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.

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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: 8155375168 **Fax #** 8155376268

HFS ID Number:

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

Type of Ownership:

- [xx] VOLUNTARY,NON-PROFIT
  - [xx] Charitable Corp.
  - [ ] Trust
- IRS Exemption Code 501c3
- [ ] PROPRIETARY
  - [ ] Individual
  - [ ] Partnership
  - [ ] Corporation
  - [ ] "Sub-S" Corp.
  - [ ] Limited Liability Co.
  - [ ] Trust
  - [ ] Other
- [ ] GOVERNMENTAL
  - [ ] State
  - [ ] County
  - [ ] Other

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/2016 to 6/30/2017 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Robin Landis
(Title) CFO

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

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

Facility Name & ID Number Winning Wheels # 0024745 Report Period Beginning: 7/1/2016 Ending: 6/30/2017

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	32,120	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	29,528	526	188	30,242	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,528	526	188	30,242	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.15%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 985

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: 06/30/2017 Fiscal Year: 06/30/2017

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

Facility Name & ID Number Winning Wheels # 0024745 Report Period Beginning: 7/1/2016 Ending: 6/30/2017

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	260,004	18,602	8,937	287,543		287,543		287,543			1
2	Food Purchase		208,868		208,868		208,868	(7,636)	201,232			2
3	Housekeeping	125,788	21,724		147,512		147,512		147,512			3
4	Laundry	74,752	26,156		100,908		100,908		100,908			4
5	Heat and Other Utilities			128,753	128,753		128,753	(865)	127,888			5
6	Maintenance	99,500	39,441	25,162	164,103		164,103		164,103			6
7	Other (specify):*											7
8	TOTAL General Services	560,044	314,791	162,852	1,037,687		1,037,687	(8,501)	1,029,186			8
	B. Health Care and Programs											
9	Medical Director			23,259	23,259		23,259		23,259			9
10	Nursing and Medical Records	1,767,923	201,561	244,034	2,213,518		2,213,518		2,213,518			10
10a	Therapy	159,555		356,358	515,913	(251,305)	264,608		264,608			10a
11	Activities	111,118	3,488	1,440	116,046		116,046		116,046			11
12	Social Services	181,739		574	182,313		182,313		182,313			12
13	CNA Training	18,356	2,383		20,739		20,739	(8,857)	11,882			13
14	Program Transportation	69,085	22,659		91,744	(53,290)	38,454		38,454			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,307,776	230,091	625,665	3,163,532	(304,595)	2,858,937	(8,857)	2,850,080			16
	C. General Administration											
17	Administrative			226,035	226,035		226,035		226,035			17
18	Directors Fees											18
19	Professional Services			156,670	156,670		156,670		156,670			19
20	Dues, Fees, Subscriptions & Promotions			32,696	32,696		32,696	(3,785)	28,911			20
21	Clerical & General Office Expenses	74,852	30,435	9,298	114,585		114,585	97,643	212,228			21
22	Employee Benefits & Payroll Taxes			478,560	478,560		478,560	12,059	490,619			22
23	Inservice Training & Education			2,349	2,349		2,349		2,349			23
24	Travel and Seminar			5,094	5,094		5,094		5,094			24
25	Other Admin. Staff Transportation			359	359		359		359			25
26	Insurance-Prop.Liab.Malpractice			55,944	55,944		55,944		55,944			26
27	Other (specify):* Penalties / Fines			35,555	35,555		35,555		35,555			27
28	TOTAL General Administration	74,852	30,435	1,002,560	1,107,847		1,107,847	105,917	1,213,764			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,942,672	575,317	1,791,077	5,309,066	(304,595)	5,004,471	88,559	5,093,030			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: 7/1/2016 Ending: 6/30/2017

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			251,628	251,628		251,628	(6,219)	245,409			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			207,863	207,863		207,863	(5,744)	202,119			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			459,491	459,491		459,491	(11,963)	447,528			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					53,290	53,290		53,290			38
39	Ancillary Service Centers					251,305	251,305		251,305			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			227,815	227,815		227,815		227,815			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			227,815	227,815	304,595	532,410		532,410			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,942,672	575,317	2,478,383	5,996,372		5,996,372	76,596	6,072,968			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: 7/1/2016 Ending: 6/30/2017

