FOR BHF USE

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2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

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: 09/10/1979

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501(C)3			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: MILT RUE **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 07/01/2009 to 06/30/2010 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) MILT RUE
(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: 07/01/2009 Ending: 06/30/2010

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	80	Skilled (SNF)	80	29,200	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	80	TOTALS	80	29,200	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			312	312	8
9	SNF/PED					9
10	ICF	26,601	1,469		28,070	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,601	1,469	312	28,382	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.20%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 01/01/1979

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 40 and days of care provided _____

Medicare Intermediary ADMINASTAR FEDERAL/NATIONAL GOVERNMENT SRVC

IV. ACCOUNTING BASIS

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

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

Tax Year: 06/30/2010 Fiscal Year: 06/30/2010

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

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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	215,605	33,281	12,966	261,852		261,852		261,852			1
2	Food Purchase		255,885		255,885		255,885	(16,883)	239,002			2
3	Housekeeping	120,674	36,456		157,130		157,130		157,130			3
4	Laundry	78,892	19,699	673	99,264		99,264		99,264			4
5	Heat and Other Utilities			113,970	113,970		113,970	(9,094)	104,876			5
6	Maintenance	116,885	83,837	29,889	230,611		230,611		230,611			6
7	Other (specify):*											7
8	TOTAL General Services	532,056	429,158	157,498	1,118,712		1,118,712	(25,977)	1,092,735			8
	B. Health Care and Programs											
9	Medical Director			43,000	43,000		43,000		43,000			9
10	Nursing and Medical Records	1,612,048	244,006	9,389	1,865,443	(25,257)	1,840,186		1,840,186			10
10a	Therapy	90,469	3,219	158,506	252,194		252,194		252,194			10a
11	Activities	37,118	9,604	16,281	63,003		63,003		63,003			11
12	Social Services	113,594			113,594		113,594		113,594			12
13	CNA Training			2,205	2,205	25,257	27,462	(3,154)	24,308			13
14	Program Transportation	44,628	32,924		77,552	(44,450)	33,102		33,102			14
15	Other (specify):* SPEECH/COGN	43,192		38,070	81,262		81,262		81,262			15
16	TOTAL Health Care and Programs	1,941,049	289,753	267,451	2,498,253	(44,450)	2,453,803	(3,154)	2,450,649			16
	C. General Administration											
17	Administrative			201,570	201,570		201,570		201,570			17
18	Directors Fees											18
19	Professional Services			69,785	69,785		69,785		69,785			19
20	Dues, Fees, Subscriptions & Promotions			33,119	33,119		33,119	(16,124)	16,995			20
21	Clerical & General Office Expenses	110,458	36,352	24,366	171,176	(929)	170,247		170,247			21
22	Employee Benefits & Payroll Taxes			433,950	433,950		433,950	3,628	437,578			22
23	Inservice Training & Education			703	703		703		703			23
24	Travel and Seminar			18,393	18,393		18,393	(4,653)	13,740			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			51,220	51,220	(4,274)	46,946		46,946			26
27	Other (specify):*											27
28	TOTAL General Administration	110,458	36,352	833,106	979,916	(5,203)	974,713	(17,149)	957,564			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,583,563	755,263	1,258,055	4,596,881	(49,653)	4,547,228	(46,280)	4,500,948			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: 07/01/2009 Ending: 06/30/2010

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			192,069	192,069		192,069		192,069			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,591	2,591		2,591		2,591			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			194,660	194,660		194,660		194,660			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					49,653	49,653		49,653			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			43,800	43,800		43,800		43,800			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			43,800	43,800	49,653	93,453		93,453			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,583,563	755,263	1,496,515	4,835,341		4,835,341	(46,280)	4,789,061			45

