175	$ 7,081		53

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Pat Boomgarden	Administrator	0	$ 89,294
(Included in AmericanHealthEnterprises fee in B below)			(89,294)
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
American Health Enterprises	$ 90,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 90,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
MDI ACHIEVE	Software Maintenance	$ 1,226
JOHN PYSE CONSULTING	Computer Consulting	8,692
MIDWEST AUTOMATED TIME	Timeclock Maintenance	650
ONSHIFT	Software Maintenance	3,770
MEDIPROCITY	Software Maintenance	1,000
WEBROOT	Software Maintenance	1,171
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 16,509

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 55,295
Unemployment Compensation Insurance	28,265
FICA Taxes	152,927
Employee Health Insurance	6,904
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
LIFE/VISION/SUPP INSURANCE	17,138
DENTAL INSURANCE	4,341
RETIREMENT	9,752
PHYSICALS	5,135
PROFESSIONAL LICENSES/TUITION	1,406
EMPLOYEE RECOGNITION	7,026
HOME OFFICE ALLOCATION	13,236
TOTAL (agree to Schedule V, line 22, col.8)	$ 301,425

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

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	2,558
Health Care Worker Background Check	1,670
(Indicate # of checks performed 55)	
Patient Background Checks 26	520
DUES AND SUBSCRIPTIONS	1,232
PUBLIC RELATIONS	1,798
LICENSES	446
ADVERTISTING / MARKETING	17,968
Less: Public Relations Expense	(1,798)
Non-allowable advertising	(17,734)
Yellow page advertising	(234)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,416

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	4,950
Seminar Expense	3,464
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,414

**See instructions.

Big Meadows, Inc. – 0021394
Report Period Beginning – 01/01/2014
Report Period Ending – 12/31/2014
DETAIL PAGE 21, SCHEDULE XIX, SECTION G

		Total Cost	Nursing	General & Administrative
1				
Name & Title	Pat Boomgarden, Administrator			
Date Travel	1/28/14 - 1/30/14			
Location	Springfield, IL			
Title of Seminar	Dementia Capable Care			
Sponsor	Crisis Prevention Institute, Inc			
Total Cost	$2,174.27	$2,174.27		$ 2,174.27
2				
Names & Titles	Joan Anderson, Director of Nursing			
Dates of Seminar	1/28/2014			
Location	Schaumburg, IL			
Title	Focus on Dementia Care			
Sponsor	CMS			
Cost	$367.02	$367.02	$367.02	
3				
Name & Title	Brenda Adland			
Dates of Seminar	5/6/2014			
Location	Joliet, IL			
Title	Activity Director			
Sponsor	Quality Therapy Consultation			
Cost	$405.97	$405.97		$405.97
4				
Names & Titles	Brenda Adland			
Dates of Seminar	5/13/14 - 5/15/14			
Location	New Lexon, IL			
Title of Seminar	Activity Director			
Sponsor	Quality Therapy Consultation			
Cost	$345.61	$345.61		$ 345.61

5

Names & Titles	Gary Stephens, Maintenance Supervisor			
Dates of Seminar	6/12/2014			
Location	Schamburg, IL			
Title of Seminar	Emergency Prepardness			
Sponsor	Life Safety			
Cost	$134.40	$134.40	$	134.40

6

Name & Title	Pat Boomgarden, Administrator			
Date Traveled	9/5/2014			
Location	Savanna, IL			
Title	Life Safety & Emergency Preparedness			
Sponsor	HIN seminars			
Total Cost	$129.00	$129.00	$	129.00

7

Name & Title	Julie Johnson, Social Services			
Name & Title	Dani Wilcox, Social Service Assistant			
Date Traveled	10/16/2014			
Location	Sinnsinawa, WI			
Title	Geriatric Issues of the Millennium			
Sponsor	Southwest Behavioral Services			
Total Cost	$150.40	$150.40	$	150.40

8

Name & Title	Joan Anderson, Director of Nursing			
Name & Title	Tonya Edwards, Lead Restorative Aide			
Date Traveled	11/6/2014			
Location	Schaumburg, IL			
Title	Fall Prevention & F323 Compliance			
Sponsor	HIN seminars			
Total Cost	$500.80	$500.80	$500.80	