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	(7,636)	2		4
5	Telephone, TV & Radio in Resident Rooms	(865)	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	(6,219)	30		9
10	Interest and Other Investment Income	(5,744)	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	(3,785)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees	(8,857)	13		27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (33,106)		$	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)	109,702	21,22	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 109,702		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 76,596		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		$ 53,290	14	38
39	MEDICARE THERAPY	xx		251,305	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)**			$ 304,595		47

Winning Wheels

ID# 0024745

Report Period Beginning: 7/1/2016

Ending: 6/30/2017

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEPRECIATION OF ASSETS UNDER $2500	$ 6,219	30	1
2	INTEREST INCOME	5,744	32	2
3	CABLE	865	5	3
4	NON-RESIDENT FOOD	7,636	2	4
5	PAC POTION OF IHCA DUES	1,778	20	5
6	NON ALLOWABLE ADVERTISING	2,007	20	6
7	C N A TRAINING FOR NON EMPLOYEES	8,857	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
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**	33,106		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Winning Wheels **#** 0024745 **Report Period Beginning:** 7/1/2016 **Ending:** 6/30/2017

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	(7,636)	0	0	0	0	0	0	0	0	0	0	(7,636)	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	(865)	0	0	0	0	0	0	0	0	0	0	(865)	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**	(8,501)	0	0	0	0	0	0	0	0	0	0	(8,501)	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	(3,785)	0	0	0	0	0	0	0	0	0	0	(3,785)	20
21	Clerical & General Office Expenses	0	97,643	0	0	0	0	0	0	0	0	0	97,643	21
22	Employee Benefits & Payroll Taxes	0	12,059	0	0	0	0	0	0	0	0	0	12,059	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**	(3,785)	109,702	0	0	0	0	0	0	0	0	0	105,917	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(12,286)	109,702	0	0	0	0	0	0	0	0	0	97,416	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Winning Wheels # 0024745 **Report Period Beginning:** 7/1/2016 **Ending:** 6/30/2017

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	(6,219)	0	0	0	0	0	0	0	0	0	0	(6,219)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,744)	0	0	0	0	0	0	0	0	0	0	(5,744)	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**	(11,963)	0	0	0	0	0	0	0	0	0	0	(11,963)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(24,249)	109,702	0	0	0	0	0	0	0	0	0	85,453	45

Facility Name & ID Number Winning Wheels # 0024745 Report Period Beginning: 7/1/2016 Ending: 6/30/2017

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	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%	97,643	97,643	5
6	V	2	Benefits		(See detailed schedule VIII, page 8)		12,059	12,059	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$ 109,702	$ * 109,702	14

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

Facility Name & ID Number Winning Wheels # 0024745 Report Period Beginning: 7/1/2016 Ending: 6/30/2017

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	CONNIE DEMARANVILLE	0	N/A		N/A			3
4	BILL SULLIVAN	0	N/A		N/A			4
5	KYLE GIBSON	0	N/A		N/A			5
6	MEREDITH HAMMER	0	N/A		N/A			6
7	MARY ANN HILL	0	N/A		N/A			7
8	RICK TURNROTH	0	N/A		N/A			8
9	CONNIE VON HOLTON	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: 7/1/2016 Ending: 6/30/2017

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: 7/1/2016 Ending: 6/30/2017