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

Winning Wheels, Inc.
701 East Third Street
Prophetstown, IL 61277
IDPH #0024745

FYE 2010

Page 3, Schedule V

RECLASSIFICATIONS

Line #		DR.	CR.
13	CNA Training	$ 12,508	
10	Nursing & Medical Records		$ 12,508
	Regi Fortune wages for training classes		
13	CNA Training	$ 12,749	
10	Nursing & Medical Records		$ 12,749
	Employee wages for attending training classes		
14	Transportation	$ 4,274	
26	Insurance		$ 4,274
	Transfer vehicle insurance premiums to transportation		
14	Transportation	$ 929	
21	Clerical & General Office		$ 929
	Transfer vehicle license fees to transportation		
38	Medically Necessary Transportation	$ 49,653	
14	Transportation		$ 49,653
	Transfer costs for medically necessary transportation		

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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	(16,883)	2		4
5	Telephone, TV & Radio in Resident Rooms	(9,094)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				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	(360)	20		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	(15,764)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees	(3,154)	13		27
28	Yellow Page Advertising				28
29	Other-Attach Schedule OUT OF STATE TRAVEL	(4,653)	24		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (49,908)		$	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			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (49,908)		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		$ 49,653	14	38
39						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)**			$ 49,653		47

WINNING WHEELS

ID# 0024745

Report Period Beginning: 07/01/2009

Ending: 06/30/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	OUT-OF-STATE TRAVEL	$ (4,653)	24	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				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**	(4,653)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WINNING WHEELS **#** 0024745 **Report Period Beginning:** 07/01/2009 **Ending:** 06/30/2010

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	(16,883)	0	0	0	0	0	0	0	0	0	0	(16,883)	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	(9,094)	0	0	0	0	0	0	0	0	0	0	(9,094)	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**	(25,977)	0	0	0	0	0	0	0	0	0	0	(25,977)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	(3,154)	0	0	0	0	0	0	0	0	0	0	(3,154)	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(3,154)	0	0	0	0	0	0	0	0	0	0	(3,154)	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	(16,124)	0	0	0	0	0	0	0	0	0	0	(16,124)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	3,628	0	0	0	0	0	0	0	0	0	3,628	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(4,653)	0	0	0	0	0	0	0	0	0	0	(4,653)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(20,777)	3,628	0	0	0	0	0	0	0	0	0	(17,149)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(49,908)	3,628	0	0	0	0	0	0	0	0	0	(46,280)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WINNING WHEELS # 0024745 **Report Period Beginning:** 07/01/2009 **Ending:** 06/30/2010

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	0	0	0	0	0	0	0	0	0	0	0	0	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**	0	0	0	0	0	0	0	0	0	0	0	0	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)**	(49,908)	3,628	0	0	0	0	0	0	0	0	0	(46,280)	45

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
WINNING WHEELS, INC.	100%	STRIVE	PROPHETSTOWN	LYNDON PROGRES	LYNDON	DAYTREATMENT
				CENTER		REHABILITATION
		BIG MEADOWS (BUILDING ONLY)	SAVANNA			
				LYNDON PLAY &	LYNDON	CHILD DAYCARE
				LEARN CENTER		
				FRONTIER HOLLOV	PROPHETSTOWN	INDEPENDENT
				APARTMENTS		LIVING FACILITY

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] 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		22	DAYCARE BENEFITS	$ 16,745	LYNDON PLAY & LEARN CENTER	100.00%	$ 20,373	$ 3,628	1
2	V									2
3	V									3
4	V									4
5	V									5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$ 16,745			$ 20,373	$ * 3,628	14

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

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/2009 Ending: 6/30/2010

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						$	$		$	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

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

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

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

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

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 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 2010 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:		
	2005	8
	2006	9
	2007	10
	2008	11
	2009	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 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 2009 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 2009.

