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.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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			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:** 815-778-3683
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 07/01/2015 to 06/30/2016 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: 07/01/2015 Ending: 06/30/2016

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 88

	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	32,208	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	32,208	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	28,581	1,062	776	30,419	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,581	1,062	776	30,419	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.45%

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 1,020

Medicare Intermediary CGS Administrators Inc.

IV. ACCOUNTING BASIS

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

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

Tax Year: 06/30/2016 Fiscal Year: 06/30/2016

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

Facility Name & ID Number Winning Wheels # 0024745 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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	252,815	18,314	10,051	281,180		281,180		281,180			1
2	Food Purchase		217,138		217,138		217,138	(4,506)	212,632			2
3	Housekeeping	128,231	21,241		149,472		149,472		149,472			3
4	Laundry	72,991	27,912		100,903		100,903		100,903			4
5	Heat and Other Utilities			122,342	122,342		122,342	(863)	121,479			5
6	Maintenance	80,529	50,953	52,343	183,825		183,825		183,825			6
7	Other (specify):*											7
8	TOTAL General Services	534,566	335,558	184,736	1,054,860		1,054,860	(5,369)	1,049,491			8
	B. Health Care and Programs											
9	Medical Director			32,910	32,910		32,910		32,910			9
10	Nursing and Medical Records	1,783,924	219,957	44,204	2,048,085		2,048,085		2,048,085			10
10a	Therapy	127,162		352,977	480,139	(235,694)	244,445		244,445			10a
11	Activities	86,487	4,042	1,625	92,154		92,154		92,154			11
12	Social Services	188,150		5,327	193,477		193,477		193,477			12
13	CNA Training	18,456	1,780		20,236		20,236	(3,201)	17,035			13
14	Program Transportation	71,181	21,602		92,783	(57,172)	35,611		35,611			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,275,360	247,381	437,043	2,959,784	(292,866)	2,666,918	(3,201)	2,663,717			16
	C. General Administration											
17	Administrative			223,000	223,000		223,000		223,000			17
18	Directors Fees											18
19	Professional Services			113,008	113,008		113,008		113,008			19
20	Dues, Fees, Subscriptions & Promotions			30,697	30,697		30,697	(5,465)	25,232			20
21	Clerical & General Office Expenses	61,925	35,171	12,386	109,482		109,482	97,005	206,487			21
22	Employee Benefits & Payroll Taxes			467,605	467,605		467,605	11,953	479,558			22
23	Inservice Training & Education			15,637	15,637		15,637		15,637			23
24	Travel and Seminar			7,599	7,599		7,599		7,599			24
25	Other Admin. Staff Transportation			928	928		928		928			25
26	Insurance-Prop.Liab.Malpractice			56,244	56,244		56,244		56,244			26
27	Other (specify):*											27
28	TOTAL General Administration	61,925	35,171	927,104	1,024,200		1,024,200	103,493	1,127,693			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,871,851	618,110	1,548,883	5,038,844	(292,866)	4,745,978	94,923	4,840,901			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Winning Wheels #0024745 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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			270,535	270,535		270,535	(6,420)	264,115			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			244,907	244,907		244,907	(937)	243,970			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			515,442	515,442		515,442	(7,357)	508,085			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					57,172	57,172		57,172			38
39	Ancillary Service Centers					235,694	235,694		235,694			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			229,005	229,005		229,005		229,005			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			229,005	229,005	292,866	521,871		521,871			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,871,851	618,110	2,293,330	5,783,291		5,783,291	87,566	5,870,857			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: 07/01/2015 Ending: 06/30/2016

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,506)	2		4
5	Telephone, TV & Radio in Resident Rooms	(863)	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	(6,420)	30		9
10	Interest and Other Investment Income	(937)	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	(2,591)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees	(3,201)	13		27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (18,518)		$	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)	108,958	21,22	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 108,958		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 90,440		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		$ 57,172	14	38
39	MEDCARE THERAPY	XX		235,694	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)**			$ 292,866		47

WINNING WHEELS - 24745
Report Period Beginning 7/1/15
Report Period Ending 6/30/16

