FOR BHF USE

LL1

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

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

I. IDPH License ID Number: 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: 9/10/79

Type of Ownership:

- [X] VOLUNTARY,NON-PROFIT
  - [X] 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 07/01/2019 to 06/30/2020 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

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

Paid Preparer

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

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

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 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	26,996	2,557	565	30,118	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,996	2,557	565	30,118	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.51%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 9/10/79

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 88 and days of care provided 565

Medicare Intermediary CGS ADMINISTRATION INC

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

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

Tax Year: 06/30/2020 Fiscal Year: 06/30/2020

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

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	273,354	43,090	10,242	326,686		326,686		326,686			1
2	Food Purchase		186,626		186,626		186,626	(5,921)	180,705			2
3	Housekeeping	114,526	33,341		147,867		147,867		147,867			3
4	Laundry	80,484	9,200		89,684		89,684		89,684			4
5	Heat and Other Utilities			134,001	134,001		134,001	(900)	133,101			5
6	Maintenance	130,782	37,922	40,343	209,047		209,047		209,047			6
7	Other (specify):*											7
8	TOTAL General Services	599,146	310,179	184,586	1,093,911		1,093,911	(6,821)	1,087,090			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	1,939,489	238,250	381,178	2,558,917		2,558,917		2,558,917			10
10a	Therapy	152,594		243,875	396,469	(305,068)	91,401		91,401			10a
11	Activities	133,896	6,309		140,205		140,205		140,205			11
12	Social Services	167,911			167,911		167,911		167,911			12
13	CNA Training	43,894	1,109	1,106	46,109		46,109	(7,291)	38,818			13
14	Program Transportation	83,212	25,914		109,126	(77,415)	31,711		31,711			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,520,996	271,582	650,159	3,442,737	(382,483)	3,060,254	(7,291)	3,052,963			16
	C. General Administration											
17	Administrative			222,000	222,000		222,000		222,000			17
18	Directors Fees											18
19	Professional Services			164,485	164,485		164,485		164,485			19
20	Dues, Fees, Subscriptions & Promotions			15,848	15,848		15,848	(1,741)	14,107			20
21	Clerical & General Office Expenses	80,911	29,978	15,700	126,589		126,589	85,663	212,252			21
22	Employee Benefits & Payroll Taxes			447,180	447,180		447,180	10,913	458,093			22
23	Inservice Training & Education			3,471	3,471		3,471		3,471			23
24	Travel and Seminar			9,607	9,607		9,607		9,607			24
25	Other Admin. Staff Transportation			2,213	2,213		2,213		2,213			25
26	Insurance-Prop.Liab.Malpractice			54,632	54,632		54,632		54,632			26
27	Other (specify):* Settlement			15,000	15,000		15,000	(15,000)				27
28	TOTAL General Administration	80,911	29,978	950,136	1,061,025		1,061,025	79,835	1,140,860			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,201,053	611,739	1,784,881	5,597,673	(382,483)	5,215,190	65,723	5,280,913			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: 07/01/2019 Ending: 06/30/2020

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			215,400	215,400		215,400	(5,363)	210,037			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			214,823	214,823		214,823		214,823			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			430,223	430,223		430,223	(5,363)	424,860			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					77,415	77,415		77,415			38
39	Ancillary Service Centers					305,068	305,068		305,068			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			239,331	239,331		239,331		239,331			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			239,331	239,331	382,483	621,814		621,814			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,201,053	611,739	2,454,435	6,267,227		6,267,227	60,360	6,327,587			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: 07/01/2019 Ending: 06/30/2020

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5,921)	2		4
5	Telephone, TV & Radio in Resident Rooms	(900)	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	(5,363)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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	(15,000)	27		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	(1,741)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees	(29,162)	13		27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (58,087)		$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule	96,876	21,22	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 96,876		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 38,789		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.	X		$ 77,415	14	38
39	MEDICARE THERAPY	XX		305,068	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)**			$ 382,483		47

