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.

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

I. IDPH License ID Number: 0021394

Facility Name: BIG MEADOWS

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: ROBIN LANDIS **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 01/01/2018 to 12/31/2018 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) Robin Landis

(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: 01/01/2018 Ending: 12/31/2018

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	83	Intermediate (ICF)	83	30,295	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	83	TOTALS	83	30,295	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	18,304	4,737		23,041	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,304	4,737		23,041	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.06%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve 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 [ ] Date _____ NO [X]

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 [ ] NO [ ]

Tax Year: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	203,750	19,197	10,423	233,370		233,370		233,370			1
2	Food Purchase		166,989		166,989		166,989	(6,595)	160,394			2
3	Housekeeping	57,277			57,277		57,277		57,277			3
4	Laundry	65,247	14,458		79,705		79,705		79,705			4
5	Heat and Other Utilities			162,939	162,939		162,939	(10,236)	152,703			5
6	Maintenance	91,011	38,661		129,672		129,672		129,672			6
7	Other (specify):*											7
8	TOTAL General Services	417,285	239,305	173,362	829,952		829,952	(16,831)	813,121			8
	B. Health Care and Programs											
9	Medical Director			27,150	27,150		27,150		27,150			9
10	Nursing and Medical Records	1,378,733	102,860	161,720	1,643,313	(4,258)	1,639,055		1,639,055			10
10a	Therapy	63,723		211,824	275,547	(205,733)	69,814		69,814			10a
11	Activities	67,021	3,358		70,379		70,379		70,379			11
12	Social Services	54,691			54,691		54,691		54,691			12
13	CNA Training			5,563	5,563		5,563		5,563			13
14	Program Transportation		3,441	5,500	8,941	(7,783)	1,158		1,158			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,564,168	109,659	411,757	2,085,584	(217,774)	1,867,810		1,867,810			16
	C. General Administration											
17	Administrative			102,000	102,000		102,000	(13,756)	88,244			17
18	Directors Fees											18
19	Professional Services			40,704	40,704		40,704		40,704			19
20	Dues, Fees, Subscriptions & Promotions			17,092	17,092		17,092	(4,665)	12,427			20
21	Clerical & General Office Expenses	88,185	12,467	10,256	110,908		110,908	2,598	113,506			21
22	Employee Benefits & Payroll Taxes			298,993	298,993		298,993	11,158	310,151			22
23	Inservice Training & Education			5,677	5,677		5,677		5,677			23
24	Travel and Seminar			8,006	8,006		8,006		8,006			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			27,971	27,971		27,971		27,971			26
27	Other (specify):* Penalties			31,535	31,535		31,535	(985)	30,550			27
28	TOTAL General Administration	88,185	12,467	542,234	642,886		642,886	(5,650)	637,236			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,069,638	361,431	1,127,353	3,558,422	(217,774)	3,340,648	(22,481)	3,318,167			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: 01/01/2018 Ending: 12/31/2018

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			17,762	17,762		17,762	125,268	143,030			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							80,588	80,588			32
33	Real Estate Taxes			40,199	40,199		40,199		40,199			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**			159,961	159,961		159,961	103,856	263,817			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					7,783	7,783		7,783			38
39	Ancillary Service Centers					205,733	205,733		205,733			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			184,006	184,006		184,006		184,006			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			184,006	184,006	213,516	397,522		397,522			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,069,638	361,431	1,471,320	3,902,389	(4,258)	3,898,131	81,375	3,979,506			45

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

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	(6,595)	2		4
5	Telephone, TV & Radio in Resident Rooms	(10,236)	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	(985)	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	(4,665)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (22,481)		$	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)	103,856		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 103,856		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 81,375		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		$ 7,783	14	38
39	**Medicare Therapy**	xx		205,302	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		4,258	10	44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 217,343		47

