		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.

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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: 10/21/0976

Type of Ownership:

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

IRS Exemption Code

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 1/1/2020 to 12/31/2020 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: 1/1/2020 Ending: 12/31/2020

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	30,378	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	83	TOTALS	83	30,378	7

B. Census-For the entire report period.

	1 Level of Care	2 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					10
11	ICF/DD	18,386	5,358		23,744	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,386	5,358		23,744	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.16%

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 [X] NO [ ]

Tax Year: 12/31/2020 Fiscal Year: 12/31/2020

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

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	231,186	21,020	5,888	258,094		258,094		258,094			1
2	Food Purchase		195,613		195,613		195,613	(8,246)	187,367			2
3	Housekeeping	61,452	21,600		83,052		83,052		83,052			3
4	Laundry	78,214			78,214		78,214		78,214			4
5	Heat and Other Utilities			160,198	160,198		160,198	(10,888)	149,310			5
6	Maintenance	96,775	31,138	23,096	151,009		151,009		151,009			6
7	Other (specify):*											7
8	TOTAL General Services	467,627	269,371	189,182	926,180		926,180	(19,134)	907,046			8
	B. Health Care and Programs											
9	Medical Director			27,300	27,300		27,300		27,300			9
10	Nursing and Medical Records	1,705,939	158,152	65,729	1,929,820		1,929,820		1,929,820			10
10a	Therapy	85,684		111,990	197,674	(144,987)	52,687		52,687			10a
11	Activities	54,805	4,379		59,184		59,184		59,184			11
12	Social Services	43,636			43,636		43,636		43,636			12
13	CNA Training											13
14	Program Transportation		2,886		2,886	(2,055)	831		831			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,890,064	165,417	205,019	2,260,500	(147,042)	2,113,458		2,113,458			16
	C. General Administration											
17	Administrative			186,000	186,000		186,000	76,377	262,377			17
18	Directors Fees											18
19	Professional Services			71,333	71,333		71,333		71,333			19
20	Dues, Fees, Subscriptions & Promotions			27,904	27,904		27,904	(4,600)	23,304			20
21	Clerical & General Office Expenses	93,646	16,905	9,423	119,974		119,974	203	120,177			21
22	Employee Benefits & Payroll Taxes			304,927	304,927		304,927	950	305,877			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,190	1,190		1,190		1,190			24
25	Other Admin. Staff Transportation			2,080	2,080		2,080		2,080			25
26	Insurance-Prop.Liab.Malpractice			28,580	28,580		28,580		28,580			26
27	Other (specify):* SALES TAX			896	896		896	(878)	18			27
28	TOTAL General Administration	93,646	16,905	632,333	742,884		742,884	72,052	814,936			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,451,337	451,693	1,026,534	3,929,564	(147,042)	3,782,522	52,918	3,835,440			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: 1/1/2020 Ending: 12/31/2020

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			20,533	20,533		20,533	127,717	148,250			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							69,865	69,865			32
33	Real Estate Taxes			42,000	42,000		42,000		42,000			33
34	Rent-Facility & Grounds			114,000	114,000		114,000	(114,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			176,533	176,533		176,533	83,582	260,115			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					2,055	2,055		2,055			38
39	Ancillary Service Centers					144,987	144,987		144,987			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			189,486	189,486		189,486		189,486			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			189,486	189,486	147,042	336,528		336,528			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,451,337	451,693	1,392,553	4,295,583		4,295,583	136,500	4,432,083			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: 1/1/2020 Ending: 12/31/2020

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(8,246)	2		4
5	Telephone, TV & Radio in Resident Rooms	(10,888)	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	(878)	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	(4,600)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				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)**	$ (24,612)		$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (24,612)		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.	x		$ 2,055	14	38
39	MEDICARE THERAPY	X		144,987	10A	39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule O2	X		1,354	10	46
47	**TOTAL (C): (sum of lines 38-46)**			$ 148,396		47

BIG MEADOWS

ID# 0021394

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

	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: 1/1/2020 Ending: 12/31/2020

