

		FOR BHF USE					

LL1

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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

I. IDPH License ID Number: 0021394

Facility Name: BIG MEADOWS

Address: 1000 LONGMOOR SAVANNA 61074
Number City 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
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☒ Corporation
☐ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2012 to 12/31/2012 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) 07/03/2013
(Date)

(Type or Print Name) MILT RUE

(Title) CHIEF FINANCIAL OFFICER

Paid
Preparer

(Signed)
(Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) () Fax # ()

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

Facility Name & ID Number BIG MEADOWS# 0021394 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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 07/10/2012

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	98	Intermediate (ICF)	76	32,018	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	98	TOTALS	76	32,018	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	12,713	4,549		17,262	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,713	4,549		17,262	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 53.91%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census?

YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 11/11/1976

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 09/19/2001 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/2012 Fiscal Year: 12/31/2012

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

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						
		1	2	3	4	5	6	7	8	9	10
	A. General Services										
1	Dietary	163,719	13,703	9,013	186,435		186,435		186,435		1
2	Food Purchase		112,025		112,025		112,025	(7,425)	104,600		2
3	Housekeeping	53,147	16,564		69,711		69,711		69,711		3
4	Laundry	45,907	10,116		56,023		56,023		56,023		4
5	Heat and Other Utilities			143,259	143,259		143,259	(10,277)	132,982		5
6	Maintenance	70,541	14,924	21,464	106,929		106,929	10,018	116,947		6
7	Other (specify):*										7
8	TOTAL General Services	333,314	167,332	173,736	674,382		674,382	(7,684)	666,698		8
	B. Health Care and Programs										
9	Medical Director			24,000	24,000		24,000		24,000		9
10	Nursing and Medical Records	934,643	111,342	1,630	1,047,615	(22,906)	1,024,709		1,024,709		10
10a	Therapy	22,833	302	76,153	99,288	(70,594)	28,694		28,694		10a
11	Activities	39,546	4,550		44,096		44,096		44,096		11
12	Social Services	47,327		2,333	49,660		49,660		49,660		12
13	CNA Training										13
14	Program Transportation		6,277	11,475	17,752	(9,596)	8,156		8,156		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,044,349	122,471	115,591	1,282,411	(103,096)	1,179,315		1,179,315		16
	C. General Administration										
17	Administrative			64,000	64,000		64,000	89,985	153,985		17
18	Directors Fees										18
19	Professional Services			20,538	20,538		20,538		20,538		19
20	Dues, Fees, Subscriptions & Promotions			29,264	29,264		29,264	(20,794)	8,470		20
21	Clerical & General Office Expenses	37,858	20,888	11,734	70,480		70,480	4,270	74,750		21
22	Employee Benefits & Payroll Taxes			258,106	258,106		258,106	18,562	276,668		22
23	Inservice Training & Education			2,774	2,774		2,774		2,774		23
24	Travel and Seminar			9,880	9,880	(2,830)	7,050		7,050		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			24,767	24,767		24,767		24,767		26
27	Other (specify):* SALES TAX			574	574		574	(574)			27
28	TOTAL General Administration	37,858	20,888	421,637	480,383	(2,830)	477,553	91,449	569,002		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,415,521	310,691	710,964	2,437,176	(105,926)	2,331,250	83,765	2,415,015		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			28,498	28,498		28,498	103,231	131,729			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			34,111	34,111		34,111	98,925	133,036			32
33	Real Estate Taxes			28,324	28,324		28,324		28,324			33
34	Rent-Facility & Grounds			115,810	115,810		115,810	(115,810)				34
35	Rent-Equipment & Vehicles			6,000	6,000	(4,200)	1,800		1,800			35
36	Other (specify):*											36
37	TOTAL Ownership			212,743	212,743	(4,200)	208,543	86,346	294,889			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					16,626	16,626		16,626			38
39	Ancillary Service Centers					93,500	93,500		93,500			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			153,055	153,055		153,055		153,055			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			153,055	153,055	110,126	263,181		263,181			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,415,521	310,691	1,076,762	2,802,974		2,802,974	170,111	2,973,085			45

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

Big Meadows, Inc. -- 0021394
Report Period Beginning -- 01/01/2012
Report Period Ending -- 12/31/2012

RECLASSIFICATIONS, Pages 3 & 4		<u>Dr.</u>	<u>Cr.</u>	<u>Line #</u>
MEDICALLY NECASSRY TRANSPORTATION	Medically Necessary Transportation	16,626		38
	Program Transportation		12,426	14
	Rent-Equipment and Vehicles		4,200	35
TRAVEL & SEMINAR FOR NURSING STAFF	Program Transportation	2,830		14
	Travel and Seminar		2,830	24
PUBLIC AID OXYGEN	Ancillary Service Center	22,906		39
	Nursing & Medical Records		22,906	10
REIMBURSED THERAPY	Ancillary Service Center	70,594		39
	Therapy		70,594	10a

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(7,425)	2		4
5	Telephone, TV & Radio in Resident Rooms	(10,277)	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	(644)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(574)	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	(13,349)	20		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(4,279)	20		28
29	Other-Attach Schedule SEE PAGE 5A	6,136			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (30,412)		\$	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)	200,523		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 200,523		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 170,111		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		\$ 16,626	14, 35	38
39	PUBLIC AID OXYGEN	XX		22,906	10	39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	THERAPY	XX		70,594	10A	44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 110,126		47

