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.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

I. IDPH License ID Number: 0024745

Facility Name: Winning Wheels

Address: 701 East 3rd Street (Number) Prophetstown (City) 61277 (Zip Code)

County: Whiteside

Telephone Number: 815-537-5168 **Fax #** 815-537-5268

HFS ID Number:

Date of Initial License for Current Owners: 09/10/1979

Type of Ownership:

xx	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
xx	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501C3			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Robin Jackson **Telephone Number:** 815-537-5168
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 07/01/2014 to 06/30/2015 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 Jackson
(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 Winning Wheels # 0024745 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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	88	Skilled (SNF)	88	32,120	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	88	TOTALS	88	32,120	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	27,257	1,233	2,021	30,511	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,257	1,233	2,021	30,511	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.99%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [xx]

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

I. On what date did you start providing long term care at this location?
Date started 09/10/1979

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [xx]

K. Was the facility certified for Medicare during the reporting year?
YES [xx] NO [ ] If YES, enter number of beds certified 88 and days of care provided 1,062

Medicare Intermediary CGS Administrators Inc.

IV. ACCOUNTING BASIS

ACCRUAL [xx] MODIFIED CASH* [ ] CASH* [ ]

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

Tax Year: 06/30/2015 Fiscal Year: 06/30/2015

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

Facility Name & ID Number Winning Wheels # 0024745 **Report Period Beginning:** 07/01/2014 **Ending:** 06/30/2015

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	260,551	18,487	8,006	287,044		287,044		287,044			1
2	Food Purchase		204,516		204,516		204,516	(8,717)	195,799			2
3	Housekeeping	142,018	22,662		164,680		164,680		164,680			3
4	Laundry	66,599	17,382		83,981		83,981		83,981			4
5	Heat and Other Utilities			133,478	133,478		133,478		133,478			5
6	Maintenance	98,595	44,779	37,546	180,920		180,920		180,920			6
7	Other (specify):*											7
8	**TOTAL General Services**	567,763	307,826	179,030	1,054,619		1,054,619	(8,717)	1,045,902			8
	B. Health Care and Programs											
9	Medical Director			30,120	30,120		30,120		30,120			9
10	Nursing and Medical Records	1,920,144	185,441	48,771	2,154,356		2,154,356		2,154,356			10
10a	Therapy		19,962	580,422	600,384	(334,493)	265,891		265,891			10a
11	Activities	83,445	7,093	5,980	96,518		96,518		96,518			11
12	Social Services	207,681		3,628	211,309		211,309		211,309			12
13	CNA Training	3,447	544		3,991		3,991	(1,030)	2,961			13
14	Program Transportation	58,138	25,449		83,587	(36,322)	47,265		47,265			14
15	Other (specify):* DENTAL			625	625		625		625			15
16	**TOTAL Health Care and Programs**	2,272,855	238,489	669,546	3,180,890	(370,815)	2,810,075	(1,030)	2,809,045			16
	C. General Administration											
17	Administrative			222,459	222,459		222,459		222,459			17
18	Directors Fees											18
19	Professional Services			123,556	123,556		123,556		123,556			19
20	Dues, Fees, Subscriptions & Promotions			26,981	26,981		26,981		26,981			20
21	Clerical & General Office Expenses	68,427	35,414	12,860	116,701		116,701	94,468	211,169			21
22	Employee Benefits & Payroll Taxes			402,888	402,888		402,888	10,772	413,660			22
23	Inservice Training & Education			23,965	23,965		23,965		23,965			23
24	Travel and Seminar			8,276	8,276		8,276	(2,434)	5,842			24
25	Other Admin. Staff Transportation			3,830	3,830		3,830		3,830			25
26	Insurance-Prop.Liab.Malpractice			52,068	52,068		52,068		52,068			26
27	Other (specify):*											27
28	**TOTAL General Administration**	68,427	35,414	876,883	980,724		980,724	102,806	1,083,530			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,909,045	581,729	1,725,459	5,216,233	(370,815)	4,845,418	93,059	4,938,477			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.