9

Name & Title	Julie Johnson, Social Services			
Date Traveled	11/20/2014			
Location	Clinton, IA			
Title	DNR training			

Sponsor	Mercy Medical Center			
Total Cost	$125.00	$125.00		$ 125.00
Total Seminars		$ 4,332.47	$ 867.82	$ 3,464.65
Travel Reimbursements		$ 5,168.41	$ 218.40	$ 4,950.01
Total - Schedule V, Line 14			**$ 1,086.22**	
Total - Schedule V, Line 24				**$ 8,414.66**
		$ 9,500.88		

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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 # 0021394 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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. $ **23,570** 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. $ **176,023**
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. $ **11,447**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **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. **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

Page 23, Schedule XX

Question 12

SALARY COSTS ALLOCATED TO MULTIPLE LINES ON SCHEDULE V

Several nursing employees participated in CNA training and their wages for the year were split between lines 10 and 13 on Schedule V.

Big Meadows
General Ledger Trial Balance for Period Ending 12/31/2014

		pg 17	pg 3&4	pg 19			
Account #	**Account Descriptions**	**Balance Sheet Code**	**Expense Report Code**	**Revenue Sheet Code**	**Debit**	**Credit**	**Total**
1100-00	PETTY CASH	1.1			200.00		200.00
1110-00	THE NATIONAL BANK	1.1			100,970.00		100,970.00
1150-00	INVESTMENT IN LTC STOCK	12.1			17,150.00		17,150.00
1210-00	PUBLIC AID	3.1			654,677.00		654,677.00
1215-00	PUBLIC AID PENDING	3.1			204,639.00		204,639.00
1230-00	PRIVATE PAY	3.1			66,179.00		66,179.00
1240-00	OXYGEN	3.1			3,203.00		3,203.00
1250-00	MED B THERAPY THROUGH WW	3.1			67,497.00		67,497.00
1260-00	PROMPT PAY INTEREST DUE	3.1			4,006.00		4,006.00
1280-00	ALLOWANCE	3.1				41,812.00	(41,812.00)
1350-00	NURSING/DIETARY/FOOD/LAUNDRY	4.1			17,466.00		17,466.00
1360-00	LINEN	4.1			-		-
1370-00	HOUSEKEEPING/MAINTENANCE	4.1			3,127.00		3,127.00
1425-00	PREPAID EXPENSES	7.1			3,980.00		3,980.00
1430-00	PREPAID INSURANCE	6.1			5,229.00		5,229.00
1440-00	PREPAID LONG TERM CARE LICENSE FEE	7.1			829.00		829.00
1730-00	LEASEHOLD IMPROVEMENTS	15.1			45,205.00		45,205.00
1740-00	ACCUM. DEPR. - LEASEHOLD IMPR.	17.1				25,949.00	(25,949.00)
1750-00	FURNITURE AND FIXTURES	16.1			671,360.00		671,360.00
1755-00	FF&E UNDER $2500	16.1			27,652.00		27,652.00
1760-00	ACCUM. DEPR. - FURN. & FIXTURE	17.1				619,444.00	(619,444.00)
1765-00	ACCUM. DEPR. - FF&E UNDER $2500	17.1				6,242.00	(6,242.00)
1770-00	VEHICLES	16.1			48,556.00		48,556.00
1780-00	ACCUM. DEPR. - VEHICLES	17.1				42,808.00	(42,808.00)
1810-00	OFFICE EQUIPMENT	16.1			145,262.00		145,262.00
1820-00	ACCUM. DEPR. - OFFICE EQUIP.	17.1				145,262.00	(145,262.00)
1840-00	CONSTRUCTION IN PROGRESS	23.1			8,265.00		8,265.00
1545-00	DUE FROM (TO) WINNING WHEELS	26.1			3,418.00		3,418.00
1546-00	DUE FROM (TO) WW INS:	26.1			-	-	-
1555-00	DUE FROM (TO) LPC	26.1			4,718.00		4,718.00
1570-00	DUE FROM (TO) PINNACLE PLACE	26.1				48,934.00	(48,934.00)
2110-00	ACCOUNTS PAYABLE	26.1				284,776.00	(284,776.00)
2120-00	ACCOUNTS PAYABLE - UNVOUCHERED	26.1				22,776.00	(22,776.00)