BIG MEADOWS

Report Period Beginning: ID# 0021394

Ending: 01/01/2012

12/31/2012

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	PUBLIC RELATIONS	\$ (1,575)	20	1
2	NEW EQUIPMENT UNDER \$2500	10,018	6	2
3	DEPRECIATION ON ASSETS UNDER \$2500	(716)	30	3
4	PAC PORTION OF IHCA DUES	(1,591)	20	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	6,136		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(7,425)	0	0	0	0	0	0	0	0	0	0	(7,425)	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	(10,277)	0	0	0	0	0	0	0	0	0	0	(10,277)	5
6	Maintenance	10,018	0	0	0	0	0	0	0	0	0	0	10,018	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(7,684)	0	0	0	0	0	0	0	0	0	0	(7,684)	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	89,985	0	0	0	0	0	0	0	0	0	89,985	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	(20,794)	0	0	0	0	0	0	0	0	0	0	(20,794)	20
21	Clerical & General Office Expenses	0	4,270	0	0	0	0	0	0	0	0	0	4,270	21
22	Employee Benefits & Payroll Taxes	0	18,562	0	0	0	0	0	0	0	0	0	18,562	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):*	(574)	0	0	0	0	0	0	0	0	0	0	(574)	27
28	TOTAL General Administration	(21,368)	112,817	0	0	0	0	0	0	0	0	0	91,449	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(29,052)	112,817	0	0	0	0	0	0	0	0	0	83,765	29

STATE OF ILLINOIS

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(716)	103,947	0	0	0	0	0	0	0	0	0	103,231	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(644)	99,569	0	0	0	0	0	0	0	0	0	98,925	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(115,810)	0	0	0	0	0	0	0	0	0	(115,810)	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	(1,360)	87,706	0	0	0	0	0	0	0	0	0	86,346	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(30,412)	200,523	0	0	0	0	0	0	0	0	0	170,111	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
AMERICAN HEALTH ENTERPRISES INC 100		WINNING WHEELS (BUILDING OWNER)	PROPHETSTOWN			
ALAN GAPINSKI	100					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	\$ 115,810	WINNING WHEELS INC - 100% BUILDING OWNER		\$	(115,810)	1
2	V	30	DEPRECIATION		WINNING WHEELS INC - 100% BUILDING OWNER		103,947	103,947	2
3	V	32	INTEREST		WINNING WHEELS INC - 100% BUILDING OWNER		99,569	99,569	3
4	V	17	PROFESSIONAL SERVICES	64,000	AMERICAN HEALTH ENTERPRISES INC	100.00%		(64,000)	4
5	V	17	HOME OFFICE COSTS		AMERICAN HEALTH ENTERPRISES INC		153,985	153,985	5
6	V	21	HOME OFFICE COSTS		AMERICAN HEALTH ENTERPRISES INC		4,270	4,270	6
7	V	22	HOME OFFICE COSTS		AMERICAN HEALTH ENTERPRISES INC		18,562	18,562	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 179,810			\$ 380,333	\$ * 200,523	14

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

Facility Name & ID Number BIG MEADOWS # 0021394 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ALAN GAPINSKI	PRESIDENT		100.00		2	4.00		\$ NONE		1
2	AMERICAN HEALTH ENTERPRISES, INC.										2
3	MANAGEMENT FEES FROM WINNING WHEELS				208,955						3
4	MANAGEMENT FEES FROM STRIVE				126,869						4
5	MANAGEMENT FEES FROM PINNACLE PLACE				35,212						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: 01/01/2012 Ending: 2/31/2012

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 ☒ NO ☐

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	Admin. Home Office Salaries	GROSS REVENUES	8,476,898	4	\$ 225,541	\$ 225,541	2,555,992	\$ 68,006	1
2	17	Administrator Salary	DIRECT COST	1	1	85,979	85,979	1	85,979	2
3	22	Employee Benefits	% OF PAYROLL	535,745	4	64,580	0	153,985	18,562	3
4	21	Office costs	GROSS REVENUES	8,476,898	4	14,160	0	2,555,992	4,270	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					\$ 390,260	\$ 311,520		\$ 176,817	25

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		XX	BUILDING MORTGAGE	\$12,058.57	06/2004	\$ 1,730,000	\$ 1,437,005	06/30/29	6.7000	\$ 99,569	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	WINNING WHEELS, INC.	XX		WORKING CAPITAL	INTEREST ONLY	10/2009	1,000,000	955,000	10/2014	5.0000	34,111	6	
7												7	
8												8	
9	TOTAL Facility Related				\$12,058.57		\$ 2,730,000	\$ 2,392,005			\$ 133,680	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 2,730,000	\$ 2,392,005			\$ 133,680	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	52,725	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	39,277	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(13,448)	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	39,277	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	2,495	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.			\$	28,324	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		200756,2488	FOR BHF USE ONLY		
		200856,5399			
		200957,46210	13	FROM R. E. TAX STATEMENT FOR 2011 \$	13
		201057,18011	14	PLUS APPEAL COST FROM LINE 5 \$	14
		201139,27712	15	LESS REFUND FROM LINE 6 \$	15
We spent \$7,486 to appeal the 2011 - 2013 real estate tax assessments. The appeal was won and the real estate taxes were lowered from \$57,180 per year to \$39,277 per year. The expense for the appeal will be taken over the 3 years as the taxes are paid. The amount on line 5 represents 1/3 of the total appeal cost.			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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME
BIG MEADOWS

