

		FOR BHF USE					

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2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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 PROPHETSTOWN 61277
Number City 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 07/01/2024 to 06/30/2025 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) Sheila Huizenga

(Title) Administrator

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
2200 Churchill Rd.
Springfield, IL 62702-3406 Phone # (217) 782-1630

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/2024 Ending: 06/30/2025

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	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	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF	5,044	20,640			1,404	187	1,225	28,500	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	5,044	20,640			1,404	187	1,225	28,500	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 88.49%

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 ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES ☐ NO ☒

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

J. Was the facility purchased or leased after January 1, 1978? YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter certified beds. number of certified beds 88

Medicare Intermediary CGS ADMINISTRATION INC

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 6/30/2025 Fiscal Year: 6/30/2025

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

STATE OF ILLINOIS

Facility Name & ID Number

WINNING WHEELS

0024745

Report Period Beginning:

07/01/2024

Ending:

06/30/2025

Page 3

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	333,412	26,313	12,225	371,950		371,950		371,950			1
2	Food Purchase		210,631		210,631		210,631	(15,804)	194,827			2
3	Housekeeping	266,020	40,757		306,777		306,777		306,777			3
4	Laundry	24,685	9,873		34,558		34,558		34,558			4
5	Heat and Other Utilities							(1,500)	(1,500)			5
6	Maintenance	153,011	45,151		198,162		198,162		198,162			6
7	Other (specify):*											7
8	TOTAL General Services	777,128	332,725	12,225	1,122,078		1,122,078	(17,304)	1,104,774			8
	B. Health Care and Programs											
9	Medical Director			4,800	4,800		4,800		4,800			9
10	Nursing and Medical Records	3,100,480	353,961	780,010	4,234,451		4,234,451		4,234,451			10
10a	Therapy			202,651	202,651		202,651		202,651			10a
11	Activities	158,950	4,946		163,896		163,896		163,896			11
12	Social Services	139,765			139,765		139,765		139,765			12
13	CNA Training											13
14	Program Transportation	170,778	27,321		198,099		198,099		198,099			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,569,973	386,228	987,461	4,943,662		4,943,662		4,943,662			16
	C. General Administration											
17	Administrative	29,893		229,289	259,182		259,182		259,182			17
18	Directors Fees											18
19	Professional Services			205,537	205,537		205,537		205,537			19
20	Dues, Fees, Subscriptions & Promotions			42,338	42,338		42,338	(2,441)	39,897			20
21	Clerical & General Office Expenses	77,597	41,576	22,226	141,399		141,399	125,133	266,532			21
22	Employee Benefits & Payroll Taxes			783,678	783,678		783,678	20,146	803,824			22
23	Inservice Training & Education			8,234	8,234		8,234		8,234			23
24	Travel and Seminar			5,435	5,435		5,435		5,435			24
25	Other Admin. Staff Transportation			1,483	1,483		1,483		1,483			25
26	Insurance-Prop.Liab.Malpractice			317,092	317,092		317,092		317,092			26
27	Other (specify):* PENALTIES/FINES			66,305	66,305		66,305		66,305			27
28	TOTAL General Administration	107,490	41,576	1,681,617	1,830,683		1,830,683	142,838	1,973,521			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,454,591	760,529	2,681,303	7,896,423		7,896,423	125,534	8,021,957			29

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			300,794	300,794		300,794	(41,382)	259,412			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			151,772	151,772		151,772		151,772			32
33	Real Estate Taxes			2,397	2,397		2,397		2,397			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			454,963	454,963		454,963	(41,382)	413,581			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					22,101	22,101		22,101			38
39	Ancillary Service Centers					125,993	125,993		125,993			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			625,901	625,901		625,901		625,901			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			625,901	625,901	148,094	773,995		773,995			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,454,591	760,529	3,762,167	8,977,287	148,094	9,125,381	84,152	9,209,533			45

THE TOTAL FOR COLUMN 5 MUST BE ZERO,PLEASE CORRECT

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

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	(15,804)	2		4
5	Telephone, TV & Radio in Resident Rooms	(1,500)	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	(3,743)	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				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,441)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (23,488)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	145,279		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 145,279		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 121,791		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		\$ 22,101	14	38
39	MEDICARE THERAPY	X		125,993	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)			\$ 148,094		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ (2,441)	20	1
2	Other Expenses Related to Lobbying Activities			2
3	DEPRECIATION OF ASSETS UNDER \$2500	(37,639)	30	3
4	NON RESIDENT FOOD	(15,804)	2	4
5	CABLE	(1,500)	5	5
6				6
7				7
8				8
9				9
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43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(57,384)		49