		DETAIL SCHEDULE - V-LINE 24	In State	Out of State
1	Name & Title	Amie Topp, Director of Human Resources		
	Date of Seminar	5/19/2015		
	Location	Springfield, IL		
	Title of Seminar	Wage and Hour Regulation for IL Employees		
	Sponsor	Il Chamber of Commerce		
	Cost	$210.71	$210.71	
2	Name & Title	Brittany Herwig, Admin Joan Clayes, Restor Nurse Chris Burks, SW / Sheila Huizenga, Admiss Coord Kelsey Kant, SW / Katht Morgan Dodge - DON Tricia Clark, MDS Coord Steve Territo, VP of Operations		
	Date of Seminar	9/15/16 - 9/17/15		
	Location	Peoria, IL		
	Title of Seminar	65th Annual Convention & Trade Show		
	Sponsor	Illinois Health Care Association		
	Cost	$3,226.10	$3,217.10	
3	Name & Title	Sheila Huizenga, Admission Coord Chris Burks, SW		
	Date of Seminar	10/22/15 - 10/23/15		
	Location	Oak Brook, IL		
	Title of Seminar	Brain Injury Conference		
	Sponsor	Brain Injury Association of Illinois		
	Cost	$165.45	$165.45	
4	Name & Title	Kerrington Johns, Activity Aide Brittany Herwig, Admin Tricia Clark, MDS Coord		
	Date of Seminar	6/30/15 - 7/1/15		
	Location	Highland Park, IL		
	Title of Seminar	SSD Basic Training Course		
	Sponsor	OSI		
	Cost	$522.80	$522.80	
5	Name & Title	Sheila Huizenga, Director of Marketing & Admissions Brittany Herwig, Administrator Katrina Gerber, SW / Chris Burks, SW Kelsey Kant, SW / Joan Clayes, Restor Nurse		
	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	$2,395.80 This was the nearest TBI Conference		$2,395.83
6	Name & Title	Amie Topp		
	Date of Seminar	9/25/15 - 9/27/15		
	Location	Oak Brook, IL		
	Title of Seminar	ILSHRM HR Conference		
	Sponsor	Il Society for Human Resource Management		
	Cost	$675.00	$675.00	
7	Name & Title	Brittany Herwig, Administrator Tricia Clark, MDS Coord		
	Date of Seminar	7/2/2015		
	Location	Lisle, IL		
	Title of Seminar	I Want My Stars Back		
	Sponsor	IHCA		
	Cost	$98.90	$98.90	
8	Name & Title	Brittany Herwig, Administrator		
	Date of Seminar	11/17/15 - 11/18/15		
	Location	Springfield, IL		
	Title of Seminar	INHAA		
	Sponsor	INHAA		
	Cost	$313.60	$313.60	
			$5,203.56	$2,395.83

Total Seminars	$7,599.39
Less: Out of State Travel & Seminars	$0.00
Mileage for seminars	$1,025.47
Seminar expense	$6,573.92
Total Travel and Seminars	$7,599.39
Total - Schedule V, Line 24 - Other	$7,599.00
Total - Schedule V, Line 24 - Adjustments	$0.00
Total - Schedule V, Line 24 - 8	$7,599.00

Winning Wheels

ID# 0024745

Report Period Beginning: 07/01/2015

Ending: 06/30/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEPRECIATION OF ASSETS UNDER $2500	$ 6,420	30	1
2	INTEREST INCOME	937	32	2
3	CABLE	863	5	3
4	NON-RESIDENT FOOD	4,506	2	4
5	PAC PORTION OF IHCA DUES	2,591	20	5
6	NON ALLOWABLE ADVERTISING	2,874	20	6
7	C N A TRAINING FOR NON-EMPLOYEES	3,201	13	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
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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**	21,392		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Winning Wheels **#** 0024745 **Report Period Beginning:** 07/01/2015 **Ending:** 06/30/2016