COUNTY
CARROLL

FACILITY IDPH LICENSE NUMBER
0021394

CONTACT PERSON REGARDING THIS REPORT
MILT RUE

TELEPHONE
815-778-3683
FAX #:
815-778-4503

A.
Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1. 08-07-03-400-003	77 SAV L73 S3 T24 R3 PT	\$ 39,277.42	\$ 39,277.42
2.	660' X 880' SE. & .28 AC ADJ	\$	\$
3.	N SIDE B77 P347 08-000-073-00	\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 39,277.42	\$ 39,277.42

B.
Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES XX NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

CARROLL COUNTY
DIANE L. POWERS
COUNTY TREASURER
P.O. BOX 198
MOUNT CARROLL, IL 61053-0198

CARROLL COUNTY PROPERTY TAX BILL
2011 PAYABLE 2012

PLEASE READ the instructions on the back of this bill regarding when to pay and where to pay your taxes. Additional information is provided for changing your mailing address and tax exemptions in which you might be entitled.

The County Collector only collects your taxes and is not responsible for the amount of your assessment or the amount of your tax bill. We will be happy to assist you or direct you to the proper authority regarding questions about your tax bill.

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

08-000-073-00

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

TAX CODE 08003 CARROLL COUNTY
ITEMIZED STATEMENT TOWNSHIP
Savanna Township

Taxing Body		Prior Year Rate	Prior Year Amount	Current Rate	Current Amount	% of Total
TRI-TWP MUNICIPAL AIRPRT		0.05767	\$322.40	0.05972	\$223.03	0.57
CARROLL COUNTY		0.68398	\$3,823.74	0.67888	\$2,535.40	6.46
CARROLL COUNTY	PENSION	0.16227	\$907.16	0.17964	\$670.90	1.71
HIGHLAND JC 519		0.47662	\$2,664.51	0.48479	\$1,810.53	4.61
HIGHLAND JC 519	PENSION	0.00848	\$47.41	0.00881	\$32.90	0.08
SAVANNA LIBRARY DIST		0.21344	\$1,193.22	0.21326	\$796.45	2.03
SAVANNA LIBRARY DIST	PENSION	0.03495	\$195.39	0.03629	\$135.53	0.35
SAVANNA PARK DIST		0.63330	\$3,540.42	0.64078	\$2,393.09	6.09
SAVANNA PARK DIST	PENSION	0.06339	\$354.38	0.06366	\$237.75	0.61
SAVANNA TWP		0.17420	\$973.85	0.17636	\$658.64	1.68
SAVANNA R&B		0.14699	\$821.74	0.14881	\$555.75	1.41
SAVANNA U300 BOND		0.00000	\$0.00	0.00000	\$0.00	0.00
WEST CARROLL U314		5.26641	\$29,441.52	5.30391	\$19,808.29	50.43
WEST CARROLL U314	PENSION	0.40313	\$2,253.65	0.41110	\$1,535.33	3.91
SAVANNA CORP		1.28374	\$7,176.66	1.41830	\$5,296.87	13.49
SAVANNA CORP	PENSION	0.61955	\$3,463.55	0.69269	\$2,586.96	6.59
Totals						
		10.22812	\$57,179.60	10.51700	\$39,277.42	

LOCATION: 1000 LONGMOOR
SAVANNA, IL

Owner Name: WINNING WHEELS INC

PLEASE SEE REVERSE SIDE FOR PAYMENT INFORMATION

PROPERTY INDEX NUMBER (PIN)
08-07-03-400-003

PROPERTY CLASS 0050

FIRST DUE DATE	1977 EQUALIZED
07/06/2012	0
FIRST INSTALLMENT	SAF BASE
\$19,638.71	0
SECOND DUE DATE	FAIR CASH VALUE
09/07/2012	1,120,398
SECOND INSTALLMENT	TOTAL ACRES
\$19,638.71	13.33
PRIOR TAX SOLD	TIF BASE
	0
FORFEITED	LAND VALUE
	45,539
	+ BUILDING VALUE
	327,927
	+ FARM BUILDING
	0
	+ FARM LAND
	0
	-HOME IMPROVEMENT
	0
	- DISABLE VET EXEMPT
	0

ASSESSED VALUE	373,466
x STATE MULTIPLIER	1.0000
= EQUALIZED VALUE	373,466
- OWNER OCCUPIED	0
- SENIOR EXMPT	0
- FREEZE EXEMPTIONS	0
- RT VETERAN EXEMPT	0
- DISABLE VET EXEMPT	0
- DISABLE PER EXEMPT	0
= NET TAXABLE VAL.	373,466
x TAX RATE	10.51700
= CURRENT TAX	\$39,277.42
- ENTERPRISE ZONE	\$0.00
+ FORFEITURE BAL.	\$0.00
= TOTAL TAX DUE	\$39,277.42