WINNING WHEELS

ID# 0024745

Report Period Beginning: 07/01/2019

Ending: 06/30/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Depreciation of assets under $2500	$ (5,363)	30	1
2	Settlement	(15,000)	27	2
3	Cable	(900)	5	3
4	Non Resident Food	(5,921)	2	4
5	PAC Portion of IHCA Dues	(1,741)	20	5
6	CN A Training for Non Employees	(29,162)	13	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(58,087)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(5,921)	0	0	0	0	0	0	0	0	0	0	(5,921)	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	(900)	0	0	0	0	0	0	0	0	0	0	(900)	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**	(6,821)	0	0	0	0	0	0	0	0	0	0	(6,821)	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	(29,162)	0	0	0	0	0	0	0	0	0	0	(29,162)	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**	(29,162)	0	0	0	0	0	0	0	0	0	0	(29,162)	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	(1,741)	0	0	0	0	0	0	0	0	0	0	(1,741)	20
21	Clerical & General Office Expenses	0	85,663	0	0	0	0	0	0	0	0	0	85,663	21
22	Employee Benefits & Payroll Taxes	0	10,913	0	0	0	0	0	0	0	0	0	10,913	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):*	(15,000)	0	0	0	0	0	0	0	0	0	0	(15,000)	27
28	**TOTAL General Administration**	(16,741)	96,576	0	0	0	0	0	0	0	0	0	79,835	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(52,724)	96,576	0	0	0	0	0	0	0	0	0	43,852	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WINNING WHEELS **#** 0024745 **Report Period Beginning:** 07/01/2019 **Ending:** 06/30/2020

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(5,363)	0	0	0	0	0	0	0	0	0	0	(5,363)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(5,363)	0	0	0	0	0	0	0	0	0	0	(5,363)	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)**	(58,087)	96,576	0	0	0	0	0	0	0	0	0	38,489	45

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V		Administrative Overhead						4
5	V	21	Clerical Salaries		Winning Wheels, Inc. (Administrative Fund)	100.00%	85,663	85,663	5
6	V	22	Benefits		(See detail schedule VIII, Page *)		10,913	10,913	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$ 96,576	$ * 96,576	14

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

Lyndon Progress Center (LPC)
For The 12 Periods Ended 6/30/2020
90 ADMINISTRATION

EXPENSES			Wheels	STRIVE
5460-90	ADMINISTRATION	$ 156,566.10	$ 85,663.00	$ 19,463.00
6460-90	ADMINISTRATIVE	$ 34,000.00		
5620-90	FICA	$ 11,492.88	$ 5,166.00	$ 1,174.00
5640-90	WORKMAN'S COMP	$ 5,345.40	$ 2,403.00	$ 546.00
5650-90	UNEMPLOYMENT	$ 254.03	$ 114.00	$ 26.00
5660-90	LIFE INSURANCE	$ 346.50	$ 156.00	$ 35.00
5665-90	VISION INSURANCE	$ 104.40	$ 47.00	$ 11.00
5671-90	HEALTH INSURANCE	$ 2,625.69	$ 1,180.00	$ 268.00
5675-90	SUPPLEMENTAL INS	$ 156.48	$ 70.00	$ 16.00
5685-90	DENTAL INSURANCE	$ 301.68	$ 136.00	$ 31.00
5690-90	ST & LT DISABILITY INS	$ 694.44	$ 312.00	$ 71.00
5695-90	VOL LIFE INS	$ 314.94	$ 142.00	$ 32.00
5730-90	CHILD CARE	$ 2,640.40	$ 1,187.00	$ 270.00
5750-90	OTHER	$ -	$ -	$ -
	Total EXPENSES:	$ 214,842.94	$ 96,576.00	$ 21,943.00