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(4,506)	0	0	0	0	0	0	0	0	0	0	(4,506)	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	(863)	0	0	0	0	0	0	0	0	0	0	(863)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(5,369)	0	0	0	0	0	0	0	0	0	0	(5,369)	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	(3,201)	0	0	0	0	0	0	0	0	0	0	(3,201)	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**	(3,201)	0	0	0	0	0	0	0	0	0	0	(3,201)	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	(5,465)	0	0	0	0	0	0	0	0	0	0	(5,465)	20
21	Clerical & General Office Expenses	0	97,005	0	0	0	0	0	0	0	0	0	97,005	21
22	Employee Benefits & Payroll Taxes	0	11,953	0	0	0	0	0	0	0	0	0	11,953	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):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(5,465)	108,958	0	0	0	0	0	0	0	0	0	103,493	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(14,035)	108,958	0	0	0	0	0	0	0	0	0	94,923	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Winning Wheels # 0024745 **Report Period Beginning:** 07/01/2015 **Ending:** 06/30/2016

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(6,420)	0	0	0	0	0	0	0	0	0	0	(6,420)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(937)	0	0	0	0	0	0	0	0	0	0	(937)	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**	(7,357)	0	0	0	0	0	0	0	0	0	0	(7,357)	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)**	(21,392)	108,958	0	0	0	0	0	0	0	0	0	87,566	45

Facility Name & ID Number Winning Wheels # 0024745 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Winning Wheels, Inc	100	STRIVE	Prophetstown	Lyndon Progress Center	Lyndon	Day Treatment
		Big Meadows (Building Only)	Savanna	Lyndon Play and Learn Center	Lyndon	Child Care
		Pinnacle Place SLF	Savanna	Frontier Hollow Apartments	Prophetstown	Independent Living Facilities

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V		Administrative Overhead						4
5	V	21	Clerical Salaries		Winning Wheels, Inc. (Administrative Fund)	100.00%	97,005	97,005	5
6	V	22	Benefits		(See detail schedule VIII, page 8)		11,953	11,953	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$ 108,958	$ * 108,958	14

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

Facility Name & ID Number Winning Wheels # 0024745 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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	0%	N/A		N/A			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: 07/01/2015 Ending: 06/30/2016

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									$		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: 07/01/2015 Ending: 6/30/2016

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 ADMIN FUND
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	7,502,488	7	$ 217,941	$ 217,941	3,339,355	$ 97,005	1
2	22	FICA	SALARIES/BENEFITS	7,502,488	7	13,308		3,339,355	5,924	2
3	22	WORKERS COMP	SALARIES/BENEFITS	7,502,488	7	5,334		3,339,355	2,374	3
4	22	LIFE INSURANCE	SALARIES/BENEFITS	7,502,488	7	460		3,339,355	205	4
5	22	HEALTH INSURANCE	SALARIES/BENEFITS	7,502,488	7	3,042		3,339,355	1,354	5
6	22	VISION INSURANCE	SALARIES/BENEFITS	7,502,488	7	170		3,339,355	76	6
7	22	DENTAL INSURANCE	SALARIES/BENEFITS	7,502,488	7	774		3,339,355	345	7
8	22	ST & LT DISABILITY INS	SALARIES/BENEFITS	7,502,488	7	1,602		3,339,355	713	8
9	22	CHILD CARE	SALARIES/BENEFITS	7,502,488	7	1,317		3,339,355	586	9
10	22	OTHER	SALARIES/BENEFITS	7,502,488	7	845		3,339,355	376	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					$ 244,793	$ 217,941		$ 108,958	25

Facility Name & ID Number Winning Wheels # 0024745 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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	01/8/15	$ 3,937,500	$ 3,937,500	1/8/50	3.7500	$ 147,660	1
2												2
3												3
4												4
5												5
	Working Capital											
6	FARMERS NATIONAL BANK		XX	LINE OF CREDIT	$7,121.00	1/21/16	705,000	680,370	1/15/21	3.9500	10,975	6
7	FARMERS NATIONAL BANK		XX	LINE OF CREDIT	$4,419.00	11/15/13	437,500	340,092	11/15/23	3.9500	14,309	7
8	FARMERS NATIONAL BANK		XX	LINE OF CREDIT		1/29/16	550,000	550,000	10/9/17	3.9500	7,000	8
9	TOTAL Facility Related				$28,905.00		$ 5,630,000	$ 5,507,962			$ 179,944	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 7,829,686	$ 5,507,962			$ 244,907	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: 07/01/2015 Ending: 06/30/2016