WINNING WHEELS - 24745
Report Period Beginning 7/1/14
Report Period Ending 6/30/15

	DETAIL SCHEDULE - V-LINE 24		In State	Out of State
1	Name & Title	Amie Topp, Director of Human Resources		
	Date of Seminar	8/20/2014		
	Location	Boilingbrook, IL		
	Title of Seminar	Hiring & Firing		
	Sponsor	IL Chamber of Commerce		
	Cost	$382.68	$382.68	
2	Name & Title	Jill Smith, Administrator Geri Purvis, Dietary Director Amie Behrens, Director of Marketing & Admissions Steven Humphrey, Activities Director Sam Card, CFO Steve Territo, VP of Operations		
	Date of Seminar	09/08/2014 - 09/11/2014		
	Location	Peoria, IL		
	Title of Seminar	64th Annual Convention & Trade Show		
	Sponsor	Illinois Health Care Association		
	Cost	$3,945.91	$3,945.91	
3	Name & Title	Amie Behrens, Director of Marketing & Admissions Kathryn Wynn-Calvin,		
	Date of Seminar	10/23/2014 - 10/25/2014		
	Location	Oak Brook, IL		
	Title of Seminar	Brain Injury Conference		
	Sponsor	Brain Injury Association of Illinois		

	Cost	$1,055.09	$1,055.09	
4	Name & Title	Amie Topp, Director of Human Resources		
	Date of Seminar	4/8/2015		
	Location	Boilingbrook, IL		
	Title of Seminar	Wage & Hour Regulations of IL employees		
	Sponsor	IL Chamber of Commerce		
	Cost	$278.75	$278.75	
5	Name & Title	Amie Behrens, Director of Marketing & Admissions		
		Katrina Gerber, Social Services		
		Sheila Huizenga, Social Services		
		Kathie Morgan-Dodge, Director of Nursing		
	Date of Seminar	03/04/2015 - 03/06/2015		
	Location	Des Moines, IA		
	Title of Seminar	Iowa Brain Injury Conference		
	Sponsor	Brain Injury Association of Iowa		
	Cost	$2,433.84	$0.00	$2,433.84
		This is the closest to Winning Wheels		
6	Name & Title	Kerrington Johns, Activity Aide		
	Date of Seminar	6/30/15 - 7/1/15		
	Location	Highland, IL		
	Title of Seminar	SSD Basic Training		
	Sponsor	OSI		
	Cost	$180.00	$180.00	
			$5,842.43	$2,433.84
		Total Seminars	$8,276.27	

Less: Out of State Travel & Seminars	$0.00
Mileage for seminars	$1,691.00
Seminar expense	$6,585.00
Total Travel and Seminars	$8,276.00

Total - Schedule V, Line 24 - Other	$8,276.27
Total - Schedule V, Line 24 - Adjustments	$0.00
Total - Schedule V, Line 24 - 8	$8,276.00

Facility Name & ID Number Winning Wheels #0024745 **Report Period Beginning:** 07/01/2014 **Ending:** 06/30/2015

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			303,944	303,944		303,944	(7,716)	296,228			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			195,175	195,175		195,175	(391)	194,784			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			499,119	499,119		499,119	(8,107)	491,012			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					36,322	36,322		36,322			38
39	Ancillary Service Centers					334,493	334,493		334,493			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			226,398	226,398		226,398		226,398			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			226,398	226,398	370,815	597,213		597,213			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,909,045	581,729	2,450,976	5,941,750		5,941,750	84,952	6,026,702			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 Winning Wheels # 0024745 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(8,717)	2		4
5	Telephone, TV & Radio in Resident Rooms	(15,219)	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	(391)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(4,142)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees	(1,030)	13		27
28	Yellow Page Advertising				28
29	Other-Attach Schedule DEPRECIATION UNDER $2500	(7,716)	30		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (37,215)		$	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)	105,240		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 105,240		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 68,025		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		$ 36,322	14	38
39	MEDICARE THERAPY	XX		333,493	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					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 369,815		47