		% of Total Salaries and Benefits	Portion of LPC Salaries and Benefits
Winning Wheels			
Salaries	$ 3,201,052.89		$ 85,663.32
Benefits	$ 447,180.39		$ 10,912.93
Total Salaries and Benefits	$ 3,648,233.28	44.95%	$ 96,576.25
STRIVE			
Salaries	$ 717,182.32		$ 19,463.15
Benefits	$ 111,714.94		$ 2,479.47
Total Salaries and Benefits	$ 828,897.26	10.21%	$ 21,942.62
Day Treatment			
Salaries	$ 192,910.87		$ 5,266.88
Benefits	$ 31,395.43		$ 670.97
Total Salaries and Benefits	$ 224,306.30	2.76%	$ 5,937.85
Frontier Hollow			
Salaries	$ 132,585.40		$ 3,529.71
Benefits	$ 17,737.99		$ 449.66
Total Salaries and Benefits	$ 150,323.39	1.85%	$ 3,979.37
Day Care			
Salaries	$ 138,822.79		$ 3,770.26
Benefits	$ 21,745.19		$ 480.31
Total Salaries and Benefits	$ 160,567.98	1.98%	$ 4,250.57
Pinnacle Place			
Salaries	$ 254,583.20		$ 6,822.51
Benefits	$ 35,974.11		$ 869.14
Total Salaries and Benefits	$ 290,557.31	3.58%	$ 7,691.65
Big Meadows			
Salaries	$ 2,473,885.33		$ 66,050.26
Benefits	$ 339,065.52		$ 8,414.36
Total Salaries and Benefits	$ 2,812,950.85	34.66%	$ 74,464.62
Total			
Salaries	$ 7,111,022.80		**$ 190,566.09**
Benefits	$ 1,004,813.57		**$ 24,276.84**
Total Salaries and Benefits	**$ 8,115,836.37**	**100.00%**	**$ 214,842.93**

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	BOARD OF DIRECTORS							1
2	JOHN GUZZARDO - PRESIDENT	0						2
3	DAN HOWARD - VICE PRESIDENT	0						3
4	CONNIE DEMANRANVILLE	0						4
5	KYLE GIBSON - TREASURER	0						5
6	RICK TURNROTH	0						6
7	CONNIE VONHOLTON	0						7
8	THOMAS NANCE	0						8
9	LINDA GRANT	0						9
10	DAVE EYRICH	0						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: 07/01/2019 Ending: 06/30/2020

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ADMINISTRATOR	ADMINISTRATOR		0.00		40	100.00	SAL/BEN	$ 100,765	17	1
2	CORPORATE	DIRECTOR OF OPS		0.00		30	0.50	SAL/BEN	95,340	17	2
3		CFO, IT, INFECTION CONTROL									3
4		CEO									4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 196,105		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.

American Health Enterprises, Inc. (AHE)
For The 12 Periods Ended 06/30/2020
Expense Statement