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: **55,835**

B. General Construction Type: Exterior **BRICK** Frame **CEMENT BLOCK** Number of Stories **1**

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

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

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

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

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO

If so, please complete the following:

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

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

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

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

	1		2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	98		2001	1968	\$ 2,659,130	\$ 68,183	39	\$ 68,183	\$	\$ 806,835	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	2001 IMPROVEMENTS			2001	1,182	79	15	79		880	9
10	2002 IMPROVEMENTS			2002	265,858	13,496	19	13,496		143,028	10
11	2003 IMPROVEMENTS			2003	103,350	6,390	14	6,390		73,877	11
12	2004 IMPROVEMENTS			2004	73,880	5,061	13	5,061		47,282	12
13	2005 IMPROVEMENTS			2005	62,770	2,529	15	2,529		39,746	13
14	2006 IMPROVEMENTS			2006	4,514	286	18	286		1,943	14
15	OUTSIDE LIGHT FIXTURES			2008	2,813	141	20	141		727	15
16	KITCHEN AREA HORN			2008	854	57	15	57		294	16
17	HOME FREE SYSTEM			2008	23,201	1,160	20	1,160		5,994	17
18	ORNAMENTAL FENCE			2008	3,836	192	20	192		975	18
19	FIRE DAMPERS			2008	5,487	274	20	274		1,395	19
20	FIRE DOORS			2008	9,647	482	20	482		2,452	20
21	SEALCOAT PARKING LOTS			2008	6,324	632	10	632		3,478	21
22	CCTV EQUIPMENT INSTALLATION			2008	6,554	655	10	655		3,605	22
23	30 TON CHILLER			2010	28,082	2,808	10	2,808		8,425	23
24	DRAIN TILING AND DRAINAGE DITCH			2010	4,600	460	10	460		1,150	24
25	HOSPICE ROOM FLOORING			2010	5,335	356	15	356		889	25
26	FLOORING			2011	3,308	473	7	473		1,181	26
27	ELEVATOR REPAIRS			2011	6,456	922	7	922		2,306	27
28	FIRE RATED DOORS			2011	935	134	7	134		334	28
29	FIRE RATED DOORS			2011	7,672	1,096	7	1,096		1,644	29
30	SMOKE DETECTORS			2011	3,433	229	15	229		458	30
31	FIRE PANEL ANNUNCIATOR			2011	4,368	291	15	291		485	31
32	FIRE RATED DOORS			2012	2,609	186	7	186		186	32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

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

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$175,031	\$23,709	\$23,709	\$	8.1	\$105,037	71
72	Current Year Purchases	15,712	1,448	1,448		5.7	1,448	72
73	Fully Depreciated Assets	659,542					659,542	73
74								74
75	TOTALS	\$850,285	\$25,157	\$25,157	\$		\$766,027	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)	\$4,285,483	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$131,729	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$131,729	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$1,915,596	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:WINNING WHEELS, INC
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.☒ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1968	98	9/19/01	\$115,810	20		3
4	Additions							4
5								5
6								6
7	TOTAL		98		\$115,810			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:☒ YES☐ NO
- Terms:VARIOUS*

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

15. Is Movable equipment rental included in building rental?☐ YES☒ NO
16. Rental Amount for movable equipment: \$Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	TRANSPORTATION	2005 FORD VAN	\$500.00	\$6,000	17
18					18
19					19
20					20
21	TOTAL		\$500.00	\$6,000	21

10. Effective dates of current rental agreement:

Beginning9/19/01
Ending9/19/2021

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

	Fiscal Year Ending	Annual Rent
12.	12/31/2013	\$141,200
13.	12/31/2014	\$173,600
14.	12/31/2015	\$194,200

* 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.

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

☒ 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

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		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)	\$			

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		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a.3	hrs	\$	1,307	\$ 31,191	\$	1,307	\$ 31,191	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		82	1,897		82	1,897	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs		2,203	43,065		2,203	43,065	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	3,592	\$ 76,153	\$	3,592	\$ 76,153	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.

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 42,994	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 11,839)	953,150		3
4	Supply Inventory (priced at COST)	30,993		4
5	Short-Term Investments			5
6	Prepaid Insurance	5,277		6
7	Other Prepaid Expenses	6,702		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,039,116	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	17,150		12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	39,604		15
16	Equipment, at Historical Cost	860,303		16
17	Accumulated Depreciation (book methods)	(786,446)		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 PROGRE	8,265		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 138,876	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,177,992	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 170,500	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	79,435		30
31	Accrued Taxes Payable (excluding real estate taxes)	26,737		31
32	Accrued Real Estate Taxes(Sch.IX-B)	39,277		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	PROVIDER TAX ASSESSMENT	57,579		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 373,528	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,538,791		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,538,791	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,912,319	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (734,327)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,177,992	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (640,400)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (640,400)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(93,927)	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)	\$ (93,927)	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)	\$ (734,327)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **BIG MEADOWS**# **0021394**Report Period Beginning: **01/01/2012**Ending: **12/31/2012****XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,586,704	1
2	Discounts and Allowances for all Levels	(12,000)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,574,704	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	94,126	6
7	Oxygen	28,891	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 123,017	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	730	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	7,425	14
15	Telephone, Television and Radio	530	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)	\$ 8,685	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	644	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 644	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	TRANSPORTATION	1,447	28
28a	SNOW PLOWING AT OTHER FACILITIES	550	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,997	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,709,047	30