BIG MEADOWS

ID# 0021394

Report Period Beginning: 01/01/2018

Ending: 12/31/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(6,595)	0	0	0	0	0	0	0	0	0	0	(6,595)	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	(10,236)	0	0	0	0	0	0	0	0	0	0	(10,236)	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**	(16,831)	0	0	0	0	0	0	0	0	0	0	(16,831)	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	(13,756)	0	0	0	0	0	0	0	0	0	(13,756)	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	(4,665)	0	0	0	0	0	0	0	0	0	0	(4,665)	20
21	Clerical & General Office Expenses	0	2,598	0	0	0	0	0	0	0	0	0	2,598	21
22	Employee Benefits & Payroll Taxes	0	11,158	0	0	0	0	0	0	0	0	0	11,158	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):*	(985)	0	0	0	0	0	0	0	0	0	0	(985)	27
28	**TOTAL General Administration**	(5,650)	0	0	0	0	0	0	0	0	0	0	(5,650)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(22,481)	0	0	0	0	0	0	0	0	0	0	(22,481)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	125,268	0	0	0	0	0	0	0	0	0	125,268	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	80,588	0	0	0	0	0	0	0	0	0	80,588	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(102,000)	0	0	0	0	0	0	0	0	0	(102,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	103,856	0	0	0	0	0	0	0	0	0	103,856	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)	(22,481)	103,856	0	0	0	0	0	0	0	0	0	81,375	45

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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		125,268	125,268	2
3	V	32	INTEREST		WINNING WHEELS - 100 % BUILDING OWNER		80,588	80,588	3
4	V	17	PROFESSIONAL SERVICES	137,527	AMERICAN HEALTH ENTERPRISES INC			(137,527)	4
5	V	17	HOME OFFICE COST		AMERICAN HEALTH ENTERPRISES INC		123,771	123,771	5
6	V	21	HOME OFFICE COST		AMERICAN HEALTH ENTERPRISES INC		2,598	2,598	6
7	V	22	HOME OFFICE COST		AMERICAN HEALTH ENTERPRISES INC		11,158	11,158	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 239,527			$ 343,383	$ * 103,856	14

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

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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: 01/01/2018 Ending: 12/31/2018

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					2	4.00		$ NONE		1
2	AMERICAN HEALTH ENTERRISES INC										2
3	MANAGEMENT FEES FROM WINNING WHEELS				222,000						3
4	MANAGEMENT FEES FROM STRIVE				126,000						4
5	MANAGEMENT FEES FROM PINNACLE PLACE				84,000						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: 01/01/2018 Ending: 2/31/2018

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 INC
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 SAL	GROSS REVENUE	11,109,077	4	$ 113,721	$ 113,721	3,800,101	$ 38,901	1
2	17	ADMINISTRATION SALARY	DIRECT COST	1	1	84,870	84,870	1	84,870	2
3	22	EMPLOYEE BENEFITS	% OF PAYROLL	518,601	4	42,259	0	137,527	11,207	3
4	21	OFFICE COSTS	GROSS REVENUE	11,109,077	4	7,595	0	3,800,101	2,598	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					$ 248,445	$ 198,591		$ 137,576	25

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	$11,565.97	6/2004	$ 1,730,000	$ 1,135,405	10/28/2020	6.0000	$ 80,588	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$11,565.97		$ 1,730,000	$ 1,135,405			$ 80,588	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,730,000	$ 1,135,405			$ 80,588	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ ZERO 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: 01/01/2018 Ending: 12/31/2018

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 41,074	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 40,173	2
3. Under or (over) accrual (line 2 minus line 1).		$ (901)	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 41,100	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.		$ 40,199	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	39,111	8
	2014	38,078	9
	2015	40,709	10
	2016	41,074	11
	2017	40,173	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BIG MEADOWS COUNTY CARROLL

FACILITY IDPH LICENSE NUMBER 0021394

CONTACT PERSON REGARDING THIS REPORT Robin Landis

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 2017 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 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-07-03-400-003	77 SAVL73 S3 R24 R3 PT	$	$ 40,173.00
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	$	$ 40,173.00