	2019 Total from G/L	Winning Wheels	Big Meadows	STRIVE	Pinnacle Place	Home Office Allocation	AHE Corp	Total	
Expenses									
SALARIES									
5340 ADMINISTRATORS	$ 476,120	$ 100,765	$ 36,057	$ 84,293	$ 63,693			$ 284,808	$ (191,312)
5360 FINANCE	$ 109,751					$ 101,502	$ -	$ 101,502	$ (8,249)
5460 CORPORATE	$ 80,929	$ 80,929	$ -	$ -	$ -	$ (14,967)	$ -	$ 65,962	$ (14,967)
Total SALARIES:	$ 666,800	$ 181,694	$ 36,057	$ 84,293	$ 63,693	$ 86,535	$ -	$ 452,272	$ (214,528)
BENEFITS									
5620 FICA	$ 29,231					$ 31,896		$ 31,896	$ 2,665
5640 WORKMENS COMP	$ 1,124					$ 548		$ 548	$ (576)
5650 UNEMPLOYMENT	$ 903					$ 732		$ 732	$ (171)
5660 DISABILITY	$ -					$ -		$ -	$ -
5690 401K	$ -					$ -		$ -	$ -
5750 OTHER	$ -					$ -		$ -	$ -
Total BENEFITS:	$ 31,258	$ -	$ -	$ -	$ -	$ 33,176	$ -	$ 33,176	$ 1,918
CONTRACT SERVICES									
6460 ADMINISTRATION	$ -					$ -		$ -	$ -
6470 DATA PROCESSING	$ 21,326						$ 12,927	$ 12,927	$ (8,399)
Total CONTRACT SERVICES:	$ 21,326	$ -	$ -	$ -	$ -	$ -	$ 12,927	$ 12,927	$ (8,399)
SUPPLIES									
7420 MAINTENANCE	$ -					$ -	$ -	$ -	$ -
7440 TRANSPORTATION	$ -					$ -	$ -	$ -	$ -
7460 OFFICE	$ -					$ -	$ -	$ -	$ -
7470 COMPUTER SUPPLIES	$ -					$ 2,566	$ -	$ 2,566	$ 2,566
Total SUPPLIES:	$ -	$ -	$ -	$ -	$ -	$ 2,566	$ -	$ 2,566	$ 2,566
GENERAL & ADMIN.									
8080 CABLE TV	$ -					$ -		$ -	$ -
9010 TELEPHONE	$ 1,560					$ 4,153		$ 4,153	$ 2,593
9020 DUES & SUBSCRIPTIONS	$ 99					$ -	$ -	$ -	$ (99)
9040 INSURANCE	$ 3,078					$ 8,400		$ 8,400	$ 5,322
9080 POSTAGE	$ -					$ -		$ -	$ -
9100 LEGAL & ACCOUNTING	$ -					$ -	$ -	$ -	$ -
9120 RECRUITMENT	$ 99					$ 99		$ 99	$ -
9140 TRAVEL & SEMINAR	$ 1,227					$ 189		$ 189	$ (1,038)
9160 LICENSE & TAXES	$ 175					$ 613		$ 613	$ 438
9170 DONATIONS	$ -					$ -		$ -	$ -
9180 OTHER	$ -					$ -	$ -	$ -	$ -
9190 COMMUNITY RELATIONS	$ -					$ -		$ -	$ -
Total GENERAL & ADMIN.:	$ 6,238	$ -	$ -	$ -	$ -	$ 13,454	$ -	$ 13,454	$ 7,216
INTEREST									
9340 INTEREST - AUTOS	$ -							$ -	$ -
Total INTEREST:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Expenses:	$ 725,622	$ 181,694	$ 36,057	$ 84,293	$ 63,693	$ 135,731	$ 12,927	$ 514,395	

Allocation to the Cost Reports		Winning Wheels	Big Meadows	STRIVE	Pinnacle Place	
Revenues	$ 12,547,972	$ 6,423,094	$ 4,242,885	$ 1,257,618	$ 624,375	
		51.19%	33.81%	10.02%	4.98%	
Total Salary for benefit %	$ 452,272	$ 225,990	$ 65,317	$ 92,966	$ 67,999	
		49.97%	14.44%	20.56%	15.03%	Allocated to the facility cost reports
Employee Benefits	$ 37,327	$ 18,651	$ 5,391	$ 7,673	$ 5,612	$ 37,329
Home Office Costs	$ 11,867	$ 6,075	$ 4,013	$ 1,189	$ 590	$ 11,867
Administrator	$ 365,737	$ 181,694	$ 36,057	$ 84,293	$ 63,693	
Home Office Salaries	$ 86,535	$ 44,296	$ 29,260	$ 8,673	$ 4,306	$ 86,535
	$ 501,466	$ 250,716	$ 74,721	$ 101,828	$ 74,201	$ 135,731