		2	
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	674,382	31
32	Health Care	1,282,411	32
33	General Administration	480,383	33
	B. Capital Expense		
34	Ownership	212,743	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	153,055	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,802,974	40
41	Income before Income Taxes (line 30 minus line 40)**	(93,927)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (93,927)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,835,387	44
45	Private Pay - Net Inpatient Revenue	739,317	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,574,704	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.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,950	2,126	\$ 68,464	\$ 32.20	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,947	8,339	192,728	23.11	3
4	Licensed Practical Nurses	9,755	10,389	208,705	20.09	4
5	CNAs & Orderlies	39,905	42,082	443,137	10.53	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,624	1,856	22,833	12.30	8
9	Activity Director	2,168	2,349	31,755	13.52	9
10	Activity Assistants	753	811	7,791	9.61	10
11	Social Service Workers	1,841	2,091	47,327	22.63	11
12	Dietician					12
13	Food Service Supervisor	2,182	2,332	32,465	13.92	13
14	Head Cook	3,715	4,108	43,418	10.57	14
15	Cook Helpers/Assistants	8,989	9,909	87,835	8.86	15
16	Dishwashers					16
17	Maintenance Workers	5,080	5,491	70,541	12.85	17
18	Housekeepers	5,324	5,844	53,147	9.09	18
19	Laundry	3,938	4,433	45,907	10.36	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	1,102	1,134	18,214	16.06	22
23	Office Manager	1,989	2,067	19,645	9.50	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	1,712	1,858	21,609	11.63	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	99,974	107,219	\$ 1,415,521 *	\$ 13.20	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	180	\$ 9,013	1.3	35
36	Medical Director	120	24,000	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	41	1,630	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	47	2,333	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	388	\$ 36,976		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

[illegible]

*** Attach copy of IMRF notifications**

****See instructions.**

Big Meadows, Inc. – 0021394
Report Period Beginning – 01/01/2012
Report Period Ending – 12/31/2012
DETAIL PAGE 21, SCHEDULE XIX, SECTION G

		Total Cost	Nursing	General & Administrative
1				
Name & Title	Julie Johnson, Social Services			
Date Travel	4/24/2012			
Location	Belmont, WI			
Title of Seminar	Ethics and Boundries			
Sponsor	Southwest Health Center			
Total Cost		\$ 127.70		\$ 127.70
2				
Names & Titles	Lisa Johnson, Medical Records Michelle Boyer, MDS Coordinator			
Dates of Seminar	5/2/12 - 5/4/12			
Location	Chicago, IL			
Title	LSN Annual Conference			
Sponsor	Life Services Network			
Cost		\$ 2,765.44	\$ 1,382.72	\$ 1,382.72
3				
Name & Title	Pat Boomgarden, Administrator Joan Anderson, DON			
Dates of Seminar	7/25/2012			
Location	Schaumburg, IL			
Title	CMS Initiative			
Sponsor	Healthcare Information Network			
Cost		\$ 358.00		\$ 358.00
4				
Names & Titles	Pat Boomgarden, Administrator Joan Anderson, DON Kelly Foley, Nurse Lois Moore, Food Service Director Jaime Barnhart, Activities Director Julie Johnson, Social Services Gary Stephens, Director of Maintenance			

Dates of Seminar	9/11/12 - 9/13/12						
Location	Peoria, IL						
Title of Seminar	Annual Conference						
Sponsor	Illinois Healthcare Association						
Cost		\$	2,576.09	\$	736.03	\$	1,840.06
5							
Names & Titles	Pat Boomgarden, Administrator Joan Anderson, DON						
Date of Seminar	11/20/2012						
Location	Schaumburg, IL						
Title	Survey Update						
Sponsor	Healthcare Information Network						
Cost		\$	358.00			\$	358.00
Total Seminars		\$	6,185.23	\$	2,118.75	\$	4,066.48
Travel Reimbursements		\$	3,695.07	\$	711.37	\$	2,983.70
Total - Schedule V, Line 14				\$	2,830.12		
Total - Schedule V, Line 24						\$	7,050.18
		\$	9,880.30				

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?

NO
- (2)

Are there any dues to nursing home associations included on the cost report?

YES

If YES, give association name and amount.

IHCA - \$4,274
- (3)

Did the nursing home make political contributions or payments to a political action organization?

YES

If YES, have these costs been properly adjusted out of the cost report?

YES
- (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?

6 YEARS
- (6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$

25,726

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.

\$

153,055

This amount is to be recorded on line 42 of Schedule V.
- (12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

NO

If YES, attach an explanation of the allocation.

- (13)

Have costs for all supplies and services which are of the type that can be billed 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.

\$

7,425
- (16)

Travel and Transportation

a. Are there costs included for out-of-state travel?