STATE OF ILLINOIS **Page 5A**

Winning Wheels

ID# 0024745

Report Period Beginning: 07/01/2014

Ending: 06/30/2015

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Depreciation of assets under $2500	$ 7,716	30	1
2	Interest Income	391	32	2
3	Cable	15,219	5	3
4	Other Facility CAN Training	1,030	13	4
5	PAC PORTION OF IHCA DUES	4,142	20	5
6	Out of State Travel	2,434	24	6
7	Non-Resident Food	8,717		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**	39,649		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Winning Wheels **#** 0024745 **Report Period Beginning:** 07/01/2014 **Ending:** 06/30/2015

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	(8,717)	0	0	0	0	0	0	0	0	0	0	(8,717)	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	0	0	0	0	0	0	0	0	0	0	0	0	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**	(8,717)	0	0	0	0	0	0	0	0	0	0	(8,717)	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	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	94,468	0	0	0	0	0	0	0	0	0	94,468	21
22	Employee Benefits & Payroll Taxes	0	10,772	0	0	0	0	0	0	0	0	0	10,772	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	2,434	0	0	0	0	0	0	0	0	0	0	2,434	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):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	2,434	105,240	0	0	0	0	0	0	0	0	0	107,674	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(6,283)	105,240	0	0	0	0	0	0	0	0	0	98,957	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Winning Wheels # 0024745 **Report Period Beginning:** 07/01/2014 **Ending:** 06/30/2015

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	7,716	0	0	0	0	0	0	0	0	0	0	7,716	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	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**	7,716	0	0	0	0	0	0	0	0	0	0	7,716	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)**	1,433	105,240	0	0	0	0	0	0	0	0	0	106,673	45

Facility Name & ID Number Winning Wheels # 0024745 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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	100	Strive	Prophetstown	Lyndon Progress Center	Lyndon	Day Treatment
		Big Meadows (Building Only)	Savanna	Lyndon Play & Learn Center	Lyndon	Child Care
		Pinnacle Place SLF	Savanna			
				Frontier Holllow Apartments	Prophetstown	Independent Living Facility

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V		Administrative Overhead						4
5	V	21	Clerical Salaries		Winning Wheels Inc (Administrative Fund	100.00%	94,468	94,468	5
6	V	22	Benefits		(See detail schedule V111, page 8)		10,772	10,772	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$ 105,240	$ * 105,240	14

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

Facility Name & ID Number Winning Wheels # 0024745 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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	BOARD OF DIRECTORS							1
2	JOHN GUZZARDO - PRESIDENT	0	n/a		n/a			2
3	DAVID MICKLEY	0	n/a		n/a			3
4	CONNIE DEMARANVILLE	0	n/a		n/a			4
5	BILL SULLIVAN	0	n/a		n/a			5
6	KYLE GIBSON	0	n/a		n/a			6
7	MEREDITH HAMMER	0	n/a		n/a			7
8	MARY ANN HILL	0	n/a		n/a			8
9	RICK TURNROTH	0	n/a		n/a			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 Winning Wheels # 0024745 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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									$		1
2											2
3											3
4											4
5											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 Winning Wheels # 0024745 Report Period Beginning: 07/01/2014 Ending: 6/30/2015

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: WINNING WHEELS ADMINISTRATIVE FUN
Street Address: 501 6TH AVE WEST
City / State / Zip Code: LYNDON IL 61261
Phone Number: (815-778-3683
Fax Number: (815-778-4503