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

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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: 07/01/2009 Ending: 06/30/2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 40,500 B. General Construction Type: Exterior MASSONARY Frame CONCRETE BLOCK Number of Stories ONE

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

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	80		1979	1979	$ 1,447,685	$ 14,497	VARIOUS	$ 14,497	$	$ 1,320,038	4
5				1985	4,226		20			4,226	5
6				1986	13,305		20			13,305	6
7											7
8											8
	Improvement Type**										
9	TILE			1985	585		20			585	9
10	AIR CONDITIONER COMPRESSOR			1986	2,576		10			2,576	10
11	LAVATORIES			1987	780		20			780	11
12	PATIO			1987	3,089		20			3,089	12
13	TRACK CURTAIN SYSTEM			1987	1,306		20			1,306	13
14	CEDAR POST RAILS			1987	230		10			230	14
15	SHOWER DOORS			1987	350		15			350	15
16	BLACKTOP PATH			1987	5,946		20			5,946	16
17	BATH IMPROVEMENTS			1988	11,342		15			11,342	17
18	TV ANTENNA BOOSTER			1988	455		10			455	18
19	FAUCETS			1988	597		15			597	19
20	HEAT A/C UNIT			1988	2,869		15			2,869	20
21	MOTORS			1988	1,037		10			1,037	21
22	EMPLOYEE LOUNGE			1988	3,235		20			3,235	22
23	DOOR OPENERS			1988	3,505		15			3,505	23
24	BATH PARTITIONS			1988	764		10			764	24
25	BLACKTOP			1988	5,023		15			5,023	25
26	COUNTERTOP SHELVES			1988	1,678		15			1,678	26
27	FITNESS TRAIL			1988	945		5			945	27
28	PARKING LOT SEALER			1988	4,000		4			4,000	28
29	BACK ROOM RENOVATIONS			1988	30,717		15			30,717	29
30	SIGNAGE			1988	872		20			872	30
31	HEATERS MOTORS THERMOSTAT			1988	1,010		5			1,010	31
32	LANDSCAPING			1989	4,715		10			4,715	32
33	BLACKTOP ROCK & SEALING			1989	5,906		15			5,906	33
34	DRAPES			1989	1,083		10			1,083	34
35	BATHROOM REMODELING			1990	11,976		8			11,976	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: 07/01/2009 Ending: 06/30/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	WATER SOFTENER	1990	$ 5,858	$	12	$	$	$ 5,858	37
38	SIGN	1990	3,700		12			3,700	38
39	PARKING LOT LIGHTS	1990	6,258		15			6,258	39
40	SHRUBS	1990	1,235		15			1,235	40
41	BATHROOM IMPROVEMENTS	1991	12,802		15			12,802	41
42	AUTOMATIC DOOR OPENERS	1991	4,455		10			4,455	42
43	REMODEL DINING ROOM	1992	34,562	1,728	20	1,728		31,105	43
44	REMODEL A & B WINGS	1992	18,929	946	20	946		16,720	44
45	HOTWATER BOILER	1992	4,272		15			4,272	45
46	RT CLINIC	1993	2,992	150	20	150		2,581	46
47	FLOWER BED	1993	1,142		10			1,142	47
48	KITCHEN LIGHTS & VENTS	1993	3,777	189	20	189		3,226	48
49	LAUNDRY ENGR. & ARCHITECT	1993	3,735	187	20	187		3,175	49
50	LAUNDRY WATER HEATER & CONDITIONER	1993	4,813		15			4,813	50
51	LOBBY & OFFICES BLINDS & VALANCES	1993	3,295		10			3,295	51
52	LAUNDRY ROOM	1993	28,023	1,401	20	1,401		23,352	52
53	INTERIOR SIGN	1994	900		11			900	53
54	RT CLINIC COUNTER TOPS	1994	1,283	64	20	64		1,058	54
55	REDECORATE LOBBY	1994	29,817	1,491	20	1,491		24,351	55
56	GAS WATER HEATER	1994	2,149		15			2,149	56
57	SHELTER ROOF	1994	514		15			514	57
58	REDECORATE OFFICE	1994	1,587		10			1,587	58
59	REDECORATE ROOMS & HALLS	1994	11,264		10			11,264	59
60	SHRUBS & PLANTS	1994	7,501		10			7,501	60
61	PATIO	1994	8,723	48	15	48		8,723	61
62	CARPETING	1994	680		5			680	62
63	COUNTER TOP	1994	1,241	62	20	62		982	63
64	DOOR ALARM SYSTEM	1994	6,962		7			6,962	64
65	DINING ROOM DECORATION	1995	1,870		10			1,870	65
66	ACCORDIAN DOORS	1995	12,071	604	20	604		9,305	66
67	AIR CONDITIONER	1995	3,575		10			3,575	67
68	ROOF	1995	42,900	2,145	20	2,145		32,175	68
69	GARAGE	1995	27,086	1,354	20	1,354		19,863	69
70	TOTAL (lines 4 thru 69)		$ 1,871,778	$ 24,866		$ 24,866	$	$ 1,705,608	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: 07/01/2009 Ending: 06/30/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	
1	Totals from Page 12A, Carried Forward		$ 1,871,778	$ 24,866		$ 24,866	$	$ 1,705,608	1
2	SWING DOOR OPERATOR	1996	4,246		10			4,246	2
3	GARAGE WIRING	1996	3,384	226	15	226		3,271	3
4	CARPET	1996	811		5			811	4
5	GARAGE DOOR	1996	1,519	76	20	76		1,101	5
6	HEATER	1996	1,506	100	15	100		1,447	6
7	WALLPAPER	1996	471		10			471	7
8	CEILING TILE	1996	4,157	208	20	208		2,997	8
9	WALLPAPER BACK OFFICE	1996	587		10			587	9
10	FLOORING	1996	425	21	20	21		306	10
11	FLOOR TILING	1996	4,105	205	20	205		2,942	11
12	FLOOR GROUT	1996	237	12	20	12		169	12
13	STAIRS	1996	200		10			200	13
14	REMODEL KITCHEN	1996	13,551	678	20	678		9,655	14
15	CORNER PROTECTORS	1996	2,200		10			2,200	15
16	CARPET	1996	415		5			415	16
17	A/C COMPRESSOR	1996	6,500		10			6,500	17
18	CARPET	1996	415		5			415	18
19	BRICK	1996	768	38	20	38		522	19
20	CARAGE DOOR	1996	667	33	20	33		453	20
21	BLACKTOP	1996	8,260	551	15	551		7,480	21
22	DISPOSAL	1996	950	63	15	63		860	22
23	CARPET	1997	2,255		5			2,255	23
24	FAUCETS	1997	738	49	15	49		668	24
25	PAINTING	1997	1,948		10			1,948	25
26	TILING	1997	18,869	943	20	943		12,815	26
27	LANDSCAPING	1997	1,480		10			1,480	27
28	SOFFIT	1997	4,495	225	20	225		2,847	28
29	SOFFIT ADDITION	1997	952	48	20	48		623	29
30	A/C COMPRESSOR & CONTROLLER	1997	10,811		10			10,811	30
31	DINING ROOM GLASS	1997	973	49	20	49		621	31
32	FOLDING ROOM WALL/DOORS	1998	5,099	255	20	255		3,187	32
33	FLOORING	1998	2,642		10			2,642	33
34	TOTAL (lines 1 thru 33)		$ 1,977,414	$ 28,646		$ 28,646	$	$ 1,792,553	34