Summary A

06/30/2025

[illegible]

Summary B

06/30/2025

[illegible]

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		DAY TREATMENT
				CENTER	LYNDON	
		BIG MEADOWS (BUILDING ONLY)	SAVANNA	LYNDON PLAY		DAY CARE
				AND LEARN	LYNDON	
		PINNACLE PLACE SLF	SAVANNA	FRONTIER HOLLOW		INDEPENDENT
				APARTMENTS	PROPHETSTOWN	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.

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V		ADMINISTRATIVE OVERHEAD						4
5	V	21	CLERICAL SALARIES		WINNING WHEELS, INC (ADMINISTRATIVE FUND)	100.00%	125,133	125,133	5
6	V	22	BENEFITS		(SEE DETAILED SCHEDULE VIII)		20,146	20,146	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$ 145,279	\$ * 145,279	14

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

Lyndon Progress Center (LPC)
For The 12 Periods Ended 6/30/2025
90 ADMINISTRATION

EXPENSES		Wheels		STRIVE	
5460-90	ADMINISTRATION	\$ 262,116.00	\$ 125,133.00	\$ 26,929.00	
6460-90	ADMINISTRATIVE	\$ 22,225.00			
5620-90	FICA	\$ 19,788.00	\$ 8,708.00	\$ 1,874.00	
5640-90	WORKMAN'S COMP	\$ 4,754.00	\$ 2,092.00	\$ 450.00	
5650-90	UNEMPLOYMENT	\$ 19.00	\$ 8.00	\$ 2.00	
5660-90	LIFE INSURANCE	\$ 340.00	\$ 150.00	\$ 32.00	
5665-90	VISION INSURANCE	\$ 239.00	\$ 105.00	\$ 23.00	
5671-90	HEALTH INSURANCE	\$ 16,815.00	\$ 7,400.00	\$ 1,592.00	
5675-90	SUPPLEMENTAL INS	\$ -	\$ -	\$ -	
5685-90	DENTAL INSURANCE	\$ 1,205.00	\$ 530.00	\$ 114.00	
5690-90	ST & LT DISABILITY INS	\$ 1,513.00	\$ 666.00	\$ 143.00	
5695-90	VOL LIFE INS	\$ -	\$ -	\$ -	
5730-90	CHILD CARE	\$ -	\$ -	\$ -	
5750-90	OTHER	\$ 1,105.00	\$ 486.00	\$ 105.00	
Total EXPENSES:		\$ 330,119.00	\$ 145,278.00	\$ 31,264.00	
			% of Total Salaries and Benefits	Portion of LPC Salaries and Benefits	
Winning Wheels					
Salaries	\$ 4,283,813.00			\$ 125,133.41	
Benefits	\$ 734,309.00			\$ 20,146.08	
Total Salaries and Benefits	\$ 5,018,122.00	44.01%		\$ 145,279.49	
STRIVE					
Salaries	\$ 902,720.00			\$ 26,928.64	
Benefits	\$ 177,177.00			\$ 4,335.43	
Total Salaries and Benefits	\$ 1,079,897.00	9.47%		\$ 31,264.07	
Day Treatment					
Salaries	\$ 196,065.00			\$ 5,882.77	
Benefits	\$ 39,847.00			\$ 947.11	
Total Salaries and Benefits	\$ 235,912.00	2.07%		\$ 6,829.88	
Frontier Hollow					
Salaries	\$ 176,757.00			\$ 4,968.96	
Benefits	\$ 22,509.00			\$ 799.99	
Total Salaries and Benefits	\$ 199,266.00	1.75%		\$ 5,768.95	
Day Care					
Salaries	\$ 251,446.00			\$ 7,594.85	
Benefits	\$ 53,124.00			\$ 1,222.75	
Total Salaries and Benefits	\$ 304,570.00	2.67%		\$ 8,817.60	
Pinnacle Place					
Salaries	\$ 405,858.00			\$ 11,884.64	
Benefits	\$ 70,742.00			\$ 1,913.39	
Total Salaries and Benefits	\$ 476,600.00	4.18%		\$ 13,798.03	
Big Meadows					
Salaries	\$ 3,511,726.00			\$ 101,947.72	
Benefits	\$ 576,599.00			\$ 16,413.26	
Total Salaries and Benefits	\$ 4,088,325.00	35.85%		\$ 118,360.98	
Total					
Salaries	\$ 9,728,385.00			\$ 284,340.99	
Benefits	\$ 1,674,307.00			\$ 45,778.01	
Total Salaries and Benefits	\$ 11,402,692.00	100.00%		\$ 330,119.00	