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	7,580,768	6.5	$ 216,357	$ 216,357	3,421,230	$ 97,643	1
2	22	FICA	SALARIES / BENEFITS	7,580,768	6.5	12,305		3,421,230	5,553	2
3	22	WORKERS COMP	SALARIES / BENEFITS	7,580,768	6.5	6,077		3,421,230	2,743	3
4	22	LIFE INSURANCE	SALARIES / BENEFITS	7,580,768	6.5	1,105		3,421,230	499	4
5	22	HEALTH INSURANCE	SALARIES / BENEFITS	7,580,768	6.5	2,600		3,421,230	1,173	5
6	22	VISION INSURANCE	SALARIES / BENEFITS	7,580,768	6.5	174		3,421,230	79	6
7	22	DENTAL INSURANCE	SALARIES / BENEFITS	7,580,768	6.5	709		3,421,230	320	7
8	22	ST & LT DISABILITY INS	SALARIES / BENEFITS	7,580,768	6.5	979		3,421,230	442	8
9	22	CHILD CARE	SALARIES / BENEFITS	7,580,768	6.5	2,770		3,421,230	1,250	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 243,076	$ 216,357		$ 109,702	25

Facility Name & ID Number Winning Wheels # 0024745 Report Period Beginning: 7/1/2016 Ending: 6/30/2017

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	$ 3,911,596	1/8/50	3.7500	$ 134,209	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	620,727	1/15/21	3.9500	25,810	6
7	FARMERS NATIONAL BANK		XX	LINE OF CREDIT	$4,419.00	11/15/13	437,500	299,774	1/15/23	3.9500	12,713	7
8	FARMERS NATIONAL BANK		XX	LINE OF CREDIT	$2,525.00	3/10/14	200,000	179,397	3/10/19	3.9500	7,581	8
9	TOTAL Facility Related				$31,430.00		$ 5,280,000	$ 5,011,494			$ 180,312	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 5,280,000	$ 5,011,494			$ 180,312	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: 7/1/2016 Ending: 6/30/2017

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		01/29/16	550,000	550,000	10/9/17	3.9500	15,000	6
7	FARMERS NATIONAL BANK		XX	LINE OF CREDIT		7/26/16	200,000	200,000	7/30/17	3.9500	7,900	7
8	FARMERS NATIONAL BANK		XX	LINE OF CREDIT		1/23/17	100,000	100,000	1/30/18	4.2500	4,650	8
9	TOTAL Facility Related						$ 850,000	$ 850,000			$ 27,550	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)						$ 850,000	$ 850,000			$ 27,550	15

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

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

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

Facility Name & ID Number Winning Wheels **#** 0024745 **Report Period Beginning:** 7/1/2016 **Ending:** 6/30/2017

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 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 2017 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:			
	2012		8
	2013		9
	2014		10
	2015		11
	2016		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.**

2016 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 2016 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 2016.

	(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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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: 7/1/2016 Ending: 6/30/2017

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: 7/1/2016 Ending: 6/30/2017

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	$	$ 1,420,527	4
5	4										5
6	8				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	2,011	13.82	2,011		563,169	10
11	2000 THERAPY ANNEX			2000	1,046,330	26,489	39.5	26,489		441,489	11
12	MULTI SENSORY ROOM			2000	14,966	379	39.5	379		6,378	12
13	INDEPENDENT WAY GARDEN			2000	34,023	1,701	20	1,701		28,353	13
14	REMODELING 2001-2009			2009	205,968	9,155	13.4	9,155		131,050	14
15											15
16	NEW ROOF ON MAIN BUILDING			2010	70,796	4,720	15	4,720		34,218	16
17	FLOORING IN ROOMS ON B WING			2010	4,995	714	7	714		4,638	17
18											18
19	LCD ANNUNCIATOR AT A WING NURSES STATION			2011	3,665	244	15	244		1,344	19
20	TILE IN SPA ROOM			2012	4,993	713	7	713		3,923	20
21	8 BED ADDITION / FACILITY RENOVATIONS			2014	4,613,381	118,394	39	118,394		473,578	21
22	PLUMBING FOR NEW WING			2014	4,000	500	7	500		2,751	22
23	ROOF REPAIR			2015	1,873	268	7	268		513	23
24	BOILER SYSTEM			2017	29,410	490	10	490		490	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: 7/1/2016 Ending: 6/30/2017

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)		$ 8,157,398	$ 179,523		$ 179,523	$	$ 3,224,566	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: 7/1/2016 Ending: 6/30/2017