**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: 07/01/2009 Ending: 06/30/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	
1	Totals from Page 12B, Carried Forward		$ 1,977,414	$ 28,646		$ 28,646	$	$ 1,792,553	1
2	ALARM SYSTEM	1998	952		10			952	2
3	CABINETS	1998	7,745	387	20	387		4,776	3
4	3.5 TON A/C	1998	1,257		10			1,257	4
5	NATURE TRIAL LANDSCAPING	1998	18,965		10			18,965	5
6	HALLWAY PAINTING	1998	1,285		10			1,285	6
7	DUMPSTER PAD & FENCING	1998	1,873		5			1,873	7
8	FENCING	1998	2,375	119	20	119		1,336	8
9	GAZEBO	1999	8,200	410	20	410		4,613	9
10	FLOORING	1999	5,553		10			5,553	10
11	REMODEL DINING ROOM	1999	6,724		10			6,724	11
12	ABOVE GROUND TANK	1999	14,566		10			14,566	12
13	LANDSCAPING	1999	6,091		7			6,091	13
14	SECURITY SYSTEM UPGRADE	1999	5,472		7			5,472	14
15	GAZEBO INSTALLATION	1999	1,998	100	20	100		1,107	15
16	FRONT LIGHT FIXTURES	1999	4,507	225	10	225		4,507	16
17	STORM WATER PUMP	1999	2,404		7			2,404	17
18	PARKING LOT	1999	13,819	691	10	691		13,819	18
19	KITCHEN & DINING ROOM ROOF	1999	41,800	2,787	15	2,787		29,492	19
20	BREAKROOM FLOORING	2000	1,293		7			1,293	20
21	BUG BLOWER	2000	1,265	63	10	63		1,265	21
22	CARPET	2000	4,597		5			4,597	22
23	MULTI-SENSORY ROOM	2000	14,966	379	39.5	379		3,726	23
24	INDEPENDENT WAY GARDEN	2000	34,023	1,701	20	1,701		16,444	24
25	THERAPY ANNEX	2000	1,046,330	26,489	39.5	26,489		256,064	25
26	NURSE STATION	2001	17,475	448	39	448		4,033	26
27	DOCTOR OFFICE TILE	2001	822	82	10	82		699	27
28	ENTRYWAYS TILE	2001	1,022	102	10	102		869	28
29	DIETARY ROOM TILE	2001	1,064	106	10	106		905	29
30	ROOM TILE	2002	1,234	123	10	123		1,049	30
31	SHRUBS & PLANTS	2002	11,706	1,171	10	1,171		8,779	31
32	CERAMIC HALLWAY TILE	2003	4,687	469	10	469		3,046	32
33	UPGRADE WANDERGUARD & MAGNETIC	2004	7,606	380	20	380		2,250	33
34	TOTAL (lines 1 thru 33)		$ 3,271,090	$ 64,878		$ 64,878	$	$ 2,222,364	34