VII. RELATED PARTIES (continued)

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

☐

YES

☐

NO

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

1		2	3	4	5	6	7	8	
Schedule V			Line	Cost Per General Ledger	Amount	Cost to Related Organization	Percent of Ownership	Operating Cost of Related Organization	Difference: Adjustments for Related Organization Costs (7 minus 4)
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

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

VII. RELATED PARTIES

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	BOARD OF DIRECTORS							1
2	JOHN GUZZARDO - PRESIDENT							2
3	TOM NANCE - VICE PRESIDENT							3
4	CONNIE DEMANRANVILLE							4
5	KYLE GIBSON - TREASURER							5
6	RICK TURNROTH							6
7	DAVE EYRICH							7
8	CRIS HICKS							8
9	LINDA LEBLANC-PARKS							9
10	DEB ROBINSON							10
11	ALAN GAPINSKI							11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
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22								22
23								23
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25								25
26								26
27								27
28								28
29								29
30								30

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	ADMINISTRATOR	ADMINISTRATOR				40	100.00	SAL/BEN	\$ 98,073	17	1
2	CORPORATE	CFO,CEO, ASST				30	0.50	SAL/BEN	73,492	17	2
3		DIRECTOR OF OPS									3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 171,565		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 9 Periods Ended 03/31/25
Expense Statement

	2024 Total from G/L	Winning Wheels	Big Meadows	STRIVE	Pinnacle Place	Home Office Administration	AHE Corp	Total	
Expenses									
SALARIES									
5340 ADMINISTRATORS	\$ 423,184	\$ 98,073	\$ 82,238	\$ 179,435	\$ 63,438			\$ 423,184	\$ -
5360 FINANCE	\$ 130,946					\$ 130,946	\$ -	\$ 130,946	\$ -
5460 CORPORATE	\$ 9,000	\$ -	\$ -	\$ 9,000	\$ -	\$ -	\$ -	\$ 9,000	\$ -
Total SALARIES:	\$ 563,130	\$ 98,073	\$ 82,238	\$ 188,435	\$ 63,438	\$ 130,946	\$ -	\$ 563,130	\$ -
BENEFITS									
5620 FICA	\$ 43,079	\$ 7,503	\$ 6,291	\$ 14,415	\$ 4,853	\$ 10,017	\$ -	\$ 43,079	\$ -
5640 WORKMENS COMP	\$ 600	\$ 104.49	\$ 87.62	\$ 200.77	\$ 67.59	\$ 139.52	\$ -	\$ 600	\$ -
5650 UNEMPLOYMENT	\$ 782	\$ 136.19	\$ 114.20	\$ 261.67	\$ 88.09	\$ 181.84	\$ -	\$ 782	\$ -
5660 HEALTH INS	\$ 35,103	\$ -	\$ 9,984	\$ 6,555	\$ 12,345	\$ 6,218	\$ -	\$ 35,103	\$ 0
5690 401K	\$ 8,160	\$ 1,421.17	\$ 1,191.71	\$ 2,730.61	\$ 919.28	\$ 1,897.54	\$ -	\$ 8,160	\$ -
5750 OTHER	\$ 5,500					\$ 5,500		\$ 5,500	\$ -
Total BENEFITS:	\$ 93,225	\$ 9,164	\$ 17,669	\$ 24,164	\$ 18,273	\$ 23,955	\$ -	\$ 93,225	\$ 0
CONTRACT SERVICES									
6460 ADMINISTRATION	\$ -					\$ -		\$ -	\$ -
6470 DATA PROCESSING	\$ 18,365					\$ -	\$ 18,365	\$ 18,365	\$ -
Total CONTRACT SERVICES:	\$ 18,365	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 18,365	\$ 18,365	\$ -
SUPPLIES									
7420 MAINTENANCE	\$ -					\$ -	\$ -	\$ -	\$ -
7440 TRANSPORTATION	\$ -					\$ -	\$ -	\$ -	\$ -
7460 OFFICE	\$ -					\$ -	\$ -	\$ -	\$ -
7470 COMPUTER SUPPLIES	\$ -					\$ -	\$ -	\$ -	\$ -
Total SUPPLIES:	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
GENERAL & ADMIN.									
8080 CABLE TV	\$ -					\$ -		\$ -	\$ -
9010 TELEPHONE	\$ 5,564					\$ -	\$ 5,564	\$ 5,564	\$ (0)
9020 DUES & SUBSCRIPTIONS	\$ 133					\$ -	\$ 133	\$ 133	\$ -
9040 INSURANCE	\$ -					\$ -		\$ -	\$ -
9080 POSTAGE	\$ 73					\$ -	\$ 73	\$ 73	\$ -
9100 LEGAL & ACCOUNTING	\$ -					\$ -	\$ -	\$ -	\$ -
9120 RECRUITMENT	\$ -					\$ -		\$ -	\$ -
9140 TRAVEL & SEMINAR	\$ 1,364					\$ -	\$ 1,364	\$ 1,364	\$ -
9160 LICENSE & TAXES	\$ 75						\$ 75	\$ 75	\$ -
9170 DONATIONS						\$ -		\$ -	\$ -
9180 OTHER	\$ 15,381					\$ -	\$ 15,381	\$ 15,381	\$ (0)
9190 COMMUNITY RELATIONS	\$ -					\$ -		\$ -	\$ -
Total GENERAL & ADMIN.:	\$ 22,591	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 22,590	\$ 22,590	\$ (1)
INTEREST									
9340 INTEREST - AUTOS	\$ -							\$ -	\$ -
Total INTEREST:	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total Expenses:	\$ 697,310	\$ 107,237	\$ 99,907	\$ 212,599	\$ 81,711	\$ 154,901	\$ 40,955	\$ 697,310	