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	$ 617,075	$ 58,715	$ 58,715	$	11	$ 498,049	71
72	Current Year Purchases	6,093	599	599		7	599	72
73	Fully Depreciated Assets	1,373,637				9.05	1,373,637	73
74								74
75	TOTALS	$ 1,996,805	$ 59,314	$ 59,314	$		$ 1,872,285	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	105,959	77
78	SNOW REMOVAL	2010 DODGE 2500	2010	32,157	2,298	2,298		7	32,156	78
79	VAN	2014 FORD E450 10WC	2014	68,431	6,843	6,843		10	17,108	79
80	TOTALS			$ 317,830	$ 12,791	$ 12,791	$		$ 250,083	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)	$ 10,495,533	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 251,628	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 251,628	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 1	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,346,934	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: 7/1/2016 Ending: 6/30/2017

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.	/2018	$
13.	/2019	$
14.	/2020	$

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: 7/1/2016 Ending: 6/30/2017

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: 96

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM: XX
- IN OTHER FACILITY:
- HOURS PER CNA: 48

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies	58	346		404
3	Classroom Wages (a)	1,360	10,876		12,236
4	Clinical Wages (b)	680	5,440		6,120
5	In-House Trainer Wages (c)				19,695
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests		2,079		2,079
9	TOTALS	$ 2,098	$ 18,741	$	$ 40,534
10	SUM OF line 9, col. 1 and 2 (e)	$ 20,839			

C. CONTRACTUAL INCOME

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

$ 8,857

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	15
2. From other facilities (f)	6
DROP-OUTS	
1. From this facility	5
2. From other facilities (f)	
TOTAL TRAINED	26

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

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10.A.3	hrs	$	1,653	$ 34,337	$	1,653	$ 34,337	1
2	Licensed Speech and Language Development Therapist	10.A.3	hrs		725	41,841		725	41,841	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10.A.3	hrs		2,115	42,277		2,115	42,277	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			9,847	251,305		9,847	251,305	12
13	Other (specify): PHYSIATRIST	10.3			68	17,000		68	17,000	13
14	TOTAL			$	14,408	$ 386,760	$	14,408	$ 386,760	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:** 7/1/2016 **Ending:** 6/30/2017

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 6/30/2017 **(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	$ 77,943	$ 97,151	1
2	Cash-Patient Deposits	37,490	41,933	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 70,414)	679,810	973,485	3
4	Supply Inventory (priced at COST)	22,203	37,043	4
5	Short-Term Investments			5
6	Prepaid Insurance	19,393	25,401	6
7	Other Prepaid Expenses	53,241	97,724	7
8	Accounts Receivable (owners or related parties)	1,434,614	1,308,718	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,324,694	$ 2,581,455	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	8,157,399	15,121,862	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,314,635	4,353,621	16
17	Accumulated Depreciation (book methods)	(5,346,934)	(10,334,417)	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		558,309	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CONSTRUCTION IN PROG		266	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 5,170,766	$ 10,092,617	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,495,460	$ 12,674,072	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 635,516	$ 989,876	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	37,489	49,737	28
29	Short-Term Notes Payable	1,749,897	1,949,897	29
30	Accrued Salaries Payable	139,156	220,661	30
31	Accrued Taxes Payable (excluding real estate taxes)	80,832	80,832	31
32	Accrued Real Estate Taxes(Sch.IX-B)		17,450	32
33	Accrued Interest Payable	13,262	13,262	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	WORKERS COMP	14,088	14,088	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,670,240	$ 3,335,803	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,911,596	5,598,401	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)**	$ 3,919,287	$ 5,647,430	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,589,527	$ 8,983,233	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 905,933	$ 3,690,839	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,495,460	$ 12,674,072	48

***(See instructions.)**

Facility Name & ID Number Winning Wheels # 0024745 Report Period Beginning: 7/1/2016 Ending: 6/30/2017

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,726,653	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,726,653	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(515,745)	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	(520,069)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,035,814)	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)**	$ 3,690,839	24 *