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											$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	FARMERS NATIONAL BANK		XX	LINE OF CREDIT	$0.00	12/22/14	1,499,686	0	10/09/2015	2.0000	55,519	6
7	FARMERS NATIONAL BANK		XX	LINE OF CREDIT	$0.00	10/24/12	500,000	0	10/09/2015	3.9500	7,253	7
8	FARMERS NATIONAL BANK		XX	LINE OF CREDIT	$0.00	10/24/12	200,000	0	01/31/16	3.9500	2,191	8
9	TOTAL Facility Related						$ 2,199,686	$ 0			$ 64,963	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ 0	14
15	TOTALS (line 9+line14)						$ 2,199,686	$ 0			$ 64,963	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: 07/01/2015 Ending: 06/30/2016

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 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 2016 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:			
	2011		8
	2012		9
	2013		10
	2014		11
	2015		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.

2015 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 2015 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 2015.

	(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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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: 07/01/2015 Ending: 06/30/2016

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 45,500 B. General Construction Type: Exterior MASONARY Frame CONRETE 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: 07/01/2015 Ending: 06/30/2016

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	$	$ 1,406,782	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	7,485	13.82	7,485		563,169	10
11	2009 THERAPY ANNEX			2009	1,312,547	39,917	13.13	39,917		591,035	11
12	NEW ROOF ON MAIN BUILDING			2010	70,796	4,720	15	4,720		29,499	12
13	FLOORING IN ROOMS ON B WING			2010	4,995	714	7	714		3,925	13
14	PAINTING IN MAIN HALLWAYS			2011	10,906	1,558	7	1,558		8,569	14
15	LCD ANNUNCIATOR AT A WING NURSES STATION			2011	3,665	244	15	244		1,099	15
16	TILE IN SPA ROOM			2012	4,993	713	7	713		3,210	16
17	8 BED ADDITION / FACILITY RENOVATIONS			2014	4,613,381	118,394	39	118,394		332,911	17
18	PLUMBING FOR NEW WING			2014	4,000	980	7	980		2,531	18
19	ROOF REPAIR			2015	1,873	245	7	245		245	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: 07/01/2015 Ending: 06/30/2016

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)		$ 8,150,155	$ 188,715		$ 188,715	$	$ 3,055,120	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: 07/01/2015 Ending: 06/30/2016

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	$ 627,039	$ 64,209	$ 57,789	$ (6,420)	7.43	$ 461,670	71
72	Current Year Purchases	19,075	2,725	2,725		7	1,785	72
73	Fully Depreciated Assets	1,350,690				9.05	1,350,690	73
74								74
75	TOTALS	$ 1,996,804	$ 66,934	$ 60,514	$ (6,420)		$ 1,814,145	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	$ 94,860	$	$	$	6.67	$ 94,860	76
77	TRANSPORT RESIDENTS	VARIOUS VANS	VARIOUS	122,382	3,650	3,650		5	102,310	77
78	SNOW REMOVALE	2010 DODGE 2500	2010	32,157	4,393	4,393		7	29,860	78
79	VAN	2014 FORD E450 10WC	2014	68,433	6,843	6,843		10	10,265	79
80	TOTALS			$ 317,832	$ 14,886	$ 14,886	$		$ 237,295	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)	$ 10,488,291	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 270,535	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 264,115	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (6,420)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,106,560	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: 07/01/2015 Ending: 06/30/2016

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.	/2017	$
13.	/2018	$
14.	/2019	$

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: 07/01/2015 Ending: 06/30/2016

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		261	608	261	1,130
3	Classroom Wages	(a)	1,840	4,812		6,652
4	Clinical Wages	(b)		2,182		2,182
5	In-House Trainer Wages	(c)	871	2,031	871	3,773
6	Transportation					
7	Contractual Payments		2,153	5,023	2,153	9,329
8	CNA Competency Tests			455	195	650
9	TOTALS		$ 5,125	$ 15,111	$ 3,480	$ 23,716
10	SUM OF line 9, col. 1 and 2	(e)	$ 20,236			