Allocation to the Cost Reports		Winning Wheels	Big Meadows	STRIVE	Pinnacle Place	Allocated to the facility cost reports \$ 23,955 \$ - \$ 130,946 \$ 154,901
Revenues	\$ 16,101,552	\$ 8,176,227	\$ 5,254,719	\$ 1,562,851	\$ 1,107,755	
		50.78%	32.63%	9.71%	6.88%	
Total Salary for benefit %	\$ 563,130	\$ 164,566	\$ 124,972	\$ 201,145	\$ 72,447	
		29.22%	22.19%	35.72%	12.87%	
Employee Benefits	\$ 23,953	\$ 6,999	\$ 5,316	\$ 8,556	\$ 3,082	
Home Office Costs	\$ -	\$ -	\$ -	\$ -	\$ -	
Administrator	\$ 432,184	\$ 98,073	\$ 82,238	\$ 188,435	\$ 63,438	
Home Office Salaries	\$ 130,946	\$ 66,493	\$ 42,734	\$ 12,710	\$ 9,009	
	\$ 587,083	\$ 171,565	\$ 130,288	\$ 209,701	\$ 75,529	

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/2024 Ending: 6/30/2025

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 Lyndon Progress Center
Street Address 501 6th Ave W
City / State / Zip Code Lyndon IL 61261
Phone Number (815-778-3683
Fax Number ()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	21	CLERICAL SALARIES	SALARIES/BENEFITS	11,402,692	7	\$ 284,341	\$	5,018,122	\$ 125,133	1
2	22	FICA	SALARIES/BENEFITS	11,402,692	7	19,788		5,018,122	8,708	2
3	22	WORKERS COMP / UE	SALARIES/BENEFITS	11,402,692	7	4,773		5,018,122	2,101	3
4	22	LIFE INSURANCE	SALARIES/BENEFITS	11,402,692	7	340		5,018,122	150	4
5	22	HEALTH INSURANCE	SALARIES/BENEFITS	11,402,692	7	16,815		5,018,122	7,400	5
6	22	VISION INSURANCE	SALARIES/BENEFITS	11,402,692	7	239		5,018,122	105	6
7	22	DENTAL INSURANCE	SALARIES/BENEFITS	11,402,692	7	1,205		5,018,122	530	7
8	22	ST & LT DISABILITY INS	SALARIES/BENEFITS	11,402,692	7	1,513		5,018,122	666	8
9	22	OTHER	SALARIES/BENEFITS	11,402,692	7	1,105		5,018,122	486	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					\$ 330,119	\$		\$ 145,279	25