NO

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

NO

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$

c. What percent of all travel expense relates to transportation of nurses and patients?

100

d. Have vehicle usage logs been maintained?

YES

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

YES

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

N/A

g. Does the facility transport residents to and from day training?

NO

Indicate the amount of income earned from providing such transportation during this reporting period.

\$
- (17)

Has an audit been performed by an independent certified public accounting firm?

NO

Firm Name:
- (18)

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

YES
- (19)

If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report?

YES

Attach invoices and a summary of services for all architect and appraisal fees.

Big Meadows, Inc. – 0021394
Report Period Beginning – 01/01/2012
Report Period Ending – 12/31/2012

Page 23, XX 19

Summary of Legal Invoices

Ward, Murray, Pace, and Johnson

1/4/2012	Defend against an employment lawsuit	\$	1,647
2/3/2012	Defend against an employment lawsuit	\$	135
3/2/2012	Defend against an employment lawsuit	\$	873
4/3/2012	Consult on Resident and POA disagreement	\$	54
5/2/2012	Defend against an employment lawsuit	\$	293
6/4/2012	Defend against an employment lawsuit	\$	2,570
6/30/2012	Consult on Resident collection issue	\$	45
8/2/2012	Consult on Resident collection issue	\$	243
9/10/2012	Consult on Resident collection issue	\$	<u>5</u>
		\$	5,864

General Ledger Trial Balance for Period Ending 12/31/2012
Big Meadows -- 0021394

Account #	Account Description	pg 17	pg 3 & 4	pg 19	Debit	Credit	Total
		Balance Sheet Code	Expense Report Code	Revenue Sheet Code			
1100-00	PETTY CASH	1.1			200.00		200.00
1110-00	THE NATIONAL BANK	1.1			42,794.33		42,794.33
1150-00	INVESTMENT IN LTC STOCK	12.1			17,150.00		17,150.00
1210-00	PUBLIC AID	3.1			854,084.55		854,084.55
1215-00	PUBLIC AID PENDING	3.1			46,691.94		46,691.94
1230-00	PRIVATE PAY	3.1			38,108.50		38,108.50
1240-00	OXYGEN	3.1			26,103.09		26,103.09
1280-00	ALLOWANCE	3.1				11,838.63	(11,838.63)
1350-00	NURSING/DIETARY/FOOD/LAUNDRY	4.1			17,465.52		17,465.52
1360-00	LINEN	4.1			10,400.04		10,400.04
1370-00	HOUSEKEEPING/MAINTENANCE	4.1			3,127.38		3,127.38
1420-00	PREPAID DUES	7.1			-		-
1425-00	PREPAID EXPENSES	7.1			5,873.02		5,873.02
1430-00	PREPAID INSURANCE	6.1			5,277.13		5,277.13
1440-00	PREPAID LONG TERM CARE LICENSE FEE	7.1			829.15		829.15
1730-00	LEASEHOLD IMPROVEMENTS	15.1			39,604.19		39,604.19
1740-00	ACCUM. DEPR. - LEASEHOLD IMPR.	17.1				19,702.71	(19,702.71)
1750-00	FURNITURE AND FIXTURES	16.1			656,466.98		656,466.98
1755-00	FF&E UNDER \$2500	16.1			10,017.81		10,017.81
1760-00	ACCUM. DEPR. - FURN. & FIXTURE	17.1				586,428.45	(586,428.45)
1765-00	ACCUM. DEPR. - FF&E UNDER \$2500	17.1				715.55	(715.55)
1770-00	VEHICLES	16.1			48,556.28		48,556.28
1780-00	ACCUM. DEPR. - VEHICLES	17.1				35,747.13	(35,747.13)
1810-00	OFFICE EQUIPMENT	16.1			145,261.96		145,261.96
1820-00	ACCUM. DEPR. - OFFICE EQUIP.	17.1				143,851.89	(143,851.89)
1840-00	CONSTRUCTION IN PROGRESS	23.1			8,264.74		8,264.74
1545-00	DUE FROM (TO) WINNING WHEELS	26.1			51,252.33		51,252.33
1546-00	DUE FROM (TO) WW INS:	26.1				4,721.33	(4,721.33)
1555-00	DUE FROM (TO) LPC	26.1			385.11		385.11
1570-00	DUE FROM (TO) PINNACLE PLACE	26.1				23,221.02	(23,221.02)
2110-00	ACCOUNTS PAYABLE	26.1				179,663.84	(179,663.84)
2120-00	ACCOUNTS PAYABLE - UNVOUCHERED	26.1				3,259.95	(3,259.95)
2130-00	DUE TO AHE	39.1			521.85		521.85
2135-00	AHE OTHER	39.1			29,378.68		29,378.68