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/2019 Ending: 6/30/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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	8,115,836	7	$ 190,566	$ 156,566	3,648,233	$ 85,663	1
2	22	FICA	SALARIES/BENEFITS	8,115,836	7	11,493		3,648,233	5,166	2
3	22	WORKERS COMP	SALARIES/BENEFITS	8,115,836	7	5,345		3,648,233	2,403	3
4	22	UNEMPLOYMENT	SALARIES/BENEFITS	8,115,836	7	254		3,648,233	114	4
5	22	LIFE INSURANCE	SALARIES/BENEFITS	8,115,836	7	346		3,648,233	156	5
6	22	HEALTH INSURANCE	SALARIES/BENEFITS	8,115,836	7	2,626		3,648,233	1,180	6
7	22	VISION INSURANCE	SALARIES/BENEFITS	8,115,836	7	104		3,648,233	47	7
8	22	DENTAL INSURANCE	SALARIES/BENEFITS	8,115,836	7	302		3,648,233	136	8
9	22	ST & LT DISABILITY INC	SALARIES/BENEFITS	8,115,836	7	1,166		3,648,233	524	9
10	22	CHILD CARE	SALARIES/BENEFITS	8,115,836	7	2,640		3,648,233	1,187	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					$ 214,842	$ 156,566		$ 96,576	25

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** 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	$ 3,716,040	1/8/50	3.7500	$ 156,566	1
2	PPP			PAYROLL PROTECTION PR			865,220	865,220				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	427,068	1/15/23	3.9500	18,162	6
7	FARMERS NATIONAL BANK		XX	LINE OF CREDIT		1/29/16	550,000	550,000	10/9/21	2.5900	18,958	7
8	FARMERS NATIONAL BANK		XX	LINE OF CREDIT	$11,309.00	5/11/18	600,000	365,847	5/5/23	4.9500	21,137	8
9	TOTAL Facility Related				$35,795.00		$ 6,657,720	$ 5,924,175			$ 214,823	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 6,657,720	$ 5,924,175			$ 214,823	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 156,566 Line # 32

* 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: 07/01/2019 Ending: 06/30/2020

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	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 2020 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:			
	2015		8
	2016		9
	2017		10
	2018		11
	2019		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME 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 2019 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2019.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,550 B. General Construction Type: Exterior MASONARY Frame CONCRETE BLCOK 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 [ ] 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	BUIDLING 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: 07/01/2019 Ending: 06/30/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	76		1979	1979	$ 1,549,706	$ 13,745	23.35	$ 13,745	$	$ 1,457,926	4
5	4										5
6	8										6
7											7
8											8
	Improvement Type**										
9	REMODELING 1980-1989			1989	105,633		14.63			105,633	9
10	REMODELING 1990-1999			1999	505,470		13.82			505,470	10
11	2000 THERAPY ANNEX			2000	1,119,049	26,489	39.5	28,330	1,841	520,957	11
12	MULTI SENSORY ROOM			2000	14,966	379	39.5	379	(0)	7,515	12
13	INDEPENDENT WAY GARDEN			2000	34,023	1,701	20	1,701	0	33,456	13
14	REMODELING 2001-2009			2009	205,968	8,007	20	10,298	2,291	157,395	14
15	NEW ROOD ON MAIN BUILDING			2010	70,796	4,720	15	4,720	(0)	48,378	15
16	FLOORING IN ROOMS ON B WING			2010	4,995		7			4,995	16
17	LCD ANNUCIATOR AT A WING NURSES STATION			2011	3,665	244	15	244	0	2,076	17
18	TILE IN SPA ROOM			2012	4,993	356	7	713	357	5,349	18
19	8 BED ADDITION / FACILITY RENOVATIONS			2014	4,448,389	118,394	39	114,061	(4,333)	828,760	19
20	PLUMBING FOR NEW WING			2014	4,000	357	7	571	214	3,822	20
21	ROOF REPAIR			2015	1,873	268	7	268	(0)	1,316	21
22	BOILER SYSTEM			2017	29,410	2,941	10	2,941		9,313	22
23	CAMERA SYSTEM			2018	21,634	3,091	7	3,091	(0)	9,272	23
24	ROOF TOP UNIT			2019	11,875	1,555	7	1,696	141	1,555	24
25	PTAC			2019	1,675	160	7	239	80	160	25
26	PTAC			2019	1,675	160	7	239	79	160	26
27	DOOR LOCK			2019	3,135	299	7	448	149	299	27
28	FURNACE / AC			2020	7,600	543	7	1,086	543	543	28
29	BACK ENTRANCE DOOR			2020	3,110	185	7	444	259	185	29
30	KITCHEN HVAC			2020	21,000	1,000	7	3,000	2,000	1,000	30
31	WATER HEATER REPLACEMENT UNDER WARRANTY			2020	4,059	97	7	580	483	97	31
32	WW RESIDENT NETWORK			2020	9,597	114	7	1,371	1,257	114	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: 07/01/2019 Ending: 06/30/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	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)		$ 8,188,296	$ 184,804		$ 190,167	$ 5,363	$ 3,705,745	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: 07/01/2019 Ending: 06/30/2020