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/2024 Ending: 6/30/2025

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	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	USDA		X	MORTGAGE	\$17,365.00	1/8/15	\$ 3,737,500	\$ 3,337,102	1/5/50	3.7500	\$ 126,814	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	FARMERS NATIONAL BANK		X	LINE OF CREDIT	\$11,344.96	10/27/23	598,487	415,575	10/9/25	5.2500	24,959	6	
7												7	
8												8	
9	TOTAL Facility Related				\$28,709.96		\$ 4,335,987	\$ 3,752,677			\$ 151,773	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 4,335,987	\$ 3,752,677			\$ 151,773	15	

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2024 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.)				\$2,397	2
3. Under or (over) accrual (line 2 minus line 1).				\$2,397	3
4. Real Estate Tax accrual used for 2025 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.				\$2,397	7
Assessed Value from Real Estate Tax Bill: 2024		8			
Real Estate Tax Bill for Calendar Year: 2020		9			
2021		10			
2022		11			
2023		12			
2024		13			
		FOR BHF USE ONLY			
		14	FROM R. E. TAX STATEMENT FOR 2024	\$	14
		15	PLUS APPEAL COST FROM LINE 5	\$	15
		16	LESS REFUND FROM LINE 6	\$	16
		17	AMOUNT TO USE FOR RATE CALCULATION	\$	17

- 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.

FACILITY NAME	WINNING WHEELS	COUNTY	WHITESIDE
---------------	----------------	--------	-----------

CONTACT PERSON REGARDING THIS REPORT Robin Landis

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	

B. Real Estate Tax Cost Allocations

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.)

Attach copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

Page 10A

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 45,500B. General Construction Type: Exterior MASONARYFrame CONCRETE BRICKNumber of Stories 1

C. Does the Operating Entity? [X] (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? [X] (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. List the bed capacity for the building if it differs from the licensed total.
G. Have you properly capitalized all major repairs and equipment purchases? YES
H. Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.
I. Are you presently operating under a sublease agreement? NO
J. Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
YES NO X If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over.

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

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number **WINNING WHEELS**

0024745

Report Period Beginning:

07/01/2024

Ending:

06/30/2025

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	76		1979	1979	\$ 1,549,706	\$	23.35	\$	\$	1,549,706
5	4									
6	8									
7										
8										
	Improvement Type**									
9	REMODELING 1980-1989			1989	105,633		14.63			105,633
10	REMODELING 1990-1999			1999	505,470		13.82			505,470
11	2000 THERAPY ANNEX			2000	1,119,049	26,551	39.5	26,551		609,420
12	MULTI SENSORY ROOM			2000	14,966	373	39.5	373		9,392
13	INDEPENDENT WAY GARDEN			2000	34,023		20			34,023
14	REMODELING 2001-2009			2009	205,968	10,298	20	10,298		200,083
15	NEW ROOD ON MAIN BUILDING			2010	70,796		15			70,796
16	FLOORING IN ROOMS ON B WING			2010	4,995		7			4,995
17	LCD ANNUCIATOR AT A WING NURSES STATION			2011	3,665	243	15	243		3,293
18	TILE IN SPA ROOM			2012	4,993		7			4,993
19	8 BED ADDITION / FACILITY RENOVATIONS			2014	4,617,381	118,142	39	118,142		1,406,196
20	ROOF REPAIR			2015	1,873	44	7	44		1,801
21	BOILER SYSTEM			2017	29,410	2,917	10	2,917		23,921
22	CAMERA SYSTEM			2018	21,634		7			21,634
23	ROOF TOP UNIT			2019	11,875	1,676	7	1,676		9,956
24	PTAC			2019	1,675	236	7	236		1,344
25	PTAC			2019	1,675	236	7	236		1,344
26	DOOR LOCK			2019	3,135	443	7	443		2,386
27	FURNACE / AC			2020	7,600	1,073	7	1,073		5,947
28	BACK ENTRANCE DOOR			2020	3,110	439	7	439		2,510
29	KITCHEN HVAC			2020	21,000	2,965	7	2,965		15,859
30	WATER HEATER REPLACEMENT UNDER WARRANTY			2020	4,059	573	7	573		2,968
31	WW RESIDENT NETWORK			2020	9,597	1,355	7	1,355		7,035
32	ROOF REPLACED			2021	156,162	10,353	15	10,353		72,645
33	SEALCOAT AND STRIPING FRONT			2021	5,090		3			5,090
34	COURTYARD EXCAVATION			2021	38,150	3,783	10	3,783		17,358
35										
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:

07/01/2024 Ending: **06/30/2025**

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	NORTH WALL EXCAVATION	2021	\$ 11,480	\$ 1,139	10	\$ 1,139	\$	\$ 5,225	37
38	BASIN EXPANSION	2021	18,600	1,845	10	1,845		8,464	38
39	PTAC UNITS - 5	2021	4,985	704	7	704		3,053	39
40	GARAGE ROOF MATERIALS	2021	1,915	190	10	190		807	40
41	CONDENSOR UNIT	2021	6,350	630	10	630		2,625	41
42	REPLACE KITCHEN DRAINAGE	2021	3,805	749	5	749		3,122	42
43	REMOVAL OF CONCRETE FOR DRAINAGE	2021	1,690	332	5	332		1,357	43
44	ELECTRICAL WORK	2022	10,635	1,501	7	1,501		5,755	44
45	REPLACE ASPHALT	2022	11,550	1,145	10	1,145		4,390	45
46	EAST PARKING LOT ASPHALT	2022	187,177	12,409	15	12,409		47,568	46
47	OUTSIDE ELECTRICAL	2023	5,865	838	7	838		2,235	47
48	BACK HALLWAY DUCT WORK	2023	6,740	674	10	674		1,685	48
49	FLOORING C1	2023	2,772	396	7	396		825	49
50	SIDEWALK	2024	28,000	1,867	15	1,867		3,734	50
51	REPLACED FRONT GATE	2024	25,000	2,500	10	2,500		4,375	51
52	PANELBOARD SURGE PROTECTOR	2024	3,660	732	5	732		793	52
53	TV ANTENNA	2025	5,657	377	10	566	189	377	53
54	VINYL FLOORING TEA ROOM	2025	3,142		10	314	314		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)		\$ 8,891,713	\$ 209,728		\$ 210,230	\$ 503	\$ 4,792,188	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$537,358	\$71,735	\$71,735	\$	7	\$350,190	71
72	Current Year Purchases	56,452	4,813	8,064	3,251	7	4,813	72
73	Fully Depreciated Assets	1,987,045					1,987,045	73
74								74
75	TOTALS	\$2,580,855	\$76,548	\$79,799	\$3,251		\$2,342,048	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	\$305,764	\$14,518	\$14,518	\$	7	\$254,046	76
77										77
78										78
79										79
80	TOTALS			\$305,764	\$14,518	\$14,518	\$		\$254,046	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$11,801,832	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$300,794	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$304,547	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$3,753	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$7,388,282	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
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: *

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

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.	/2026	\$
13.	/2027	\$
14.	/2028	\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM☐

IN OTHER FACILITY☐

COMMUNITY COLLEGE☐

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM☐

IN OTHER FACILITY☐

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

(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.

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A.1	hrs	\$	21,945	\$ 115,409	\$	21,945	\$ 115,409	1
2	Licensed Speech and Language Development Therapist	10A.1	hrs		2,235	23,089		2,235	23,089	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A.1	hrs		9,022	61,116		9,022	61,116	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): <u>MEDICARE THERAPY</u>	39.2/3				11,792			11,792	12
13	Other (specify): _____									13
14	TOTAL			\$	33,202	\$ 211,406	\$	33,202	\$ 211,406	14