General Ledger Trial Balance for Period Ending 12/31/2012
Big Meadows -- 0021394

Account #	Account Description	pg 17	pg 3 & 4	pg 19	Debit	Credit	Total
		Balance Sheet Code	Expense Report Code	Revenue Sheet Code			
2140-00	ACCRUED RENT-WINNING WHEELS	39.1				611,556.30	(611,556.30)
2150-00	ACCRUED WORKMEN'S COMP	26.1				15,271.55	(15,271.55)
2160-00	ACCRUED UNEMPLOYMENT	31.1				6,035.08	(6,035.08)
2170-00	ACCRUED SALES TAX	31.1				574.00	(574.00)
2180-00	ACCRUED ASSESSMENT	36.1				57,579.12	(57,579.12)
2250-00	ACCRUED PAYROLL	30.1				42,731.51	(42,731.51)
2260-00	ACCRUED VACATION	30.1				36,703.02	(36,703.02)
2310-00	ACCRUED FICA	31.1				10,952.41	(10,952.41)
2320-00	ACCRUED FEDERAL W/H	31.1				6,249.83	(6,249.83)
2330-00	ACCRUED ILLINOIS W/H	31.1				2,557.70	(2,557.70)
2340-00	ACCRUED IOWA W/H	31.1				368.00	(368.00)
2350-00	CREDIT UNION	30.1				-	-
2370-00	GARNISHMENTS	30.1				-	-
2371-00	VOLUNTARY LIFE	30.1				-	-
2372-00	MEDICAL	26.1				-	-
2373-00	DENTAL	26.1				-	-
2374-00	VISION	26.1				-	-
2375-00	INDIVIDUAL INS	26.1				-	-
2376-00	SUPPLEMENTAL INS.	26.1				-	-
2378-00	BLUE CROSS	26.1				-	-
2390-00	ANNUITY	26.1				-	-
2430-00	ACCRUED REAL ESTATE TAXES	32.1				39,277.44	(39,277.44)
2460-00	DUE TO PINNACLE HEALTH-VAN	26.1			4,000.00		4,000.00
2515-00	LINE OF CREDIT - WW	39.1				955,000.00	(955,000.00)
2560-00	PUBLIC AID ADVANCE - D.T.	39.1				2,135.46	(2,135.46)
2650-00	RESIDENT S.S.	36.1				-	-
2910-00	COMMON STOCK	47.1				1,000.00	(1,000.00)
2920-00	PAID-IN CAPITAL	47.1				31,000.00	(31,000.00)
3200-00	RETAINED EARNINGS - PRIOR	47.1			672,400.48		672,400.48
3920-00	PUBLIC AID					12,290.00	(12,290.00)
3925-00	PUBLIC AID PENDING					485.00	(485.00)
3940-00	PRIVATE PAY					4,697.00	(4,697.00)
3999-00	PATIENT DAYS OFFSET TOTAL				17,472.00		17,472.00
4020-00	PUBLIC AID			1		1,765,157.91	(1,765,157.91)

General Ledger Trial Balance for Period Ending 12/31/2012
Big Meadows -- 0021394

Account #	Account Description	pg 17	pg 3 & 4	pg 19	Debit	Credit	Total
		Balance Sheet Code	Expense Report Code	Revenue Sheet Code			
4025-00	PUBLIC AID PENDING			1		70,228.92	(70,228.92)
4040-00	PRIVATE PAY			1		743,070.69	(743,070.69)
4060-00	SUPPLIES			1		8,246.56	(8,246.56)
4070-00	PHYSICAL THERAPY			6		94,125.67	(94,125.67)
4100-00	OXYGEN			7		28,890.71	(28,890.71)
4120-00	ASSESSMENT FEES - P.A.		42.3		153,055.31		153,055.31
4150-00	BAD DEBTS			2	12,000.00		12,000.00
4240-00	TRANSPORTATION			28		1,447.80	(1,447.80)
4280-00	CABLE TV			15		530.00	(530.00)
4300-00	MEALS			14		7,425.00	(7,425.00)
4320-00	VENDING MACHINES			12		724.62	(724.62)
4360-00	INTEREST			25		644.27	(644.27)
4370-00	EMPLOYEES AT OTHER FACILITIES			28a		550.00	(550.00)
4380-00	MISCELLANEOUS			12		5.00	(5.00)
5050-00	NURSING ADMIN.		10.1		68,464.34		68,464.34
5060-00	NURSES		10.1		401,432.33		401,432.33
5070-00	AIDES		10.1		443,136.82		443,136.82
5075-00	RESTORATIVE AIDES		101.1		22,833.00		22,833.00
5120-00	RECREATION THERAPY		11.1		39,545.81		39,545.81
5140-00	SOCIAL SERVICES		12.1		47,327.27		47,327.27
5340-00	MEDICAL RECORDS		10.1		21,609.21		21,609.21
5360-00	DIETARY		1.1		163,718.74		163,718.74
5380-00	HOUSEKEEPING		3.1		53,146.56		53,146.56
5390-00	LAUNDRY		4.1		45,907.43		45,907.43
5420-00	MAINTENANCE		6.1		70,541.04		70,541.04
5460-00	ADMINISTRATION		21.1		37,858.38		37,858.38
5620-00	FICA		22.3		106,505.01		106,505.01
5640-00	WORKMENS COMP.		22.3		53,136.02		53,136.02
5650-00	UNEMPLOYMENT		22.3		54,785.71		54,785.71
5670-00	LIFE INSURANCE		22.3		3,181.28		3,181.28
5680-00	HEALTH INSURANCE		22.3		16,321.46		16,321.46
5685-00	DENTAL INSURANCE		22.3		1,605.00		1,605.00
5690-00	RETIREMENT		22.3		8,780.19		8,780.19
5700-00	PHYSICALS		22.3		1,567.25		1,567.25