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	(8,246)	0	0	0	0	0	0	0	0	0	0	(8,246)	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	(10,888)	0	0	0	0	0	0	0	0	0	0	(10,888)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(19,134)	0	0	0	0	0	0	0	0	0	0	(19,134)	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	76,377	0	0	0	0	0	0	0	0	0	76,377	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	(4,600)	0	0	0	0	0	0	0	0	0	0	(4,600)	20
21	Clerical & General Office Expenses	0	203	0	0	0	0	0	0	0	0	0	203	21
22	Employee Benefits & Payroll Taxes	0	950	0	0	0	0	0	0	0	0	0	950	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):*	(878)	0	0	0	0	0	0	0	0	0	0	(878)	27
28	**TOTAL General Administration**	(5,478)	77,530	0	0	0	0	0	0	0	0	0	72,052	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(24,612)	77,530	0	0	0	0	0	0	0	0	0	52,918	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BIG MEADOWS **#** 0021394 **Report Period Beginning:** 1/1/2020 **Ending:** 12/31/2020

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	127,717	0	0	0	0	0	0	0	0	0	127,717	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	69,865	0	0	0	0	0	0	0	0	0	69,865	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(114,000)	0	0	0	0	0	0	0	0	0	(114,000)	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	83,582	0	0	0	0	0	0	0	0	0	83,582	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)**	(24,612)	161,112	0	0	0	0	0	0	0	0	0	136,500	45

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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 ENTERPRISES	100					

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

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

1 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	$ 114,000	WINNING WHEELS - 100% BUILDING OWNER		$	$ (114,000)	1
2	V	30	DEPRECIATION		WINNING WHEELS - 100% BUILDING OWNER		127,717	127,717	2
3	V	32	INTEREST		WINNING WHEELS - 100% BUILDING OWNER		69,865	69,865	3
4	V	17	PROFESSIONAL SERVICES	78,558	AMERICAN HEALTH ENTERPRISES INC		78,558		4
5	V	17	HOME OFFICE COST		AMERICAN HEALTH ENTERPRISES INC		76,377	76,377	5
6	V	21	HOME OFFICE COST		AMERICAN HEALTH ENTERPRISES INC		203	203	6
7	V	22	HOME OFFICE COST		AMERICAN HEALTH ENTERPRISES INC		950	950	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 192,558			$ 353,670	$ * 161,112	14

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

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	ALAN GAPINSKI	100						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: 1/1/2020 Ending: 12/31/2020

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		$		1
2	AMERICAN HEALTH ENTERPRISES 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				90,000						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: 1/1/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: AMERICAN HEALTH ENTERPRISES INC
Street Address: 501 6TH AVE W
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	14,416,003	4	$ 156,088	$ 103,201	5,891,015	$ 63,784	1
2	17	ADMINISTRATION SALARY	DIRECT COST	1	1	78,558		1	78,558	2
3	22	EMPLOYEE BENEFITS	% OF PAYROLL	555,962	4	3,409		154,935	950	3
4	21	OFFICE COSTS	GROSS REVENUE	14,416,003	4	496		5,891,015	203	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					$ 238,551	$ 103,201		$ 143,495	25

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1	MIDLAND STATES BANK		X	BUILDING MORTAGE	$11,565.97	6/2004	$ 1,730,000	$ ZERO	12/28/2021	6.0000	$ 65,491	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	$			$ 65,491	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	$			$ 65,491	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: 1/1/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 42,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 38,094	2
3. Under or (over) accrual (line 2 minus line 1).		$ (3,906)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 42,000	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.		$ 38,094	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	40,709	8
	2016	41,074	9
	2017	40,173	10
	2018	40,199	11
	2019	38,094	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	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.

2019 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 2019 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 2019.