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	CLERICAL SALARIES	SALARIES/BENEFITS	7,320,171	7	$ 208,797	$	3,311,932	$ 94,468	1
2	22	FICA	SALARIES/BENEFITS	7,320,171	7	12,957		3,311,932	5,862	2
3	22	WORKERS COMP	SALARIES/BENEFITS	7,320,171	7	4,048		3,311,932	1,831	3
4	22	LIFE INSURANCE	SALARIES/BENEFITS	7,320,171	7	670		3,311,932	303	4
5	22	HEALTH INSURANCE	SALARIES/BENEFITS	7,320,171	7	1,327		3,311,932	600	5
6	22	VISION INSURANCE	SALARIES/BENEFITS	7,320,171	7	161		3,311,932	73	6
7	22	DENTAL INSURANCE	SALARIES/BENEFITS	7,320,171	7	759		3,311,932	343	7
8	22	ST & LT DISABILITY INS	SALARIES/BENEFITS	7,320,171	7	435		3,311,932	197	8
9	22	CHILD CARE	SALARIES/BENEFITS	7,320,171	7	3,350		3,311,932	1,516	9
10	22	OTHER	SALARIES/BENEFITS	7,320,171	7	102		3,311,932	46	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					$ 232,606	$		$ 105,239	25

Facility Name & ID Number Winning Wheels # 0024745 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	USDA			MORTGAGE	$17,365.00	1/8/15	$ 3,937,500	$ 3,937,500	1/8/50	3.7500	$ 73,830	1
2	FARMERS NATIONAL BANK			CONTRUCTION LOAN		4/9/13	3,900,000		12/31/14	3.9500	77,025	2
3												3
4												4
5												5
	Working Capital											
6	FARMERS NATIONAL BANK		X	LINE OF CREDIT		12/22/14	1,499,686	1,499,686	10/09/2015	2.0000	28,590	6
7	FARMERS NATIONAL BANK		X	LINE OF CREDIT		10/24/12	1,387,500	1,302,825	10/15/2015	3.9500	15,730	7
8												8
9	TOTAL Facility Related				$17,365.00		$ 10,724,686	$ 6,740,011			$ 195,175	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 10,724,686	$ 6,740,011			$ 195,175	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 Winning Wheels **#** 0024745 **Report Period Beginning:** 07/01/2014 **Ending:** 06/30/2015

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	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.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$	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.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010		8
	2011		9
	2012		10
	2013		11
	2014		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Winning Wheels COUNTY Whiteside

FACILITY IDPH LICENSE NUMBER 0024745

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2014 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 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

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 _____ 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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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

Facility Name & ID Number Winning Wheels # 0024745 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 45,500 B. General Construction Type: Exterior MASONARY Frame CONCRETE BLOCK Number of Stories 1

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

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

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

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	BUILDING SITE	504,424	1973	$ 23,500	1
2					2
3	TOTALS	504,424		$ 23,500	3

Facility Name & ID Number Winning Wheels # 0024745 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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	76		1979	1979	$ 1,447,685	$ 13,745	23.35	$ 13,745	$	$ 1,393,037	4
5	4			1986							5
6	8			2014	SEE BELOW						6
7											7
8											8
	Improvement Type**										
9	REMODELING - 1980 - 1989			1989	112,145		14.63			112,145	9
10	REMODELING - 1990 - 1999			1999	563,169	8,830	13.82	8,830		555,684	10
11	2009 THERAPY ANNEX			2009	1,312,547	39,917	13.13	39,917		551,118	11
12	NEW ROOF OF MAIN BUILDING			2010	70,796	4,720	15	4,720		24,779	12
13	FLOORING IN ROOMS ON B WING			2010	4,995	714	7	714		3,211	13
14	PAINTING IN MAIN HALLWAYS			2011	10,906	1,558	7	1,558		7,011	14
15	LCD ANNUNCIATOR AT A WING NURSES STATION			2011	3,665	244	15	244		855	15
16	TILE IN SPA ROOM			2012	4,993	713	7	713		2,497	16
17	8 BED ADDITION/FACILITY RENOVATION			2014	4,617,381	118,394	39	118,394		214,517	17
18	PLUMBING FOR NEW WING			2014	4,000	980	7	980		1,551	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