C. CONTRACTUAL INCOME

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

$ 3,201

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	7
2. From other facilities (f)	3
DROP-OUTS	
1. From this facility	3
2. From other facilities (f)	
TOTAL TRAINED	13

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

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A.3	hrs	$	4,963	$ 100,901	$	4,963	$ 100,901	1
2	Licensed Speech and Language Development Therapist	10A.3	hrs		807	46,136		807	46,136	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A.3	hrs		8,311	153,828		8,311	153,828	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): MEDICARE THERAP	39			7,636	235,694		7,636	235,694	12
13	Other (specify): PHYSIATRIST	10.3			180	22,500		180	22,500	13
14	TOTAL			$	21,897	$ 559,059	$	21,897	$ 559,059	14

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

STATE OF ILLINOIS

Facility Name & ID Number Winning Wheels # 0024745 **Report Period Beginning:** 07/01/2015 **Ending:** 06/30/2016

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/2016 (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	$ 391,548	$ 475,328	1
2	Cash-Patient Deposits	29,216	31,020	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 81,520)	636,201	874,256	3
4	Supply Inventory (priced at COST)	26,587	44,450	4
5	Short-Term Investments			5
6	Prepaid Insurance	15,189	17,673	6
7	Other Prepaid Expenses	36,038	60,308	7
8	Accounts Receivable (owners or related parties)	1,276,788	974,207	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,411,567	$ 2,477,242	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	23,500	359,861	13
14	Buildings, at Historical Cost	8,127,989	15,080,919	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,314,636	3,463,420	16
17	Accumulated Depreciation (book methods)	(5,106,560)	(8,318,678)	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		554,770	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)**	$ 5,381,731	$ 11,182,734	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,793,298	$ 13,659,976	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 620,297	$ 819,985	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	38,174	44,831	28
29	Short-Term Notes Payable	1,570,462	1,772,650	29
30	Accrued Salaries Payable	279,392	344,321	30
31	Accrued Taxes Payable (excluding real estate taxes)	74,262	74,262	31
32	Accrued Real Estate Taxes(Sch.IX-B)		39,753	32
33	Accrued Interest Payable	57,080	57,080	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	WORKERS COMP	25,388	25,388	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,665,055	$ 3,178,270	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,937,500	5,706,024	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	PUBLIC AID ADVANCE	7,691	49,029	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,945,191	$ 5,755,053	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,610,246	$ 8,933,323	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,183,052	$ 4,726,653	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,793,298	$ 13,659,976	48

***(See instructions.)**

Facility Name & ID Number Winning Wheels # 0024745 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,581,574	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,581,574	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(262,001)	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) RELATED ENTITIES	407,080	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 145,079	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)**	$ 4,726,653	24 *

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

Facility Name & ID Number Winning Wheels # 0024745 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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	$ 5,233,990	1
2	Discounts and Allowances for all Levels	(12,000)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,221,990	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	233,137	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 233,137	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	3,201	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	4,506	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)**	$ 7,707	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	937	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 937	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	TRANSPORTATION	57,172	28
28a	MISC	347	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 57,519	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,521,290	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,054,860	31
32	Health Care	2,959,784	32
33	General Administration	1,024,200	33
	B. Capital Expense		
34	Ownership	515,442	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	229,005	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,783,291	40
41	**Income before Income Taxes (line 30 minus line 40)****	(262,001)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (262,001)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,315,556	44
45	Private Pay - Net Inpatient Revenue	494,241	45
46	Medicare - Net Inpatient Revenue	412,193	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,221,990	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: 07/01/2015 Ending: 06/30/2016