	(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 RT	$	$ 38,094.00
2.		600' X 880' SE. & .28 AC ADJ	$	$
3.		N SIDE B77 P347 08-000-073-00	$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$ 38,094.00

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 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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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
2019 PAYABLE 2020

LEGAL DESC:
77 SAV L73 S3 124 R3 PT 660' X 390' SE &
.26 AC ADJ N SIDE B77 P347

08 000 073 00

PROPERTY INDEX NUMBER (PIN)	08-07-03-400-003
PROPERTY CLASS	0050
FIRST DUE DATE	07/01/2020
FIRST INSTALLMENT	$19,046.75
SECOND DUE DATE	09/01/2020
SECOND INSTALLMENT	$19,046.75
PRIOR TAX SOLD	
FORFEITED	

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

TAX CODE	CARROLL COUNTY ITEMIZED STATEMENT	TOWNSHIP
08003		Savanna Township

Taxing Body		Prior Year Rate	Prior Year Amount	Current Rate	Current Amount	% of Total
TRI-TWP MUNICIPAL AIRPRT		0.07183	$245.17	0.07338	$232.22	0.61
CARROLL COUNTY		0.66598	$2,283.39	0.66737	$2,112.59	5.55
CARROLL COUNTY	PENSION	0.19395	$661.39	0.17569	$556.15	1.46
HIGHLAND JC 519		0.54772	$1,869.48	0.56175	$1,778.23	4.07
HIGHLAND JC 519	PENSION	0.00783	$26.04	0.00741	$23.46	0.06
SAVANNA LIBRARY DIST		0.19728	$673.35	0.18390	$582.14	1.53
SAVANNA LIBRARY DIST	PENSION	0.00946	$32.29	0.02248	$71.16	0.19
SAVANNA PARK DIST		0.43989	$1,501.43	0.44735	$1,416.10	3.72
SAVANNA PARK DIST	PENSION	0.07255	$247.63	0.07963	$252.07	0.66
SAVANNA TWP		0.18026	$615.26	0.18005	$569.95	1.50
SAVANNA R&B		0.19282	$658.13	0.20217	$639.97	1.68
WEST CARROLL U314		5.60306	$19,124.37	5.55309	$17,578.43	46.15
WEST CARROLL U314	PENSION	0.41321	$1,410.36	0.41332	$1,308.36	3.43
SAVANNA CORP		1.98812	$6,785.85	2.13088	$6,744.03	17.71
SAVANNA CORP	PENSION	1.30020	$4,437.84	1.33565	$4,228.04	11.10
Totals		11.85696	$40,472.58	12.03388	$38,093.50	

LOCATION: 3683 LONGMOOR
SAVANNA IL

Owner Name: WINNING WHEELS INC

PLEASE SEE REVERSE SIDE FOR PAYMENT INFORMATION

1977 EQUALIZED	0
FAT BASE	0
FAIR CASH VALUE	949,750
TOTAL ACRES	13.03
TIF FROZ	0
LAND VALUE	39,500
+ BUILDING VALUE	276,952
+ FARM BUILDING	0
+ FARM LAND	0
- HOME IMPROVEMENT	0
- DISABLE VET EXEMPT	0
ASSESSED VALUE	316,552
× STATE MULTIPLIER	1.0000
= EQUALIZED VALUE	316,552
- OWNER OCCUPIED	0
- SENIOR EXEMPT	0
- OTHER EXEMPTIONS	0
- RT VETERAN EXEMPT	0
DISABLE VET EXEMPT	0
DISABLED PER EXEMPT	0
= NET TAXABLE VAL	316,552
× TAX RATE	12.03388
= CURRENT TAX	$38,093.50
- ENTERPRISE ZONE	$0.00
+ FORFEITURE	$0.00
= TOTAL TAX DUE	$38,093.50

-BM

RETURN THIS PORTION WITH PAYMENT

FOR THE YEAR	FORFEITED TAXES OR YEARS	
2019		
PROPERTY INDEX NUMBER (PIN) 08-07-03-400-003	FIRST INSTALLMENT $19,046.75	
	DUE DATE 07/01/2020	
PAID BY	PENALTY	COSTS
TOTAL TAX DUE $38,093.50	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	FORFEITED TAXES OR YEARS	
2019		
PROPERTY INDEX NUMBER (PIN) 08-07-03-400-003	SECOND INSTALLMENT $19,046.75	
	DUE DATE 09/01/2020	
PAID BY	PENALTY	COSTS
TOTAL TAX DUE $38,093.50	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: 1/1/2020 Ending: 12/31/2020