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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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
www.carroll-county.net

CARROLL COUNTY PROPERTY TAX BILL
2017 PAYABLE 2018

[illegible]

[illegible]

LEGAL DESC
77 SAV L73 S3 T24 R3 PT 660' X 687 Sub
.28 AC ADJ N S.ST R77 P347

08-300-073 00

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

PROPERTY INDEX NUMBER (PIN)	08-07-03-400-003
PROPERTY CLASS	0050
FIRST DUE DATE	07/13/2018
FIRST INSTALLMENT	$20,086.31
SECOND DUE DATE	09/13/2018
SECOND INSTALLMENT	$20,086.31
PRIOR TAX SOLD	
FORFEITED	

2017 EQUALIZED	
SAF BASE	
FAIR CASH VALUE	1,024,06[illegible]
TOTAL ACRES	10.3[illegible]
LEASE	[illegible]
LAND VALUE	41,207
+ BUILDING VALUE	300,113
+ FARM BUILDING	0
+ FARM LAND	0
+ HOME IMPROVEMENT	0
- DISABLE VET EXEMPT	0
ASSESSED VALUE	341,320
x STATE MULTIPLIER	1.0000
EQUALIZED VALUE	341,320
- OWNER OCCUPIED	0
SENIOR EXEMPT	0
- FREEZE EXEMPTION	0
- RT VETERAN EXEMPT	0
- DISABLE VET EXEMPT	0
- DISABLE H/P EXEMPT	0
NET TAXABLE VAL.	341,320
x TAX RATE	11.76978
= CURRENT TAX	$40,172.62
- ENTERPRISE ZONE	$0.00
+ FORFEITURE BAL.	$0.00
= TOTAL TAX DUE	$40,172.62

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		0.07080	$240.26	0.07172	$244.79	0.61
CARROLL COUNTY		0.66114	$2,250.62	0.67104	$2,290.40	5.70
CARROLL COUNTY	PENSION	0.19900	$678.08	0.19930	$680.20	1.69
HIGHLAND JC 519		0.55346	$1,889.07	0.54883	$1,873.27	4.66
HIGHLAND JC 519	PENSION	0.00747	$25.50	0.00784	$26.76	0.07
SAVANNA LIBRARY DIST		0.21200	$720.87	0.21175	$722.74	1.80
SAVANNA LIBRARY DIST	PENSION	0.02875	$98.13	0.02990	$102.06	0.25
SAVANNA PARK DIST		0.50901	$1,737.38	0.43717	$1,492.15	3.71
SAVANNA PARK DIST	PENSION	0.07325	$250.01	0.07363	$251.31	0.63
SAVANNA TWP		0.19291	$658.44	0.18860	$643.73	1.60
SAVANNA R&B		0.17398	$593.86	0.20516	$700.25	1.74
SAVANNA J300 BOND		0.00000	$0.00	0.00000	$0.00	0.00
WEST CARROLL U314		5.69069	$19,423.45	5.44303	$18,578.96	46.23
WEST CARROLL U314	PENSION	0.34545	$1,173.10	0.34978	$1,193.80	2.97
SAVANNA CORP		2.01543	$6,879.06	2.06423	$7,047.84	17.54
SAVANNA CORP	PENSION	1.30115	$4,441.09	1.26927	$4,332.28	10.78
Totals		12.03407	$41,074.70	11.76978	$40,172.62	