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

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 71,432	\$ 422,781	1
2	Cash-Patient Deposits	63,910	103,878	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (21,551))	481,235	1,137,163	3
4	Supply Inventory (priced at COST)	39,535	6,730	4
5	Short-Term Investments			5
6	Prepaid Insurance	26,366	26,366	6
7	Other Prepaid Expenses	100,565	113,600	7
8	Accounts Receivable (owners or related parties)	(710,076)	39,625	8
9	Other(specify): HFS INCENTIVE REC	131,363	184,542	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 204,330	\$ 2,034,685	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	23,500	218,708	13
14	Buildings, at Historical Cost	8,891,713	16,775,449	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,580,855	5,668,030	16
17	Accumulated Depreciation (book methods)	(7,388,282)	(15,060,986)	17
18	Deferred Charges	22,166	22,166	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		652,409	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): LEASE ASSETS	167,367	167,367	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,297,319	\$ 8,443,143	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,501,649	\$ 10,477,828	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,061,441	\$ 1,228,531	26
27	Officer's Accounts Payable	93,910	103,878	27
28	Accounts Payable-Patient Deposits		99,503	28
29	Short-Term Notes Payable	200,328	200,328	29
30	Accrued Salaries Payable	358,796	874,889	30
31	Accrued Taxes Payable (excluding real estate taxes)	27,448	126,167	31
32	Accrued Real Estate Taxes(Sch.IX-B)		62,018	32
33	Accrued Interest Payable	11,960	12,235	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	LEASES	71,614	71,614	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,825,497	\$ 2,779,163	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	3,552,349	3,695,050	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	LEASES	144,452	144,452	43
44	PAID IN CAPITAL		32,000	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,696,801	\$ 3,871,502	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,522,298	\$ 6,650,665	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,020,649)	\$ 3,827,163	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,501,649	\$ 10,477,828	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,350,665	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,350,665	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,020,649)	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	(502,853)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,523,502)	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)	\$ 3,827,163	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number WINNING WHEELS

0024745

Report Period Beginning: 07/01/2024

Ending: 06/30/2025

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

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

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

1			
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 8,077,866	1
2	Discounts and Allowances for all Levels	(12,000)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,065,866	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	198,793	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 198,793	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	15,804	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)	\$ 15,804	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,561	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,561	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	BUILDING RENTAL / TRANSPORTATION	136,101	28
28a	HFS INCENTIVES / MISC	393,660	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 529,761	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,814,785	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,104,774	31
32	Health Care	4,943,662	32
33	General Administration	1,973,521	33
	B. Capital Expense		
34	Ownership	413,581	34
	C. Ancillary Expense		
35	Special Cost Centers	773,995	35
36	Provider Participation Fee	625,901	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,835,434	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,020,649)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,020,649)	43

III. Net Inpatient Revenue detailed by Payer Source for each line			
44	Medicaid Fee for Service	\$ 1,365,386.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	5,589,298.00	45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	418,089.00	48
49	Medicare Part A	126,139.00	49
50	Other-(specify) VA	562,463.00	50
51	Other-(specify) TBI BED HOLDS	16,491.00	51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,077,866	56

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,923	2,407	\$ 161,618	\$ 67.14	1
2	Assistant Director of Nursing	345	371	17,304	46.64	2
3	Registered Nurses	6,079	7,186	327,044	45.51	3
4	Licensed Practical Nurses	14,573	19,208	803,518	41.83	4
5	CNAs & Orderlies	56,203	66,105	1,675,607	25.35	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,022	2,119	50,208	23.69	9
10	Activity Assistants	6,207	6,623	108,742	16.42	10
11	Social Service Workers	6,349	6,685	139,765	20.91	11
12	Dietician					12
13	Food Service Supervisor	1,904	2,129	60,703	28.51	13
14	Head Cook	6,760	7,496	130,108	17.36	14
15	Cook Helpers/Assistants	8,671	10,191	142,601	13.99	15
16	Dishwashers					16
17	Maintenance Workers	6,656	7,577	153,011	20.19	17
18	Housekeepers	14,230	15,218	266,020	17.48	18
19	Laundry	1,202	1,421	24,685	17.37	19
20	Administrator	455	463	29,893	64.56	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,676	2,932	77,598	26.47	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care: MDS	1,881	2,126	115,189	54.18	32
33	Other(specify) TRANSPORT	4,769	11,912	170,978	14.35	33
34	TOTAL (lines 1 - 33)	142,905	172,169	\$ 4,454,592 *	\$ 25.87	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	244	\$ 12,225	1.3	35
36	Medical Director	12	4,800	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	125	6,250	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)				46
47	LAB/XRAY	46	1,401	10.3	47
48					48
49	TOTAL (lines 35 - 48)	427	\$ 24,676		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,201	\$ 91,281	10.3	50
51	Licensed Practical Nurses	1,708	136,473	10.3	51
52	Certified Nurse Assistants/Aides	4,627	195,289	10.3	52
53	TOTAL (lines 50 - 52)	7,536	\$ 423,043		53

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

** See instructions.

XX. GENERAL INFORMATION:

- (1)

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

NO
- (2)

Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below.
Use the drop down list to identify the association.