**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: 07/01/2009 Ending: 06/30/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	
1	Totals from Page 12C, Carried Forward		$ 3,271,090	$ 64,878		$ 64,878	$	$ 2,222,364	1
2	FENCE W/GATE PLUS INSTALLATION	2004	12,483	832	15	832		4,716	2
3	CONCRETE SIDEWALKS	2004	6,242	312	20	312		1,743	3
4	WALLCOVERING & CERAMIC	2005	4,642	464	10	464		2,553	4
5	DINING ROOM WINDOW	2005	1,732	87	20	87		440	5
6	A WING DAYROOM FLOORING	2005	2,475	248	10	248		1,114	6
7	FABRICATE ENTRANCE ARBOR W/PLANTER	2005	1,390	139	10	139		625	7
8	WINDOW TREATMENTS	2005	2,305	230	10	230		1,037	8
9	REAR ENTRANCE MATS	2005	2,681	383	7	383		1,724	9
10	WALL TRIM	2005	606	61	10	61		273	10
11	INSTALLATION OF CHAPEL WALL CARPET	2005	2,440	244	10	244		1,098	11
12	6 INSULATED WINDOWS	2006	1,520	76	20	76		342	12
13	BLACKTOP PARKING LOT	2006	3,400	680	5	680		2,380	13
14	CANVAS CANOPY	2007	3,260	326	10	326		1,141	14
15	RETILE 18 ROOM IN B WING	2007	12,594	630	20	630		2,151	15
16	GARAGE DOOR	2007	1,030	51	20	51		167	16
17	BOMANITE PATIO	2007	14,052	703	20	703		2,108	17
18	CARPETING	2009	5,594	400	7	400		400	18
19	ANNEX DOOR ALERT FOR NURSE'S STATION	2009	3,135	224	7	224		224	19
20	COVE CAP	2009	1,044	75	7	75		75	20
21	DOOR CONTROL	2009	3,250	232	7	232		232	21
22	FRONT PARKING LOT	2009	67,321	2,618	15	2,618		2,618	22
23	ROOF FOR MAIN BUILDING	2009	70,796	1,180	15	1,180		1,180	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,495,082	$ 75,073		$ 75,073	$	$ 2,250,705	34