*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 Winning Wheels # 0024745 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 8,152,282	$ 189,815		$ 189,815	$	$ 2,866,405	70

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

Facility Name & ID Number Winning Wheels # 0024745 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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	$ 611,486	$ 83,775	$ 83,775	$	7.43	$ 417,747	71
72	Current Year Purchases	15,553	1,722	1,722		7	1,722	72
73	Fully Depreciated Assets	1,322,421				9.05	1,322,421	73
74								74
75	TOTALS	$ 1,949,460	$ 85,497	$ 85,497	$		$ 1,741,890	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	TRANSPORT RESIDENTS	VARIOUS VANS	VARIOUS	$ 116,259	$ 11,677	$ 11,677	$	6.67	$ 88,524	76
77	TRANSPORT RESIDENTS	VARIOUS VANS	VARIOUS	156,932	1,224	1,224		5	156,319	77
78	SNOW REMOVAL	2010 DODGE 2500	2010	32,157	4,594	4,594		7	25,266	78
79	VAN	2014 FORD E450 10WC	2014	68,433	3,421	3,421		10	3,421	79
80	TOTALS			$ 373,781	$ 20,916	$ 20,916	$		$ 273,530	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)	$ 10,499,023	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 296,228	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 296,228	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)	$ 4,881,825	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 Winning Wheels # 0024745 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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. ☐ 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:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			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: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2016	$
13.	/2017	$
14.	/2018	$

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			$	$	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 Winning Wheels # 0024745 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

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

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

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

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [XX]
- 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		190	94	284
3	Classroom Wages (a)		616		616
4	Clinical Wages (b)		411		411
5	In-House Trainer Wages (c)		1,614	806	2,420
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests		130	130	260
9	TOTALS	$	$ 2,961	$ 1,030	$ 3,991
10	SUM OF line 9, col. 1 and 2 (e)	$ 2,961			

C. CONTRACTUAL INCOME

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

$ 1,296

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	2
2. From other facilities (f)	2
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	1
TOTAL TRAINED	5

(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.

f.
Big Meadows
1000 Longmoor Ave
Savanna, IL 61074

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a.3	hrs	$	4,390	$ 86,117	$	4,390	$ 86,117	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		820	43,171		820	43,171	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs		5,588	117,641		5,588	117,641	4
5	Physician Care		visits							5
6	Dental Care	15	visits		6	625		6	625	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	10a.3	# of prescrpts		34	6,085		34	6,085	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Medicare Therapy	39			12,345	333,493		12,345	333,493	12
13	Other (specify): Pysiatrian	10a.3			172	21,500		172	21,500	13
14	TOTAL			$	23,355	$ 608,632	$	23,355	$ 608,632	14

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

Facility Name & ID Number Winning Wheels # 0024745 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2015 (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	$ 548,837	$ 546,253	1
2	Cash-Patient Deposits	36,697	38,501	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 133,589)	679,594	975,472	3
4	Supply Inventory (priced at COST)	36,961	49,297	4
5	Short-Term Investments			5
6	Prepaid Insurance	15,160	17,333	6
7	Other Prepaid Expenses	27,767	96,257	7
8	Accounts Receivable (owners or related parties)	1,476,323	1,226,694	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,821,339	$ 2,949,807	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	23,500	369,861	13
14	Buildings, at Historical Cost	8,130,116	16,182,193	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,323,241	3,842,949	16
17	Accumulated Depreciation (book methods)	(4,904,097)	(10,447,056)	17
18	Deferred Charges	22,166	33,115	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		1,446,362	21
22	Other Long-Term Assets (spe NON DEPR ASSET		9,061	22
23	Other(specify): CONSTRUCTION IN PROG		266	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 5,594,926	$ 11,436,751	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 8,416,265	$ 14,386,558	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 945,949	$ 1,046,658	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	34,271	43,034	28
29	Short-Term Notes Payable	2,802,511	2,802,511	29
30	Accrued Salaries Payable	242,271	333,327	30
31	Accrued Taxes Payable (excluding real estate taxes)	99,214	99,214	31
32	Accrued Real Estate Taxes(Sch.IX-B)		17,450	32
33	Accrued Interest Payable	67,700	68,330	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	WORKERS COMP	41,128	41,128	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,233,044	$ 4,451,652	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,937,500	5,251,206	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	PUBLIC AID ADVANCE	60,788	102,126	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,998,288	$ 5,353,332	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 8,231,332	$ 9,804,984	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 184,933	$ 4,581,574	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 8,416,265	$ 14,386,558	48