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

Facility Name & ID Number Winning Wheels # 0024745 Report Period Beginning: 7/1/2016 Ending: 6/30/2017

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	$ 5,476,637	1
2	Discounts and Allowances for all Levels	(70,096)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,406,541	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	7,369	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	7,636	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)**	$ 15,005	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,744	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5,744	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	TRANSPORTATION	53,290	28
28a	MISC	47	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 53,337	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,480,627	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,037,687	31
32	Health Care	3,163,532	32
33	General Administration	1,107,847	33
	B. Capital Expense		
34	Ownership	459,491	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	227,815	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,996,372	40
41	**Income before Income Taxes (line 30 minus line 40)****	(515,745)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (515,745)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,681,001	44
45	Private Pay - Net Inpatient Revenue	162,832	45
46	Medicare - Net Inpatient Revenue	632,804	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,476,637	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: 7/1/2016 Ending: 6/30/2017

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	1,752	1,886	$ 68,304	$ 36.22	1
2	Assistant Director of Nursing	2,411	2,637	85,648	32.48	2
3	Registered Nurses	9,771	10,473	314,190	30.00	3
4	Licensed Practical Nurses	19,440	20,759	539,734	26.00	4
5	CNAs & Orderlies	51,532	53,442	731,910	13.70	5
6	CNA Trainees	2,159	2,159	18,356	8.50	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,627	11,491	159,555	13.89	8
9	Activity Director	2,442	2,884	41,523	14.40	9
10	Activity Assistants	5,798	6,036	69,595	11.53	10
11	Social Service Workers	7,580	8,402	181,739	21.63	11
12	Dietician					12
13	Food Service Supervisor	1,980	2,160	62,605	28.98	13
14	Head Cook	4,775	5,369	63,891	11.90	14
15	Cook Helpers/Assistants	14,011	14,917	133,508	8.95	15
16	Dishwashers					16
17	Maintenance Workers	7,318	8,026	99,500	12.40	17
18	Housekeepers	11,912	13,116	125,788	9.59	18
19	Laundry	7,390	7,918	74,752	9.44	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	2,280	2,481	46,423	18.71	22
23	Office Manager	2,044	2,186	28,429	13.01	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	1,949	2,129	28,137	13.22	31
32	Other Health Care(specify)					32
33	Other(specify) TRANSPORTATI	5,610	6,092	69,085	11.34	33
34	TOTAL (lines 1 - 33)	172,781	184,563	$ 2,942,672 *	$ 15.94	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	199	$ 8,937	1.3	35
36	Medical Director	162	24,258	9.3	36
37	Medical Records Consultant	8	1,040	10.3	37
38	Nurse Consultant	290	21,743	10.3	38
39	Pharmacist Consultant	160	7,175	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	9	579	12.3	45
46	Other(specify) MUSIC THERAPY	24	1,440	11.3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	852	$ 65,172		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	20	$ 563	10.3	50
51	Licensed Practical Nurses	20	858	10.3	51
52	Certified Nurse Assistants/Aides	5,970	192,294	10.3	52
53	TOTAL (lines 50 - 52)	6,010	$ 193,715		53

Facility Name & ID Number Winning Wheels # 0024745 Report Period Beginning: 7/1/2016 Ending: 6/30/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Brittany Herwig (7/16 - 12/16)	Administrator	0	$ 51,589
Amie Behrens (1/17 - 6/17)	Administrator	0	38,797
(Included in American Health Enterprises)			(90,386)
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
American Health Enterprises	$ 226,035
TOTAL (agree to Schedule V, line 17, col. 3)	$ 226,035
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
ESOLUTIONS	SOFTWARE FEES	$ 1,413
JOHN PYSE CONSULTING	IT CONSULTANT	48,816
E HEALTH DATA SOLUTIONS	RISK MANAGEMENT	4,350
RELIAS	SOFTWARE INSERVICE	12,576
MARCUM LP	AUDIT / 990 RETURN	21,899
WARD MURRAY PACE	LEGAL SERVICES	3,851
MEDIPROCITY	HIPPA SOFTWARE	483
TERRILL CONSULTING	MDS CONSULTANT	25,580
DUANE MORRIS	LEGAL SERVICES	31,062
WILKENSON TITLE CO	TITLE SERVICE	6,606
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 156,636