General Ledger Trial Balance for Period Ending 12/31/2012
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Account #	Account Description	pg 17	pg 3 & 4	pg 19	Debit	Credit	Total
		Balance Sheet Code	Expense Report Code	Revenue Sheet Code			
5720-00	UNIFORMS		10.2		1,293.16		1,293.16
5730-00	PROFESSIONAL TRAINING		22.3		4,423.11		4,423.11
5735-00	PROFESSIONAL LICENSE FEES		22.3		1,510.45		1,510.45
5750-00	OTHER		22.3		6,290.42		6,290.42
6030-00	PHYSICANS		9.3		24,000.00		24,000.00
6100-00	PHYSICAL THERAPY		101.3		76,152.79		76,152.79
6140-00	SOCIAL SERVICES		12.3		2,333.00		2,333.00
6200-00	PHARMACY		10.3		1,630.00		1,630.00
6360-00	DIETARY		1.3		9,012.50		9,012.50
6440-00	TRANSPORTATION		14.3		11,475.00		11,475.00
6460-00	ADMINISTRATIVE		17.3		64,000.00		64,000.00
6470-00	DATA PROCESSING		19.3		14,673.70		14,673.70
7060-00	NURSING		10.2		51,303.61		51,303.61
7065-00	BRIEFS		10.2		25,051.68		25,051.68
7070-00	OXYGEN		10.2		22,906.10		22,906.10
7080-00	MATTRESSES/CUSHIONS		10.2		1,104.32		1,104.32
7120-00	RECREATION THERAPY		11.2		4,550.12		4,550.12
7140-00	PT & OT		101.2		301.99		301.99
7145-00	THICKENERS		10.2		793.19		793.19
7200-00	PHARMACY		10.2		5,932.88		5,932.88
7210-00	O.T.C. MEDS		10.2		2,957.37		2,957.37
7360-00	DIETARY		1.2		13,702.65		13,702.65
7370-00	FOOD		2.2		106,776.64		106,776.64
7375-00	SUPPLEMENTALS		2.2		5,248.80		5,248.80
7380-00	HOUSEKEEPING		3.2		16,564.45		16,564.45
7390-00	LAUNDRY		4.2		10,115.65		10,115.65
7420-00	MAINTENANCE		6.2		14,923.88		14,923.88
7440-00	TRANSPORTATION		14.2		6,276.93		6,276.93
7460-00	OFFICE		21.2		19,415.91		19,415.91
7470-00	COMPUTER SUPPLIES		21.2		1,471.79		1,471.79
8010-00	ELECTRIC & GAS		5.3		107,159.52		107,159.52
8040-00	WATER & SEWER		5.3		14,998.05		14,998.05
8060-00	TRASH REMOVAL		5.3		10,553.82		10,553.82
8080-00	CABLE TV		5.3		10,547.42		10,547.42

General Ledger Trial Balance for Period Ending 12/31/2012
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Account #	Account Description	pg 17	pg 3 & 4	pg 19	Debit	Credit	Total
		Balance Sheet Code	Expense Report Code	Revenue Sheet Code			
8090-00	INTERNET		21.3		989.55		989.55
8100-00	REPAIRS & MAINTENANCE		6.3		21,464.33		21,464.33
8120-00	RENT		34.3		115,810.46		115,810.46
8125-00	RENT - VAN		35.3		6,000.00		6,000.00
8130-00	REAL ESTATE TAXES		33.3		28,323.78		28,323.78
9010-00	TELEPHONE		21.3		5,735.76		5,735.76
9020-00	DUES & SUBSCRIPTIONS		20.3		7,233.66		7,233.66
9040-00	INSURANCE		26.3		24,766.81		24,766.81
9080-00	POSTAGE		21.3		3,553.59		3,553.59
9100-00	LEGAL & ACCOUNTING		19.3		5,863.90		5,863.90
9110-00	MARKETING		20.3		4,281.26		4,281.26
9120-00	RECRUITMENT		20.3		1,643.37		1,643.37
9130-00	ADVERTISING		20.3		13,205.47		13,205.47
9140-00	TRAVEL & SEMINAR		24.3		6,185.23		6,185.23
9141-00	TRAVEL EXPENSES-NON SEMINAR		24.3		3,695.07		3,695.07
9150-00	TRAINING		23.3		2,751.68		2,751.68
9151-00	NURSE AID TRAINING		23.3		22.75		22.75
9160-00	LICENSE & TAXES		21.3		806.48		806.48
9170-00	SALES TAX		27.3		574.00		574.00
9175-00	BACKGROUND CHECK		20.3		1,325.00		1,325.00
9180-00	OTHER		21.3		649.01		649.01
9190-00	COMMUNITY RELATIONS		20.3		1,574.70		1,574.70
9335-00	INTEREST-WW		32.3		34,111.23		34,111.23
9450-00	DEPRECIATION		30.3		28,497.86		28,497.86

5,566,661.07 -