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 264,138	$ 2,176	$ 2,176	$ 0	11	$ 203,396	71
72	Current Year Purchases	134,238	8,414	8,414		7	8,414	72
73	Fully Depreciated Assets	1,787,284				9	1,787,284	73
74								74
75	TOTALS	$ 2,185,660	$ 10,590	$ 10,590	$ 0		$ 1,999,094	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 RESDIENTS	VARIOUS VANS	VARIOUS	$ 237,283	$ 10,493	$ 10,493	$		$ 201,016	76
77	SNOW REMOVAL	2010 DODGE 2500	2010	32,157					32,157	77
78	VAN	2019	2019	49,804	4,150	4,150			4,150	78
79										79
80	TOTALS			$ 319,244	$ 14,643	$ 14,643	$		$ 237,323	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)	$ 10,716,700	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 210,037	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 215,400	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 5,363	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,942,162	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: 07/01/2019 Ending: 06/30/2020

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ 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.	/2021	$
13.	/2022	$
14.	/2023	$

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: 07/01/2019 Ending: 06/30/2020

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [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			2,215		2,215
3	Classroom Wages	(a)		18,594		18,594
4	Clinical Wages	(b)		9,578		9,578
5	In-House Trainer Wages	(c)		15,722		15,722
6	Transportation					
7	Contractual Payments					
8	CNA Competency Tests					
9	TOTALS		$	$ 46,109	$	$ 46,109
10	SUM OF line 9, col. 1 and 2	(e)	$ 46,109			

C. CONTRACTUAL INCOME

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

$ 7,291

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	6
2. From other facilities (f)	2
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	8

(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	$	2,841	$ 61,216	$	2,841	$ 61,216	1
2	Licensed Speech and Language Development Therapist	10.A.3	hrs		692	40,090		692	40,090	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10.A.3	hrs		3,569	76,643		3,569	76,643	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			431	27,958		431	27,958	12
13	Other (specify):									13
14	TOTAL			$	7,533	$ 205,907	$	7,533	$ 205,907	14

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

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/2020 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 558,891	$ 950,325	1
2	Cash-Patient Deposits	82,893	87,336	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (12,000))	512,371	411,442	3
4	Supply Inventory (priced at COST)	27,067	38,667	4
5	Short-Term Investments			5
6	Prepaid Insurance	22,845	32,635	6
7	Other Prepaid Expenses	44,221	55,870	7
8	Accounts Receivable (owners or related parties)	1,105,714	704,714	8
9	Other(specify): BIG MEADOWS ALLOWANCE		401,000	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,354,002	$ 2,681,989	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	23,500	180,861	13
14	Buildings, at Historical Cost	8,188,296	13,874,835	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,482,472	3,447,848	16
17	Accumulated Depreciation (book methods)	(5,942,162)	(9,872,575)	17
18	Deferred Charges	22,432	31,227	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		665,056	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,774,538	$ 8,327,252	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,128,540	$ 11,009,241	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 275,903	$ 435,237	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	82,893	87,336	28
29	Short-Term Notes Payable	2,376,984	1,826,983	29
30	Accrued Salaries Payable	195,437	279,195	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,909	12,727	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	75,755	75,755	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,015,881	$ 2,717,233	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,716,040	5,290,237	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,716,040	$ 5,290,237	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,731,921	$ 8,007,470	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 396,619	$ 3,001,771	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,128,540	$ 11,009,241	48