Big Meadows
General Ledger Trial Balance for Period Ending 12/31/2014

		pg 17	pg 3&4	pg 19			
Account #	**Account Descriptions**	**Balance Sheet Code**	**Expense Report Code**	**Revenue Sheet Code**	**Debit**	**Credit**	**Total**
2130-00	DUE TO AHE	39.1				70,388.00	(70,388.00)
2135-00	AHE OTHER	39.1			81,399.00		81,399.00
2140-00	ACCRUED RENT-WINNING WHEELS	39.1				646,922.00	(646,922.00)
2150-00	ACCRUED WORKERS COMP	26.1				25,976.00	(25,976.00)
2160-00	ACCRUED UNEMPLOYMENT	31.1				1,455.00	(1,455.00)
2170-00	ACCRUED SALES TAX	31.1				738.00	(738.00)
2180-00	ACCRUED ASSESSMENT	36.1				19,617.00	(19,617.00)
2181-00	BED TAX	36.1				13,033.00	(13,033.00)
2250-00	ACCRUED PAYROLL	30.1				73,091.00	(73,091.00)
2260-00	ACCRUED VACATION	30.1				57,792.00	(57,792.00)
2310-00	ACCRUED FICA	31.1				19,320.00	(19,320.00)
2320-00	ACCRUED FEDERAL W/H	31.1				9,482.00	(9,482.00)
2330-00	ACCRUED ILLINOIS W/H	31.1				3,933.00	(3,933.00)
2340-00	ACCRUED IOWA W/H	31.1				385.00	(385.00)
2350-00	CREDIT UNION	30.1			2,005.00	-	2,005.00
2360-00	ADVANCES/TUITION	30.1			1,754.00	-	1,754.00
2370-00	GARNISHMENTS	30.1				350.00	(350.00)
2371-00	VOLUNTARY LIFE	30.1				-	-
2372-00	MEDICAL	26.1			-		-
2373-00	DENTAL	26.1				-	-
2374-00	VISION	26.1				-	-
2376-00	SUPPLEMENTAL INS.	26.1				-	-
2378-00	BLUE CROSS	26.1				-	-
2390-00	ANNUITY	26.1				1,588.00	(1,588.00)
2430-00	ACCRUED REAL ESTATE TAXES	32.1				40,300.00	(40,300.00)
2515-00	LINE OF CREDIT - WW	39.1				635,375.00	(635,375.00)
2560-00	PUBLIC AID ADVANCE - D.T.	39.1				121,604.00	(121,604.00)
2650-00	RESIDENT S.S.	26.1			2,733.00	-	2,733.00
2910-00	COMMON STOCK	47.1				1,000.00	(1,000.00)
2920-00	PAID-IN CAPITAL	47.1				31,000.00	(31,000.00)
3200-00	RETAINED EARNINGS - PRIOR	47.1			820,349.00		820,349.00
3920-00	PUBLIC AID					12,986.00	(12,986.00)
3921-00	UNPAID BEDHOLDS: OPE					66.00	(66.00)