LOCATION: 1900 LONGMOOR
SAVANNA, IL

Owner Name: WINNING WHEELS INC

PLEASE SEE REVERSE SIDE FOR PAYMENT INFORMATION

RETURN THIS PORTION WITH PAYMENT

FOR THE YEAR: 2017	FORFEITED TAXES OR YEARS
PROPERTY INDEX NUMBER (PIN): 08-07-03-400-003	FIRST INSTALLMENT: $20,086.31
	DUE DATE: 07/13/2018
PAID BY	PENALTY / COSTS
TOTAL TAX DUE: $40,172.62	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: 2017	FORFEITED TAXES OR YEARS
PROPERTY INDEX NUMBER (PIN): 08-07-03-400-003	SECOND INSTALLMENT: $20,086.31
	DUE DATE: 09/13/2018
PAID BY	PENALTY / COSTS
TOTAL TAX DUE: $40,172.62	AMOUNT PAID

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

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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 GROUND	580,800	2001	$ 13,900	1
2					2
3	TOTALS	580,800		$ 13,900	3

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	31	$ 68,183	$	$ 1,215,931	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	IMPROVEMENTS 2001			2001	1,182		15			1,182	9
10	IMPROVEMENTS 2002			2002	265,858	12,685	19	12,685		221,926	10
11	IMPROVEMENTS 2003			2003	103,349	2,637	14.17	2,637		95,952	11
12	IMPROVEMENTS 2004			2004	73,880	2,715	12.5	2,715		73,879	12
13	IMPROVEMENTS 2005			2005	62,770	2,529	1.5	2,529		54,920	13
14	IMPROVEMENTS 2006			2006	4,514	165	17.5	165		3,558	14
15	IMPROVEMENTS 2008			2008	58,716	2,306	16.88	2,306		38,550	15
16	IMPROVEMENTS 2010			2010	38,017	3,624	11.66	3,624		31,852	16
17	IMPROVEMENTS 2011			2011	26,172	1,068	9.66	1,068		21,914	17
18	IMPROVEMENTS 2012			2012	2,609	372	7	372		2,422	18
19	IMPROVEMENTS 2013			2013	31,483	3,110	7	3,110		26,019	19
20	FIRE SUPRESSION SYSTEM			2014	336,167	13,436	25	13,436		71,659	20
21	TOILETS FOR E WING			2014	6,043	403	15	403		2,149	21
22	ELEVATOR REPAIRS			2014	2,449	245	10	245		1,347	22
23	INSTALL DOOR RESTRICTOR TO AD EDGE			2014	2,449	350	7	350		1,574	23
24	NEW FLOORING			2014	3,490	499	7	499		2,244	24
25	REMODEL DINING ROOM			2014	2,117	302	7	302		1,361	25
26	TEAR OUT HAUL BLOCK WIRE; CAP 2 WALL			2014	7,300	730	10	730		3,285	26
27	INSTALL METAL DOOR IN F WING			2015	2,249	321	7	321		1,446	27
28	PUMP			2015	8,532	853	10	853		3,839	28
29	ENGINEERING			2015	836	167	5	167		752	29
30	LIFT STATION UPGRADES			2015	23,700	1,580	15	1,580		5,925	30
31	REPAIR OF DRAIN			2016	3,926	561	7	561		1,963	31
32	KONE ELEVATOR REPAIR			2017	5,515	788	7	788		2,364	32
33	MAG LOCK DOOR FUSING			2017	3,038	607	5	607		1,823	33
34	KONE ELEVATOR REPAIR			2017	5,834	833	7	833		1,736	34
35	DINING ROOM HVAC			2017	9,740	1,391	7	1,391		2,087	35
36	WALK IN COOLER			2017	5,750	1,232	7	1,232		1,232	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: 01/01/2018 Ending: 12/31/2018

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	CAMERA	2017	$ 540	$ 77	7	$ 77	$	$ 116	37
38	GENERATOR HOOK UP	2018	10,497	1,500	7	1,500		2,249	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)		$ 3,767,852	$ 125,268		$ 125,268	$	$ 1,897,256	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: 01/01/2018 Ending: 12/31/2018