**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: 07/01/2009 Ending: 06/30/2010

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	$ 554,923	$ 71,198	$ 71,198	$		$ 403,177	71
72	Current Year Purchases	147,560	13,402	13,402			13,402	72
73	Fully Depreciated Assets	901,024					901,024	73
74								74
75	TOTALS	$ 1,603,507	$ 84,600	$ 84,600	$		$ 1,317,603	75

D. Vehicle Depreciation (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	$ 148,785	$ 15,464	$ 15,464	$	5	$ 109,738	76
77	TRANSPORT RESIDENTS	VARIOUS BUSES	VARIOUS	150,810	14,325	14,325		5	136,293	77
78	SNOW REMOVAL	2010 DODGE 2500	2010	36,502	2,607	2,607		7	2,607	78
79										79
80	TOTALS			$ 336,097	$ 32,396	$ 32,396	$		$ 248,638	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)	$ 5,458,186	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 192,069	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 192,069	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,816,946	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	NEW PROJECT	$ 38,450	92
93	RENOVATIONS	9,158	93
94			94
95		$ 47,608	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: 07/01/2009 Ending: 06/30/2010

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.	/2011	$
13.	/2012	$
14.	/2013	$

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: 07/01/2009 Ending: 06/30/2010

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? [X] 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 [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER CNA 96

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- 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	150	224	199	573
3	Classroom Wages (a)	1,733	7,344		9,077
4	Clinical Wages (b)		3,672		3,672
5	In-House Trainer Wages (c)	1,396	8,877	2,235	12,508
6	Transportation				
7	Contractual Payments	113	254	225	592
8	CNA Competency Tests	60	485	495	1,040
9	TOTALS	$ 3,452	$ 20,856	$ 3,154	$ 27,462
10	SUM OF line 9, col. 1 and 2 (e)	$ 24,308			

C. CONTRACTUAL INCOME

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

$ 3,154

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	9
2. From other facilities (f)	8
DROP-OUTS	
1. From this facility	6
2. From other facilities (f)	
TOTAL TRAINED	23

(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.

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a.3		hrs	$	960	$ 48,018	$	960	$ 48,018	1
2	Licensed Speech and Language Development Therapist	10a.1 / 10a.3	486	hrs	15,553	846	38,070		1,332	53,623	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a.3		hrs		2,552	108,581		2,552	108,581	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):										12
13	Other (specify):										13
14	TOTAL				$ 15,553	4,358	$ 194,669	$	4,844	$ 210,222	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: 07/01/2009 Ending: 06/30/2010

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/2010 (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	$ 448,873	$ 461,887	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 37,075 / 41,709)	665,112	977,516	3
4	Supply Inventory (priced at COST)	36,634	43,770	4
5	Short-Term Investments	678,915	678,915	5
6	Prepaid Insurance	10,592	10,592	6
7	Other Prepaid Expenses	30,026	30,026	7
8	Accounts Receivable (owners or related parties)	695,036	1,152,040	8
9	Other(specify): ATTACHED	417,969	417,969	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,983,157	$ 3,772,715	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	23,500	319,861	13
14	Buildings, at Historical Cost	3,495,082	8,277,074	14
15	Leasehold Improvements, at Historical Cost		151,205	15
16	Equipment, at Historical Cost	1,939,604	2,672,201	16
17	Accumulated Depreciation (book methods)	(3,816,946)	(6,107,048)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		1,634,591	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CONSTR IN PROGRESS	47,608	69,199	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,688,848	$ 7,017,083	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,672,005	$ 10,789,798	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 77,659	$ 80,568	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	187,670	247,778	30
31	Accrued Taxes Payable (excluding real estate taxes)	17,059	19,336	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	WORK COMP INSURANCE	108,370	109,715	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 390,758	$ 457,397	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,540,658	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	PUBLIC AID ADVANCE	7,691	49,028	43
44	RESERVE FUND	2,767	2,767	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 10,458	$ 1,592,453	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 401,216	$ 2,049,850	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,270,789	$ 8,739,948	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,672,005	$ 10,789,798	48

***(See instructions.)**

Winning Wheels, Inc.
701 East Third Street FYE10
Prophetstown, IL 61277
IDPH #0024745