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Account #	**Account Descriptions**	**Balance Sheet Code**	**Expense Report Code**	**Revenue Sheet Code**	**Debit**	**Credit**	**Total**
3925-00	PUBLIC AID PENDING					2,902.00	(2,902.00)
3940-00	PRIVATE PAY					6,724.00	(6,724.00)
3999-00	PATIENT DAYS OFFSET TOTAL				22,678.00		22,678.00
4020-00	PUBLIC AID			1.0		1,866,157.00	(1,866,157.00)
4025-00	PUBLIC AID PENDING			1.0		422,340.00	(422,340.00)
4040-00	PRIVATE PAY			1.0		1,128,588.00	(1,128,588.00)
4060-00	SUPPLIES			1.0		7,710.00	(7,710.00)
4070-00	THERAPY SERVICES			6.0		163,900.00	(163,900.00)
4100-00	OXYGEN			7.0		7,337.00	(7,337.00)
4120-00	ASSESSMENT FEES - P.A.		42.3		176,023.00		176,023.00
4150-00	BAD DEBTS			2.0	24,000.00		24,000.00
4240-00	TRANSPORTATION			28.0		1,492.00	(1,492.00)
4260-00	CNA TRAINING REIMBURSEMENT			11.0		11,739.00	(11,739.00)
4300-00	MEALS			14.0		11,447.00	(11,447.00)
4320-00	VENDING MACHINES			12.0		1,133.00	(1,133.00)
4360-00	INTEREST			25.0		-	-
4380-00	MISCELLANEOUS			12.0		226.00	(226.00)
4390-00	DONATIONS			25.0		759.00	(759.00)
5050-00	NURSING ADMIN.		10.1		76,653.00		76,653.00
5060-00	NURSES		10.1		499,566.00		499,566.00
5070-00	AIDES		10.1		456,465.00		456,465.00
5090-00	CONNECTIONS		10.1		349,972.00		349,972.00
5100-00	RESTORATIVE AIDES		101.1		51,198.00		51,198.00
5120-00	RECREATION THERAPY		11.1		41,174.00		41,174.00
5140-00	SOCIAL SERVICES		12.1		69,159.00		69,159.00
5340-00	MEDICAL RECORDS		10.1		21,103.00		21,103.00
5360-00	DIETARY		1.1		190,988.00		190,988.00
5380-00	HOUSEKEEPING		3.1		56,618.00		56,618.00
5390-00	LAUNDRY		4.1		48,481.00		48,481.00
5420-00	MAINTENANCE		6.1		92,538.00		92,538.00
5460-00	ADMINISTRATION		21.1		80,699.00		80,699.00
5620-00	FICA		22.3		152,927.00		152,927.00
5640-00	WORKERS COMP.		22.3		55,295.00		55,295.00

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Account #	**Account Descriptions**	**Balance Sheet Code**	**Expense Report Code**	**Revenue Sheet Code**	**Debit**	**Credit**	**Total**
5650-00	UNEMPLOYMENT		22.3		28,265.00		28,265.00
5660-00	SUPPLEMENTAL INS.		22.3		11,734.00		11,734.00
5670-00	LIFE INSURANCE		22.3		4,346.00		4,346.00
5675-00	VISION INSURANCE		22.3		1,058.00		1,058.00
5680-00	HEALTH INSURANCE		22.3		6,904.00		6,904.00
5685-00	DENTAL INSURANCE		22.3		4,341.00		4,341.00
5690-00	RETIREMENT		22.3		9,752.00		9,752.00
5700-00	PHYSICALS		22.3		5,135.00		5,135.00
5720-00	UNIFORMS		10.2		2,828.00		2,828.00
5730-00	PROFESSIONAL TRAINING		23.3		956.00		956.00
5735-00	PROFESSIONAL LICENSE FEES		22.3		656.00		656.00
5740-00	TUITION ASSISTANCE		22.3		750.00		750.00
5750-00	OTHER		22.3		7,026.00		7,026.00
6030-00	PHYSICANS		9.3		24,000.00		24,000.00
6060-00	NURSES		10.3		7,081.00		7,081.00
6100-00	SKILLED THERAPY		101.3		124,924.00		124,924.00
6140-00	SOCIAL SERVICES		12.3		2,519.00		2,519.00
6200-00	PHARMACY		10.3		4,758.00		4,758.00
6220-00	LAB		10.3		-		-
6360-00	DIETARY		1.3		13,450.00		13,450.00
6440-00	TRANSPORTATION		14.3		9,024.00		9,024.00
6460-00	ADMINISTRATIVE		17.3		90,000.00		90,000.00
	ADMINISTRATIVE		19.3		-		-
6470-00	DATA PROCESSING		19.3		16,509.00		16,509.00
7060-00	NURSING		10.2		44,709.00		44,709.00
7065-00	BRIEFS		10.2		23,569.00		23,569.00
7070-00	OXYGEN		10.2		17,756.00		17,756.00
7080-00	MATTRESSES/CUSHIONS		10.2		1,700.00		1,700.00
7120-00	RECREATION THERAPY		11.2		5,707.00		5,707.00
7140-00	PT & OT		101.2		651.00		651.00
7145-00	THICKENERS		10.2		805.00		805.00
7160-00	EQUIPMENT LEASES		15.3		95.00		95.00
7200-00	PHARMACY		10.2		5,103.00		5,103.00