Association Name	Amount
IL HEALTHCARE ASSOCIATION (IHCA)	5,320
	5,320 Total
- (3)

List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.

The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

IL HEALTHCARE ASSOCIATION (IHCA)	2,441
	2,441 Total
- (4)

EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE
(2 and 3 combined)

IL HEALTHCARE ASSOCIATION (IHCA)	7,761
	7,761 Total
- (5)

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

\$ 49,890 Line 10
- (6)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

YES If NO, attach a complete explanation.
- (7)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 625,901

This amount is to be recorded on line 42 of Schedule V.
- (8)

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.

- (9)

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
- (10)

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.
- (11)

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. \$
- (12)

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?

NO

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

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

100

d. Have vehicle usage logs been maintained?

YES

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

YES

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

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
- (13)

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

Firm Name: RKL

YES
- (14)

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

YES
- (15)

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.

WINNING WHEELS - 24745
Report Period Beginning 7/1/2024
Report Period Ending 6/30/25
DETAIL SCHEDULE - V-LINE 24

		In State	Out of State
1	Name & Title	Sheila Huizenga, Administrator Addison Glassburn, Activity Director Kayla Sweeney, Social Worker Megan Budijuma, Office Manager Robin Landis, CFO Ellie Woods, MDS Coordinator	
	Date of Seminar	9/9/2024 - 9/12/2024	
	Location	Peoria IL	
	Title of Seminar	IHCA	
	Sponsor	74th Annual Convention	
	Cost	\$945 Conference / \$354.56 Meals / \$815.96 Hotels	\$2,115.52
2	Name & Title	Sheila Huizenga, Admissions	
	Date of Seminar	3/6/25 - 3/7/25	
	Location	West Des Moines, IA	
	Title of Seminar	32nd Annual Brain Injury. Conference	
	Sponsor	BIAIA	
	Cost	\$266.56 Hotel / \$122.55 Meals	\$389.11
3	Name & Title	Pricilla Reiling	
	Date of Seminar	8/12/25 - 8/15/25	
	Location	Springfield IL	
	Title of Seminar	Mandt Training	
	Sponsor	Mandt	
	Cost	\$2,249 Seminar / \$459.15 Hotel / \$113.15 Meals	\$2,929.84
		\$108.54 Mileage	\$0.00
		<u>\$5,045.36</u>	<u>\$389.11</u>
Total Seminars		\$5,434.47	
Less: Out of State		<u>(\$389.11)</u>	
Total Travel and Seminars		\$5,045.36	
Total - Schedule V, Line 24 - Other		\$5,434.47	
Total - Schedule V, Line 24 - Adjustments		<u>(\$389.11)</u>	
Total - Schedule V, Line 24 - 8		<u>\$5,045.36</u>	

LEGAL INVOICES
07/01/2024 - 6/30/2025

INVOICE DATE	FIRM NAME	AMOUNT	DESCRIPTION OF SERVICES
3/7/2025	WARD MURRAY PACE AND JOHNSON PC	390.00	AUDIT LETTER RESPONSE
		390.00	
7/30/2024	POLSINELLI PC	1,209.00	IDPH TAG - APPEAL
8/28/2024	POLSINELLI PC	882.5	IDPH TAG - SETTLEMENT PROPOSAL
12/31/2024	POLSINELLI PC	320.00	IDPH TAG - FINAL ORDER
1/29/2025	POLSINELLI PC	1,192.00	IDPH TAG - FINAL ORDER / AUDIT LETTER
2/25/2025	POLSINELLI PC	930.00	AUDIT LETTER
5/13/2025	POLSINELLI PC	4,202.50	DON LICENSURE ISSUE / MDS CERTS
		8,736.00	

TRAINING
07/01/2024 - 6/30/2025

INVOICE DATE	FIRM NAME	AMOUNT	DESCRIPTION OF SERVICES
7/31/2024	RELIAS	8,234.00	ONLINE TRAINING

8,234.00