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	$ 120,241	$ 16,352	$ 16,352	$	7	$ 96,324	71
72	Current Year Purchases	9,870	1,410	1,410		7	1,410	72
73	Fully Depreciated Assets	794,545					794,545	73
74								74
75	TOTALS	$ 924,656	$ 17,762	$ 17,762	$		$ 892,279	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)	$ 4,706,408	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 143,030	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 143,030	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)	$ 2,789,535	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: 01/01/2018 Ending: 12/31/2018

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [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	9/19/2001	$ 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 09/19/2001
Ending 09/19/2021

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

	Fiscal Year Ending	Annual Rent
12.	/2019	$ 102,000
13.	/2020	$ 102,000
14.	/2021	$ 102,000

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: 01/01/2018 Ending: 12/31/2018

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	
COMMUNITY COLLEGE	XX
HOURS PER CNA	

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	XX
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	$	$	$ 5,563	$ 5,563
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$ 5,563	$ 5,563
10	SUM OF line 9, col. 1 and 2 (e)	$			

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	3
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	1
2. From other facilities (f)	
TOTAL TRAINED	4

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

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

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A.3	hrs	$	137	$ 2,615	$	137	$ 2,615	1
2	Licensed Speech and Language Development Therapist	10A.3	hrs		17	1,191		17	1,191	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A.3	hrs		105	2,285		105	2,285	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): MEDICARE				8,897	205,733		8,897	205,733	13
14	TOTAL			$	9,156	$ 211,824	$	9,156	$ 211,824	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2018 (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	$ 5,247	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 66,693)	652,598		3
4	Supply Inventory (priced at)	20,593		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	3,000		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 681,438	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	17,150		12
13	Land	45,205		13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	924,656		16
17	Accumulated Depreciation (book methods)	(892,279)		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 PROG	8,265		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 102,997	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 784,435	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 285,266	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	169,476		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,140		31
32	Accrued Real Estate Taxes(Sch.IX-B)	39,199		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 499,081	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	951,031		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)**	$ 951,031	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,450,112	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (665,677)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 784,435	$	48

***(See instructions.)**

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (591,310)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (591,310)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(74,367)	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)**	$ (74,367)	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)**	$ (665,677)	24 *

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

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	$ 3,536,525	1
2	Discounts and Allowances for all Levels	(24,000)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,512,525	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	294,724	6
7	Oxygen	4,258	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 298,982	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	700	11
12	Gift and Coffee Shop	1,437	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	6,595	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)**	$ 8,732	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	7,783	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 7,783	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,828,022	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	829,952	31
32	Health Care	2,085,584	32
33	General Administration	642,886	33
	B. Capital Expense		
34	Ownership	159,961	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	184,006	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,902,389	40
41	**Income before Income Taxes (line 30 minus line 40)****	(74,367)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (74,367)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,646,877	44
45	Private Pay - Net Inpatient Revenue	883,808	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) SUPPLIES	5,840	47
48	Other-(specify) ALLOWANCES	(24,000)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,512,525	49

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

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

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

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

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	1,936	2,104	$ 88,775	$ 42.19	1
2	Assistant Director of Nursing	2,142	2,306	69,578	30.17	2
3	Registered Nurses	6,075	6,599	209,525	31.75	3
4	Licensed Practical Nurses	10,459	11,338	308,975	27.25	4
5	CNAs & Orderlies	53,311	56,342	680,968	12.09	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,302	4,541	63,723	14.03	8
9	Activity Director	4,228	4,543	67,021	14.75	9
10	Activity Assistants					10
11	Social Service Workers	1,989	2,230	54,691	24.53	11
12	Dietician					12
13	Food Service Supervisor	1,901	2,175	30,630	14.08	13
14	Head Cook	4,359	4,392	64,142	14.60	14
15	Cook Helpers/Assistants	10,229	11,144	108,978	9.78	15
16	Dishwashers					16
17	Maintenance Workers	6,016	6,744	91,011	13.50	17
18	Housekeepers	6,296	6,622	57,277	8.65	18
19	Laundry	5,164	5,959	65,247	10.95	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	1,960	2,104	57,049	27.11	22
23	Office Manager	1,892	2,076	31,136	15.00	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	1,904	2,050	20,912	10.20	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	124,163	133,269	$ 2,069,638 *	$ 15.53	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	210	$ 10,423	1.3	35
36	Medical Director	130	27,150	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	118	5,910	10.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	458	$ 43,483		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	375	$ 18,367	10.3	50
51	Licensed Practical Nurses	927	43,249	10.3	51
52	Certified Nurse Assistants/Aides	2,938	94,194	10.3	52
53	TOTAL (lines 50 - 52)	4,240	$ 155,810		53