BALANCE SHEET PAGE 17

9	OTHER CURRENT ASSETS	
	Depoit in Frontier Hollow	$ 348,372
	Deposit in Pinnacle Place	97,601
	Investment in Al's Place Limited Partnership	(28,004)
	Total	$ 417,969

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 5,114,540	1
2	Restatements (describe):		2
3	CONSOLIDATED BALANCES, BEGINNING OF YEAR	3,948,632	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 9,063,172	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(266,640)	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) SUBSIDIARY COMPANIES		15
16	Other (describe) NET INCOME (LOSS)	(56,584)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (323,224)	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)**	$ 8,739,948	24 *

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

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,449,530	1
2	Discounts and Allowances for all Levels	(6,000)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,443,530	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	29,536	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	16,883	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)**	$ 46,419	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	19,344	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 19,344	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	TRANSPORTATION	59,285	28
28a	MISC	123	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 59,408	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,568,701	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,118,712	31
32	Health Care	2,498,253	32
33	General Administration	979,916	33
	B. Capital Expense		
34	Ownership	194,660	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	43,800	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,835,341	40
41	**Income before Income Taxes (line 30 minus line 40)****	(266,640)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (266,640)	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A 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: 07/01/2009 Ending: 06/30/2010

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	3,892	4,177	$ 121,775	$ 29.15	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,905	8,596	199,256	23.18	3
4	Licensed Practical Nurses	14,757	16,435	326,130	19.84	4
5	CNAs & Orderlies	82,850	88,266	923,608	10.46	5
6	CNA Trainees	1,413	1,413	12,710	9.00	6
7	Licensed Therapist	481	486	15,553	32.00	7
8	Rehab/Therapy Aides	9,514	9,514	127,587	13.41	8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	8,582	9,422	141,233	14.99	11
12	Dietician					12
13	Food Service Supervisor	1,511	1,717	20,463	11.92	13
14	Head Cook	3,991	4,359	48,767	11.19	14
15	Cook Helpers/Assistants	15,761	17,188	146,375	8.52	15
16	Dishwashers					16
17	Maintenance Workers	9,543	10,480	116,885	11.15	17
18	Housekeepers	13,001	13,796	120,674	8.75	18
19	Laundry	6,936	7,757	78,892	10.17	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	3,680	4,140	65,746	15.88	22
23	Office Manager	1,947	2,128	23,139	10.87	23
24	Clerical	1,836	2,059	21,573	10.48	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	1,850	1,970	28,569	14.50	31
32	Other Health Care(specify)					32
33	Other(specify) TRANSPORTATI	3,477	3,951	44,628	11.30	33
34	TOTAL (lines 1 - 33)	192,927	207,854	$ 2,583,563 *	$ 12.43	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	297	$ 11,870	1.3	35
36	Medical Director	192	24,000	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant	27	2,179	10.3	38
39	Pharmacist Consultant	50	1,950	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	44	2,175	11.3	46
47	PSYCHIATRIC EVALUATIONS	12	1,800	10a.3	47
48	PHYSIATRIST CONSULTANT	152	19,000	9.3	48
49	TOTAL (lines 35 - 48)	774	$ 62,974		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	24	$ 594	10.3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	24	$ 594		53

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
TAMI TEGELER	ADMINISTRATOR		$
(SALARY INCLUDED IN MANAGEMENT FEES, LINE 17, COL 3)			
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
AMERICAN HEALTH ENTERPRISES	$ 198,000
BENEFIT PLANNING CONSULTANTS	3,570
TOTAL (agree to Schedule V, line 17, col. 3)	$ 201,570
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
John Pyse Consulting	Computer Consulting	$ 30,760
MDI Achieve	Software fees	8,316
SAGE Software	Financial software	1,825
eHealth Data Solutions	Software fees	4,865
Midwest Audtomated Time	Time clock maintenance	730
T6 Broadband	Email / Web filtering	1,848
GoToMyPC	Remote access software	1,709
Lindgren, Callihan, Van Osdol	Year end audit fees	16,146
Ward, Murray, Pace, Johnson	Legal Services	763
Margel Peddicord, CPA	Cost Report Consulting	1,664
Other computer and software	Software / maintenance fees	1,159
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 69,785