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILTIY 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: 1/1/2020 Ending: 12/31/2020

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	$	$ 1,352,297	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		247,296	10
11	IMPROVEMENTS 2003			2003	103,349	2,637	14.17	2,637		101,226	11
12	IMPROVEMENTS 2004			2004	73,880		12.5			73,880	12
13	IMPROVEMENTS 2005			2005	62,770	2,529	1.5	2,529		59,978	13
14	IMPROVEMENTS 2006			2006	4,514	165	17.5	165		3,888	14
15	IMPROVEMENTS 2008			2008	58,716	2,306	16.88	2,306		43,162	15
16	IMPROVEMENTS 2010			2010	38,017	2,541	11.66	2,541		38,017	16
17	IMPROVEMENTS 2011			2011	26,172	1,068	9.66	1,068		23,150	17
18	IMPROVEMENTS 2012			2012	2,609		7			2,609	18
19	IMPROVEMENTS 2013			2013	31,483	2,354	7	2,354		31,483	19
20	FIRE SUPRESSION SYSTEM			2014	336,167	13,436	25	13,436		98,531	20
21	TOILETS FOR E WING			2014	6,043	403	15	403		2,955	21
22	ELEVATOR REPAIRS			2014	2,449	245	10	245		1,837	22
23	INSTALL DOOR RESTRICTOR TO AD EDGE			2014	2,449	350	7	350		2,274	23
24	NEW FLOORING			2014	3,490	499	7	499		3,242	24
25	REMODEL DINING ROOM			2014	2,117	302	7	302		1,965	25
26	TEAR OUT HAUL BLOCK WIRE; CAP 2 WALL			2014	7,300	730	10	730		4,745	26
27	INSTALL METAL DOOR IN F WING			2015	2,249	321	7	321		2,088	27
28	PUMP			2015	8,532	853	10	853		5,545	28
29	ENGINEERING			2015	836	83	5	83		836	29
30	LIFT STATION UPGRADES			2015	23,700	1,580	15	1,580		9,085	30
31	REPAIR OF DRAIN			2016	3,926	561	7	561		3,085	31
32	KONE ELEVATOR REPAIR			2017	5,515	788	7	788		3,940	32
33	MAG LOCK DOOR FUSING			2017	3,038	607	5	607		3,037	33
34	KONE ELEVATOR REPAIR			2017	5,834	833	7	833		3,402	34
35	DINING ROOM HVAC			2017	9,740	1,391	7	1,391		3,315	35
36	WALK IN COOLER			2017	5,750	1,232	7	1,232		3,156	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	$	$ 270	37
38	GENERATOR HOOK UP	2018	10,497	1,500	7	1,500		5,249	38
39	ELEVATOR REPAIR	2019	2,185	182	7	182		364	39
40	ELECTRICAL REPAIR	2019	3,469	496	7	496	0	496	40
41	LIFT STATION PUMP REPLACEMENT	2020	17,798	1,780	10	1,780		1,780	41
42	LIFT STATION PUMP WORK	2020	6,270	627	10	627		627	42
43	LIFT STATION PUMP WORK	2020	4,141	414	10	414		414	43
44	LIFT STATION PUMP WORK	2020	3,264	326	10	326		326	44
45	LIFT STATION PUMP WORK	2020	2,613	373	7	373		33	45
46	ELECTRICAL REPAIR LIFT STATION	2020	955	141	7	141		141	46
47	A/C REPAIRS	2020	2,900	414	7	414		414	47
48	REWORK EXTRA LIFT STATION PUMP	2020	6,147	410	15	410		410	48
49	DINING ROOM ROOF REPLACEMENT	2020	16,816	1,682	10	1,682		1,682	49
50	DINING ROOM ROOF A/C MOVE	2020	5,150	613	7	613		613	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)		$ 3,839,560	$ 127,717		$ 127,717	$ 0	$ 2,144,025	70