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	1,800	2,008	$ 71,351	$ 35.53	1
2	Assistant Director of Nursing	2,214	2,466	77,300	31.35	2
3	Registered Nurses	12,037	12,805	370,536	28.94	3
4	Licensed Practical Nurses	15,603	17,008	431,243	25.36	4
5	CNAs & Orderlies	58,433	63,674	808,764	12.70	5
6	CNA Trainees	2,088	2,171	18,456	8.50	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,824	11,913	127,162	10.67	8
9	Activity Director	1,466	1,636	28,744	17.57	9
10	Activity Assistants	5,113	3,862	57,743	14.95	10
11	Social Service Workers	7,944	8,510	188,150	22.11	11
12	Dietician					12
13	Food Service Supervisor	1,924	2,080	59,544	28.63	13
14	Head Cook	4,771	5,579	66,396	11.90	14
15	Cook Helpers/Assistants	11,529	12,042	126,875	10.54	15
16	Dishwashers					16
17	Maintenance Workers	6,494	7,442	80,529	10.82	17
18	Housekeepers	9,303	10,356	128,231	12.38	18
19	Laundry	5,645	6,432	72,991	11.35	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	1,902	2,072	39,979	19.29	22
23	Office Manager	1,511	1,984	21,946	11.06	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	1,733	1,918	24,730	12.89	31
32	Other Health Care(specify)					32
33	Other(specify) TRANSPORTATI	6,482	6,960	71,181	10.23	33
34	TOTAL (lines 1 - 33)	168,816	182,918	$ 2,871,851 *	$ 15.70	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	209	$ 10,051	1.3	35
36	Medical Director	240	32,910	9.3	36
37	Medical Records Consultant	30	4,236	10.3	37
38	Nurse Consultant	106	7,689	10.3	38
39	Pharmacist Consultant	45	7,802	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	82	5,328	12.3	45
46	Other(specify) MUSIC THERAPY	33	1,625	11.3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	745	$ 69,641		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	75	1,977	10.3	52
53	TOTAL (lines 50 - 52)	75	$ 1,977		53

Facility Name & ID Number Winning Wheels # 0024745 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
BRITTANY HERWIG	ADMINISTRATOR	0	$ 85,000
(INCLUDED IN AMERICAN HEALTH ENTERPRISES)			(85,000)
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 0

B. Administrative - Other

Description	Amount
AMERICAN HEALTH ENTERPRISES	$ 223,000
	0
TOTAL (agree to Schedule V, line 17, col. 3)	$ 223,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
ESOLUTIONS	SOFTWARE FEES	$ 6,747
JOHN PYSE CONSULTING	IT CONSULTANT	53,953
CAREVOYANT	MDS SOFTWARE	8,091
E HEALTH DATA SOLUTIONS	RISK MANAGEMENT	3,198
RELIAS	SOFTWARE INSERVICE	6,994
MIDWEST AUTOMATED TIME	TIMECLOCK SOFTWARE	970
MARCUM LLP	AUDIT / 990 RETURN	19,150
WARD, MURRAY, PACE	LEGAL SERVICES	13,145
MEDIPROCITY	HIPPA SOFTWARE	760
		0
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 113,008

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 100,847
Unemployment Compensation Insurance	9,239
FICA Taxes	232,256
Employee Health Insurance	62,087
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
LIFE/DENTAL/VISION INSURANCE	19,228
ST&LT DISABIITY INS	21,535
PHYSICALS	1,753
CHILDCARE	16,666
TUITION/TRAINING/LICENSE	4,340
MISC EMP BENEFITS (XMAS GIFTS/ EMP RECOGNITION BANQ)	11,607
TOTAL (agree to Schedule V, line 22, col.8)	$ 479,558

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	13,073
Health Care Worker Background Check	1,371
(Indicate # of checks performed 45)	
Patient Background Checks 20	200
CARF	4,183
ADVERTISING / MARKETING	2,874
ASSOCIATION DUES	5,016
IHCA DUE PAC PORTION	(2,591)
Less: Public Relations Expense	( )
Non-allowable advertising	(2,874)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 25,232

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 2,396
NEAREST TBI TRAINING	
In-State Travel	1,025
Seminar Expense	4,178
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,599

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Winning Wheels # 0024745 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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 - $5,016**

(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 $2,591**

(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. $ **22,572** 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. $ **229,005**
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. $ **4,056**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **YES**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **YES** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **57,172**
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: **MARCUM LLP**

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

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

Facility Name & ID Number Winning Wheels # 0024745 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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