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
PAT TRICKER	ADMIN	0	$ 25,840
ETHAN GAPINSKI	ADMIN	0	54,331
Included in part B below			
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 80,171

B. Administrative - Other

Description	Amount
AMERICAN HEALTH ENTERPRISES	$ 102,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 102,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
JOHN PYSE CONSULT	IT CONSULTANT	$ 3,624
MIDWEST AUTOMATED TIME	TIMECLOCK MAINT	758
CAREVOYANT	PATIENT SOFTWARE	7,770
MEDIPROCITY	HIPPA SOFTWARE	1,500
WARD MURRAY PACE	ATTORNEY	284
ESOLUTIONS	BILING SOFTWAE	1,600
TERRILL CONSULTING	CMI CONSULTANT	16,460
ONSHIFT	SCHEDULING SOFTWARE	6,840
BRIGGS	ELECTRONIC NURSING FOR	1,068
LOGMEIN	REMOTE DESKTOP SOFTWA	800
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 40,704

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 49,366
Unemployment Compensation Insurance	17,923
FICA Taxes	155,108
Employee Health Insurance	34,131
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
LIFE/VISION/SUPP INS	6,859
DENTAL INS	3,524
RETIREMENT	25,882
PHYSICALS	526
PROFESSIONAL LICENSE / TUITION	2,524
EMPLOYEE RECOGNITION	3,150
HOME OFFICE ALLOCATION	11,158
TOTAL (agree to Schedule V, line 22, col.8)	$ 310,151

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	$
Advertising: Employee Recruitment	2,274
Health Care Worker Background Check	
(Indicate # of checks performed 24)	755
Patient Background Checks 20	600
DUES AND SUBSCRIPTS	4,717
PUBLIC RELATIONS	1,454
LICENSE	4,081
ADVERTISING/MARKETING	3,211
Less: Public Relations Expense	(1,454)
Non-allowable advertising	(3,211)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,427

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 767
Closest Dementia Instructor Training	
In-State Travel	6,089
Seminar Expense	1,150
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,006

**See instructions.

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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. **NO**

(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. $ **27,541** 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. $ **184,006**
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. $ **6,595**

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

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name:

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **YES**
Attach invoices and a summary of services for all architect and appraisal fees

BIG MEADOWS - 0021394
Report Period Beginning 01/01/2018
Report Period Ending 12/31/2018

			Total Cost
1	**Name & Title**	Trinity Solomon	
	Date Traveled	8/7/18-8/9/18	
	Location	Milwaukee WI	
	Title	CPI Dementia Instructor Training	
	Sponsor	CPI	1,150.00
	Total Cost	$1,918.62	768.60
2	**Name & Title**	Tonya Edwards, Julie Johnson, Amber Johnson, Ethan Gapinski	
	Date Traveled	9/9/18-9/12/18	
	Location	Peoria IL	
	Title	IHCA Conference	
	Sponsor	IHCA Conference	
	Total Cost	$523.08	503.46

Total Seminars	$1,150.00
Mileage	$6,855.88
	$8,005.88
Total - Schedule V, Line 24 - Other	$8,005.88
Total - Schedule V, Line 24 - Adjustments	-$1,918.62
Total - Schedule V, Line 24 - 8	$6,087.26