***(See instructions.)**

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,886,155	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,886,155	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	369,385	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) RELATED FACILITIES	(253,769)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 115,616	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)**	$ 3,001,771	24 *

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

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,596,501	1
2	Discounts and Allowances for all Levels	(12,000)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,584,501	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	29,162	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	5,291	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)**	$ 34,453	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	603	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 603	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	TRANSPORTATION	77,415	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 77,415	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,696,972	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,087,090	31
32	Health Care	3,052,963	32
33	General Administration	1,140,860	33
	B. Capital Expense		
34	Ownership	424,860	34
	C. Ancillary Expense		
35	Special Cost Centers	621,814	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,327,587	40
41	**Income before Income Taxes (line 30 minus line 40)****	369,385	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 369,385	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,391,435	44
45	Private Pay - Net Inpatient Revenue	730,739	45
46	Medicare - Net Inpatient Revenue	474,327	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,596,501	49

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

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

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

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

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,048	2,578	$ 106,948	$ 41.48	1
2	Assistant Director of Nursing	1,997	2,251	77,109	34.26	2
3	Registered Nurses	3,012	3,611	130,153	36.04	3
4	Licensed Practical Nurses	14,213	17,451	579,539	33.21	4
5	CNAs & Orderlies	49,910	55,291	1,019,790	18.44	5
6	CNA Trainees	2,990	3,111	43,894	14.11	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,608	9,856	152,594	15.48	8
9	Activity Director	1,656	1,680	34,364	20.45	9
10	Activity Assistants	7,047	7,508	99,532	13.26	10
11	Social Service Workers	6,966	7,738	167,911	21.70	11
12	Dietician					12
13	Food Service Supervisor	3,147	3,589	81,140	22.61	13
14	Head Cook	5,848	6,723	87,551	13.02	14
15	Cook Helpers/Assistants	9,524	10,154	104,663	10.31	15
16	Dishwashers					16
17	Maintenance Workers	8,015	8,697	130,782	15.04	17
18	Housekeepers	9,286	10,022	114,525	11.43	18
19	Laundry	7,543	7,994	80,484	10.07	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	3,833	4,187	80,911	19.32	22
23	Office Manager					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	1,813	1,977	25,951	13.13	31
32	Other Health Care(specify)					32
33	Other(specify) Transportation	5,573	6,153	83,212	13.52	33
34	TOTAL (lines 1 - 33)	153,029	170,571	$ 3,201,053 *	$ 18.77	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	200	$ 10,242	1.3	35
36	Medical Director	160	24,000	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	130	6,240	10.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) MUSIC THERAPY	18	1,370	11.3	46
47	LAB	95	4,760	10.3	47
48	XRAY	25	1,520	10.3	48
49	TOTAL (lines 35 - 48)	628	$ 48,132		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	300	$ 15,298	10.3	50
51	Licensed Practical Nurses	2,168	102,057	10.3	51
52	Certified Nurse Assistants/Aides	8,028	248,240	10.3	52
53	TOTAL (lines 50 - 52)	10,496	$ 365,595		53