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Account #	**Account Descriptions**	**Balance Sheet Code**	**Expense Report Code**	**Revenue Sheet Code**	**Debit**	**Credit**	**Total**
7210-00	O.T.C. MEDS		10.2		4,254.00		4,254.00
7360-00	DIETARY		1.2		11,490.00		11,490.00
7370-00	FOOD		2.2		140,135.00		140,135.00
7375-00	SUPPLEMENTALS		2.2		6,073.00		6,073.00
7380-00	HOUSEKEEPING		3.2		28,322.00		28,322.00
7390-00	LAUNDRY		4.2		12,587.00		12,587.00
7420-00	MAINTENANCE		6.2		20,573.00		20,573.00
7440-00	TRANSPORTATION		14.2		5,699.00		5,699.00
7460-00	OFFICE		21.2		20,032.00		20,032.00
7470-00	COMPUTER SUPPLIES		21.2		1,597.00		1,597.00
8010-00	ELECTRIC & GAS		5.3		132,664.00		132,664.00
8040-00	WATER & SEWER		5.3		16,460.00		16,460.00
8060-00	TRASH REMOVAL		5.3		14,572.00		14,572.00
8080-00	CABLE TV		5.3		10,958.00		10,958.00
8090-00	INTERNET		21.3		1,429.00		1,429.00
8100-00	REPAIRS & MAINTENANCE		6.3		25,940.00		25,940.00
8120-00	RENT		34.3		102,000.00		102,000.00
8125-00	RENT - VAN		35.3		-		-
8130-00	REAL ESTATE TAXES		33.3		41,774.00		41,774.00
9010-00	TELEPHONE		21.3		6,102.00		6,102.00
9020-00	DUES & SUBSCRIPTIONS		20.3		1,263.00		1,263.00
9040-00	INSURANCE		26.3		24,750.00		24,750.00
9080-00	POSTAGE		21.3		3,485.00		3,485.00
9100-00	LEGAL & ACCOUNTING		19.3		-		-
9110-00	MARKETING		20.3		11,457.00		11,457.00
9120-00	RECRUITMENT		20.3		2,558.00		2,558.00
9130-00	ADVERTISING		20.3		6,529.00		6,529.00
9140-00	TRAVEL & SEMINAR		24.3		4,332.00		4,332.00
9141-00	TRAVEL EXPENSES-NON SEMINAR		24.3		5,168.00		5,168.00
9150-00	TRAINING		23.3		3,080.00		3,080.00
9151-00	NURSE AID TRAINING		13.3		4,190.00		4,190.00
9160-00	LICENSE & TAXES		20.3		2,435.00		2,435.00
9170-00	SALES TAX		27.3		748.00		748.00

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Account #	**Account Descriptions**	**Balance Sheet Code**	**Expense Report Code**	**Revenue Sheet Code**	**Debit**	**Credit**	**Total**
9175-00	BACKGROUND CHECK		20.3		2,190.00		2,190.00
9180-00	OTHER		21.3		717.00		717.00
9190-00	COMMUNITY RELATIONS		20.3		1,798.00		1,798.00
9450-00	DEPRECIATION		30.3		26,021.00		26,021.00
					6,656,858.00	6,656,858.00	-

Revenues	(3,598,828.00)
Expenses	3,598,352.00
	(476.00)
Assets	1,213,935.00
Liabilities	(2,001,808.00)
Owner's Equity	788,349.00
	476.00
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