***(See instructions.)**

Facility Name & ID Number Winning Wheels # 0024745 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 5,026,237	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 5,026,237	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(254,604)	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) **NET INCOME / LOSS**	(190,059)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (444,663)	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)**	$ 4,581,574	24 *

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

Facility Name & ID Number Winning Wheels # 0024745 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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	$ 5,397,010	1
2	Discounts and Allowances for all Levels	(13,479)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,383,531	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	236,615	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 236,615	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	11,945	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	7,409	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)**	$ 19,354	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	381	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 381	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	TRANSPORTATION	47,265	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 47,265	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,687,146	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,054,619	31
32	Health Care	2,810,075	32
33	General Administration	980,724	33
	B. Capital Expense		
34	Ownership	499,119	34
	C. Ancillary Expense		
35	Special Cost Centers	370,815	35
36	Provider Participation Fee	226,398	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,941,750	40
41	**Income before Income Taxes (line 30 minus line 40)****	(254,604)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (254,604)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,498,360	44
45	Private Pay - Net Inpatient Revenue	558,670	45
46	Medicare - Net Inpatient Revenue	353,459	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,410,489	49

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

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

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

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

Facility Name & ID Number Winning Wheels # 0024745 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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	1,748	1,864	$ 64,974	$ 34.86	1
2	Assistant Director of Nursing	2,338	2,490	76,001	30.52	2
3	Registered Nurses	13,677	14,586	398,096	27.29	3
4	Licensed Practical Nurses	15,922	16,909	404,252	23.91	4
5	CNAs & Orderlies	62,927	66,234	781,021	11.79	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	12,467	13,829	176,151	12.74	8
9	Activity Director	1,937	2,097	40,169	19.16	9
10	Activity Assistants	4,030	4,317	43,277	10.02	10
11	Social Service Workers	9,588	10,541	207,681	19.70	11
12	Dietician					12
13	Food Service Supervisor	1,926	2,080	58,476	28.11	13
14	Head Cook	4,882	5,462	66,449	12.17	14
15	Cook Helpers/Assistants	13,914	14,510	135,625	9.35	15
16	Dishwashers					16
17	Maintenance Workers	7,055	7,707	98,595	12.79	17
18	Housekeepers	13,167	14,248	142,018	9.97	18
19	Laundry	6,681	7,181	66,598	9.27	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	2,132	2,212	40,521	18.32	22
23	Office Manager	1,949	2,110	27,907	13.23	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	1,641	1,877	23,096	12.30	31
32	Other Health Care(specify)					32
33	Other(specify) Transportation	3,036	3,663	58,138	15.87	33
34	TOTAL (lines 1 - 33)	181,017	193,917	$ 2,909,045 *	$ 15.00	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	164	$ 8,006	1.3	35
36	Medical Director	240	30,120	9.3	36
37	Medical Records Consultant	21	1,470	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	34	6,085	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	62	4,030	11.3	44
45	Social Service Consultant	56	3,628	12.3	45
46	Other(specify) Music Therapy	40	1,950	11.3	46
47	Physiatrist	172	21,500	10.3	47
48					48
49	TOTAL (lines 35 - 48)	789	$ 76,789		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	802	21,186	10.3	52
53	TOTAL (lines 50 - 52)	802	$ 21,186		53