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

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	$ 111,748	$ 12,030	$ 12,030	$		$ 82,644	71
72	Current Year Purchases	70,261	7,488	7,488			7,488	72
73	Fully Depreciated Assets	824,942					824,942	73
74								74
75	TOTALS	$ 1,006,951	$ 19,518	$ 19,518	$		$ 915,074	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	Maintenance	2004 Ford F-250	2020	$ 20,090	$ 718	$ 718	$	7	$ 718	76
77	Maintenance	Western Snowplow	2020	8,308	297	297		7	297	77
78										78
79										79
80	TOTALS			$ 28,398	$ 1,015	$ 1,015	$		$ 1,015	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)	$ 4,888,809	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 148,250	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 148,250	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 0	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,060,114	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: 1/1/2020 Ending: 12/31/2020

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. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1968	83	9/19/2001	$ 114,000	20		3
4	Additions							4
5								5
6								6
7	TOTAL		83		$ 114,000 **			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: [X] YES [ ] NO Terms: VARIOUS *

10. Effective dates of current rental agreement:
Beginning 9/19/2001
Ending 09/19/2021

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

	Fiscal Year Ending	Annual Rent
12.	/2021	$ 114,000
13.	/2022	$
14.	/2023	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	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: 1/1/2020 Ending: 12/31/2020

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?
   - [ ] YES
   - [x] 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 [ ]
   - HOURS PER CNA ____

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
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	$	$	$	$
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	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(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	10.A.3	hrs	$	236	$ 5,046	$	236	$ 5,046	1
2	Licensed Speech and Language Development Therapist	10.A.3	hrs		13	940		13	940	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10.A.3	hrs		240	5,138		240	5,138	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				4,551	94,735		4,551	94,735	13
14	TOTAL			$	5,040	$ 105,859	$	5,040	$ 105,859	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: 1/1/2020 Ending: 12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2020 (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	$ 1,726,655	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 13,309)	530,874		3
4	Supply Inventory (priced at COST)	20,593		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	353,426		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,631,548	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	17,150		12
13	Land	53,470		13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	981,879		16
17	Accumulated Depreciation (book methods)	(916,089)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 136,410	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,767,958	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 173,284	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	109,714		30
31	Accrued Taxes Payable (excluding real estate taxes)	11,361		31
32	Accrued Real Estate Taxes(Sch.IX-B)	44,533		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)**	$ 338,892	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	835,960		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)**	$ 835,960	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,174,852	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,593,106	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,767,958	$	48

***(See instructions.)**

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 180,236	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 180,236	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,412,870	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)**	$ 1,412,870	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)**	$ 1,593,106	24 *

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

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	$ 4,240,269	1
2	Discounts and Allowances for all Levels	(24,000)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,216,269	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	122,925	6
7	Oxygen	1,354	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 124,279	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	383	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	8,246	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)**	$ 8,629	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,494	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,494	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	TRANSPORTATION	2,055	28
28a	HHS / CURES	1,490,228	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,492,282	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,844,953	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	907,046	31
32	Health Care	2,113,458	32
33	General Administration	814,936	33
	B. Capital Expense		
34	Ownership	260,115	34
	C. Ancillary Expense		
35	Special Cost Centers	147,042	35
36	Provider Participation Fee	189,486	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,432,083	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,412,870	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,412,870	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,150,627	44
45	Private Pay - Net Inpatient Revenue	1,079,979	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) SUPPLIES	9,662	47
48	Other-(specify) ALLOWANCES	(24,000)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,216,269	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: 1/1/2020 Ending: 12/31/2020