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 117,438
Unemployment Compensation Insurance	12,548
FICA Taxes	217,888
Employee Health Insurance	69,040
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
LIFE/DENTAL/VISION INSURANCE	27,445
ST & LT DISABILITY INS	13,069
PHYSICALS	1,530
CHILDCARE	13,089
TUITION/TRAINING/LICENSE	2,556
MISC EMP BENEFITS (XMAS GIFTS/	0
EMP RECOGNITION BANQ)	16,016
TOTAL (agree to Schedule V, line 22, col.8)	$ 490,619

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	$ 2,040
Advertising: Employee Recruitment	14,098
Health Care Worker Background Check	
(Indicate # of checks performed 41)	1,240
Patient Background Checks 20	200
COMMUNITY RELATIONS	10,021
ADVERTISING / MARKETING	2,277
ASSOCIATION DUES	4,598
IHCA DUE PAC PORTION	(1,778)
Less: Public Relations Expense	( )
Non-allowable advertising	(3,785)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 28,911

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 1,309
NEAREST TBI TRAINING	
In-State Travel	603
Seminar Expense	3,182
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,094

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IHCA - $4,598**

(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 $1,778**

(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. $ **26,081** 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. $ **227,815**
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. $ **7,636**

(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. $ **53,290**
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

WINNING WHEELS - 24745
Report Period Beginning 7/1/16
Report Period Ending 6/30/17

	DETAIL SCHEDULE - V-LINE 24		In State	Out of State	Mileage
1	Name & Title	Amie Topp, Director of Human Resources			
	Date of Seminar	10/12/2016			
	Location	Bollingbrook, IL			
	Title of Seminar	Employee Policy and Handbook Revie Seminar			
	Sponsor	Il Chamber of Commerce			
	Cost	$227.04	$ 159.00		$ 68.04
2	Name & Title	Brittany Herwig, Admin / Tracy Styles, ADON			
		Joan Clayes, Restor Nurse / Brandi Cooper - RN			
		Chris Burks, SW / Brooke Rowe - DON			
		Katrina Gerber, SW			
		Tricia Clark, MDS Coord			
		Kathy McGuire - Director of Ops			
	Date of Seminar	9/12/2016-9/15/2016			
	Location	Peoria, IL			
	Title of Seminar	67th Annual Convention & Trade Show			
	Sponsor	Illinois Health Care Association			
	Cost	$2,966.84	$ 2,778.92		$ 187.92
3	Name & Title	Sheila Huizenga, Admission Coord			
	Date of Seminar	10/27/2016 - 10/29/2016			
	Location	Oak Brook, IL			
	Title of Seminar	Brain Injury Conference			
	Sponsor	Brain Injury Association of Illinois			
	Cost	$387.26	$ 244.16		$ 143.10
4	Name & Title	Sheila Huizenga, Director of Marketing & Admissions			
		Amie Behrens, Administrator			
	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	$1,308.94	$ -	$ 1,308.94	
		This was the nearest TBI Conference			
5	Name & Title	Amie Topp			
	Date of Seminar	9/26/2016-9/27/2016			
	Location	Oakbrook, IL			
	Title of Seminar	ILSHRM HR Conference and Expo			
	Sponsor	Il Society for Human Resource Management			
	Cost	$203.90	$ -		$ 203.90
			$ 3,182.08	$ 1,308.94	$ 602.96

Total Seminars	$ 5,093.98
Less: Out of State Travel & Seminars	$ 1,308.94
Mileage for seminars	$ 602.96
Seminar expense	$ 3,182.08
Total Travel and Seminars	$ 5,093.98
Total - Schedule V, Line 24 - Other	$ 3,785.04
Total - Schedule V, Line 24 - Adjustments	$ 1,308.94
Total - Schedule V, Line 24 - 8	$ 5,093.98

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