Facility Name & ID Number Winning Wheels # 0024745 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
BRITTANY HERWIG	ADMINSTRATOR	0	$ 32,696
JILL SMITH	ADMINSTRATOR	0	37,183
(INCLUDED IN AMERICAN HEALTH			
ENTERPRISES FEE IN B)			(69,879)
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
AMERICAN HEALTH ENTERPRISES	$ 222,459
TOTAL (agree to Schedule V, line 17, col. 3)	$ 222,459
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
ESOLUTIONS	SOFTWARE FEES	$ 5,040
JOHN PYSE CONSULTING	IT CONSULTANT	35,470
CAREVOYANT	MDS SOTWARE	18,144
E HEALTH DATA SOLUTIONS	RISK MANAGEMENT	4,265
SILVER CHAIR	SOFTWARE INSERVICE TRA	3,507
MIDWEST AUTOMATED TIME	TIME CLOCK SOFTWARE	1,029
FROST, RUTTENBERG, ROTH	AUDIT SERVICES/990 RETUF	38,486
WARD, MURRAY, PACE	LEGAL SERVICE	10,702
OTHER CONSULTANTS	OTHER CONSULT FEES	2,207
MEDIPROCITY	HIPPA SOFTWARE	1,200
GO TO MY ASSIST	DATA PROCESSING SOFT	828
GO TO MY PC	COMPUTER SOFTWARE	2,678
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 123,556

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 77,458
Unemployment Compensation Insurance	92
FICA Taxes	224,217
Employee Health Insurance	33,827
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	0
LIFE/DENTAL/VISION INSURANCE	22,533
ST & LT DISABILITY INS	11,604
PHYSICALS	2,023
CHILDCARE	11,312
TUITION/TRAINING/LINCENSE	4,520
MISC EMP BENEFITS (ANNAUL XMAS	15,302
PARTY/GIFTS/ANNUAL 5 YR BANQ	
TOTAL (agree to Schedule V, line 22, col.8)	$ 402,888

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	9,386
Health Care Worker Background Check	2,379
(Indicate # of checks performed 49)	
Patient Background Checks 53	530
ASSOCIATION DUES	3,096
CARF	1,547
NEWSPAPER MAGAZINES	3,132
ADVERTISING/MARKETING	4,871
BRAIN INJURY ASSOC	50
Less: Public Relations Expense	(4,142)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 22,839

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 2,434
NEAREST TBI TRAINING	
In-State Travel	1,691
Seminar Expense	4,151
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,276

**See instructions.

Facility Name & ID Number Winning Wheels # 0024745 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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	PAINTING	2000	$ 4,551	5	$	$	$	$	$	$	$	$	$
2	PAINTING	2000	1,262	5									
3	EXTRAS	2000	560	5									
4	DINING ROOM	2005	1,592	5									
5	PAINTING	2007	3,295	5									
6	PAINTING HALLWAY	2011	10,097	7					723	1,442	1,442	1,442	1,442
7	FLOORING	2011	809	7					56	116	116	116	116
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 22,166		$	$	$	$	$ 779	$ 1,558	$ 1,558	$ 1,558	$ 1,558

Facility Name & ID Number Winning Wheels # 0024745 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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 - TBI ASSOCIATION $3096; $50**

(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 $1870**

(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. $ **18,467** 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. $ **226,398**
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. $ **7,409**

(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? **YES** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **47,265**
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? YES
Indicate the amount of income earned from providing such transportation during this reporting period. $ **NONE**

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **FROST, RUTTENBERG, & ROTHBLATT**

(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. **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.