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
AMIE BEHRENS	ADMIN	0	$ 100,765
(INCLUDED IN AMERICAN HEALTH ENTERPRISES)			(100,765)
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
AMERICAN HEALTH ENTERPRISES	$ 222,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 222,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
JOHN PYSE CONSULTING	IT CONSULTANT	$ 44,625
MARCUM LLP	AUDIT / 990 FILING	35,117
WARDS MURRAY PACE JOHN	ATTORNEY	10,724
TERRILL CONSULTING	MDS CONSULTING	28,581
POINTCLICKCARE	RESIDENT SOFTWARE	10,726
CAREVOYANT	RESIDENT SOFTWARE	12,000
ESOLUTIONS	BILLING SOFTWARE	5,820
ONSHIFT	SCHEDULING SOFTWARE	9,612
MEPROCITY	HIPPA TEXTING	3,400
MIDWEST AUTOTIME	TIMECLOCK	3,880
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 164,485

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 106,897
Unemployment Compensation Insurance	10,283
FICA Taxes	240,452
Employee Health Insurance	23,911
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
LIFE/DENTAL/VISION INS	22,601
ST & LT DISABILITY INS	9,553
DRUG TEST/NAME BADGE	1,296
CHILDCARE	24,702
TUITION/TRAINING/LICENSE	100
MISC EMP BENEFITS	7,385
(EMP RECOGNITION/XMAS GIFTS)	
TOTAL (agree to Schedule V, line 22, col.8)	$ 447,180

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,219
Advertising: Employee Recruitment	1,046
Health Care Worker Background Check	
(Indicate # of checks performed 30)	1,080
Patient Background Checks 10	200
COMMUNITY RELATIONS	23
ADVERTSING/MARKETING	2,343
ASSOCIATION DUES	9,937
IHCA DUE PAC PORTION	(1,741)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,107

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
NEAREST TBI TRAINING	1,166
NEAREST MANDT TRAINING	975
In-State Travel	2,568
Seminar Expense	4,897
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,607

**See instructions.

WINNING WHEELS - 24745
Report Period Beginning 7/1/2019
Report Period Ending 6/30/20

		DETAIL SCHEDULE - V-LINE 24	In State	Out of State
1	Name & Title	Sheila Huizenga, Admissions Pat Frye, Nurse Consultant Amie Topp, HR Director Megan Budijuma, Office Manager Robin Landis, CFO Katrina Gerber, Social Services Amie Behrens, Administrator Tracy Styles, DON Michelle Thompson, CN A Coordinator Ethan Gapinski, Assistant VP of Operations		
	Date of Seminar	9/10/2019 - 9/12/2019		
	Location	Springfield, IL		
	Title of Seminar	IHCA		
	Sponsor	69th Annual Convention		
	Cost	$3,718.46	$3,718.46	
2	Name & Title	Sheila Huizenga, Admissions Amie Behrens, Administrator Michelle Yaklich, SW		
	Date of Seminar	3/05/2020 - 3/06/2020		
	Location	West Des Moines, IA		
	Title of Seminar	27th Annual Brain Injury. Conference		
	Sponsor	BIAIA		
	Cost	$2,631.26		$2,631.26
3	Name & Title	Ethan Gapinski, ADOP		
	Date of Seminar	12/8/2020 - 12/12/2020		
	Location	Waterford WI 53185		
	Title of Seminar	MANDT Training		
	Sponsor	MANDT		
	Cost	$2,630.28		$2,630.28
4	Name & Title	Amie Behrens, Administrator Ellie Woods, MDS Coordinator Holly Reece, Medical Records		
	Date of Seminar	2/5/2020		
	Location	Schaumburg IL		
	Title of Seminar	Best Practices for Accurate Code Assignment		
	Sponsor	Healthcare InformationNetwork		
	Cost	$627.00	$627.00	$0.00
			$4,345.46	$5,261.54

Total Seminars	$9,607.00
Less: Out of State	($5,261.54)
Total Travel and Seminars	$4,345.46

Total - Schedule V, Line 24 - Other	$9,607.00
Total - Schedule V, Line 24 - Adjustments	($5,261.54)
Total - Schedule V, Line 24 - 8	$4,345.46

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IHCA $6336**

(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? **$1,741**

(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. $ **30,853** 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. $ **239,331**
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. $ **5,291**

(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. $ **77,415**
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 out of Schedule V? **YES**

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