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	1,984	2,168	$ 92,401	$ 42.62	1
2	Assistant Director of Nursing	2,056	2,277	73,922	32.46	2
3	Registered Nurses	7,495	7,962	256,267	32.19	3
4	Licensed Practical Nurses	11,459	12,606	375,504	29.79	4
5	CNAs & Orderlies	52,174	55,901	849,470	15.20	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,491	4,846	85,684	17.68	8
9	Activity Director	4,044	4,407	71,728	16.28	9
10	Activity Assistants	1,548	1,719	19,292	11.22	10
11	Social Service Workers	1,770	1,963	43,636	22.23	11
12	Dietician					12
13	Food Service Supervisor	2,015	2,168	37,857	17.46	13
14	Head Cook	5,986	6,403	87,282	13.63	14
15	Cook Helpers/Assistants	9,794	10,420	106,046	10.18	15
16	Dishwashers					16
17	Maintenance Workers	5,527	6,062	96,775	15.96	17
18	Housekeepers	5,780	6,279	61,452	9.79	18
19	Laundry	6,226	6,750	78,214	11.59	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	1,567	1,827	55,873	30.58	22
23	Office Manager	2,055	2,284	37,773	16.54	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	1,756	2,000	22,161	11.08	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	127,727	138,042	$ 2,451,337 *	$ 17.76	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	110	$ 5,888	1.3	35
36	Medical Director	130	27,300	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	95	5,360	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)	335	$ 38,548		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	278	$ 15,554	10.3	50
51	Licensed Practical Nurses	635	33,047	10.3	51
52	Certified Nurse Assistants/Aides	27	864	10.3	52
53	TOTAL (lines 50 - 52)	940	$ 49,465		53

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JULIE JOHNSON	ADMIN	0	$ 78,558
(INCLUDED IN B: AHE)			
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 78,558

B. Administrative - Other

Description	Amount
AMERICAN HEALTH ENTERPRISES	$ 186,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 186,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
JOHN PYSE CONSULT	IT CONSULT	$ 9,903
MIDWEST AUTOMATED TIME	TIMECLOCK MAINT	1,010
POINTCLICKCARE	PATIENT SOFTWARE	34,976
MEDIPROCITY	HIPPA SOFTWARE	1,752
ESOLUTIONS	BILLING SOFTWARE	2,886
TERRILL CONSULTING	CMI CONSULTANT	12,194
ONSHIFT	SCHEDULING SOFTWARE	4,840
LOGMEIN	REMOTE DESKTOP SOFTWA	854
BARRACUDA	EMAILSOFTWARE	2,918
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 71,333

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 26,961
Unemployment Compensation Insurance	7,095
FICA Taxes	189,045
Employee Health Insurance	8,478
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
LIFE/VISION/SUPP INS	9,025
DENTAL INS	4,375
RETIREMENT	23,695
PROFESSIONAL LICENSE/TUITION	500
EMPLOYEE RECOGNITION	35,753
TOTAL (agree to Schedule V, line 22, col.8)	$ 304,927

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	9,237
Health Care Worker Background Check	
(Indicate # of checks performed 30)	488
Patient Background Checks 16	500
DUES AND SUBSCRIPTIONS	7,130
PUBLIC RELATIONS	1,710
LICENSE	2,263
ADVERTISING/MARKETING	6,576
Less: Public Relations Expense	(1,976)
Non-allowable advertising	(2,624)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 23,304

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,190
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,190

**See instructions.

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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. $ 28,531 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ 189,486
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. $ 8,246

(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?
Firm Name: NO

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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 01/01/2020
Report Period Ending 12/31/2020

			Total Cost
1	**Name & Title**	Trinity Solomon	
	Date Traveled	7/28 - 7/30	
	Location	Milwaukee WI	
	Title	Dementia Capable Care - Instructor Renewl	
	Sponsor	CPI	-
	Total Cost	$940.00	940.00
2	**Name & Title**	Julie Johnson, Stan Schuleng, Christa Darr, Amber Johnson, Anna Kuhl, Trinity Solomon	
	Date Traveled	9/12 - 9/14	
	Location	Online	
	Title	IHCA Annual Conference	
	Sponsor	IHCA	
	Total Cost	$250.00	250.00
3	**Name & Title**		
	Date Traveled		
	Location		
	Title		
	Sponsor		
	Total Cost		

Total Seminars	$1,190.00
Mileage	$0.00
	$1,190.00
Total - Schedule V, Line 24 - Other	$1,190.00
Total - Schedule V, Line 24 - Adjustments	$0.00
Total - Schedule V, Line 24 - 8	$1,190.00