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 89,827
Unemployment Compensation Insurance	21,500
FICA Taxes	193,438
Employee Health Insurance	34,456
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
LIFE INSURANCE	8,688
RETIREMENT	10,745
DENTAL	3,730
DISABILITY	21,260
CHILDCARE	20,373
TUITION / TRAINING / LICENSES	10,168
MISC. EMPLOYEE BENEFITS	23,393
TOTAL (agree to Schedule V, line 22, col.8)	$ 437,578

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	$ 995
Advertising: Employee Recruitment	3,554
Health Care Worker Background Check	
(Indicate # of checks performed 63)	2,420
Patient Background Checks	
IHCA	4,195
CARF	1,413
DUES, FEES, AND SUBSCRIPTIONS	4,726
COMMUNITY RELATIONS/MARKETING	15,816
LESS: DONATIONS	(360)
Less: Public Relations Expense	(12,412)
Non-allowable advertising	(3,352)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,995

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ (4,653)
In-State Travel	4,158
Seminar Expense	14,235
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 13,740

**See instructions.

WINNING WHEELS - 24745
Report Period Beginning – 7/1/2009
Report Period Ending – 6/30/2010
DETAIL SCHEDULE V-LINE 24

1			
Names & Titles	Kathy Vanderslice, DON		
Dates of Seminar	7/8/09-7/13/09		
Location	Indianapolis, IN		
Title of Seminar	Wound Care		
Sponsor	Wound Care Education Institute		
Cost		$	556
2			
Name & Title	Tami Tegeler, Administrator		
	Chris Burkes, Social Worker		
	Diana Dynes, Social Worker		
	Kevin Everly, C.N.A.		
Dates of Seminar	7/14/2009		
Location	Peoria, IL		
Title	MDS Medicaid		
Sponsor	LSN		
Cost		$	411
3			
Name & Title	Valorie Armstrong, Dietary Manager		
	Sue Wheetly, Dietary		
Date Travel	8/6/2009		
Location	Davenport, IA		
Title of Seminar	Martin Brothers Food Show		
Sponsor	Martin Brothers		
Total Cost		$	416
4			
Names & Titles	Tami Tegeler, Adminiatrator		
	Mary Burgess, Director of Rehab		
	Sheri Kenworthy, Social Worker		
	Karen Morales, RN		
	Misty Pollock, CNA		
	Kathy Vanderslice, DON		
	Juanita Wisley, CNA		
Date of Seminar	9/14/09-9/17/09		
Location	Peoria, IL		
Title	IHCA Annual Conference		
Sponsor	IHCA		
Cost		$	3,427
5			
Name & Title	Chris Burks, Social Worker		
	Gayla Bohms, Social Worker		
Date Travel	09/17-09/18		
Location	Indianapolis, IN		
Title of Seminar	BIA of Indiana		
Sponsor	BIA of Indiana		
Total Cost		$	1,239
6			
Name & Title	Chris Burks, Social Worker		
Date Travel	10/29 - 10/31/09		
Location	Urbandale, IA		
Title of Seminar	BIA conference		
Sponsor	BIA of IA		
Total Cost		$	300
7			
Name & Title	Mary Burgess, Director of Rehab		
Date Travel	10/31/2009		
Location	Oak Brook, IL		
Title of Seminar	BIA conference		
Sponsor	BIA of IL		
Total Cost		$	451
8			
Name & Title	Tami Tegeler, Administrator		
	Neal Gapinski, Regional Administrator		
	Milt Rue, CFO		
Date Travel	11/3/09 - 11/4/09		
Location	Springfield, IL		
Title of Seminar	INHAA - Annual convention & trade show		
Sponsor	IL Nursing Home Administrator's Assoc.		
Total Cost		$	790
9			
Name & Title	Mary Burgess, Director of Rehab		
	Carol Brown, Director of Clinical Services		
	Neal Gapinski, Regional Administrator		
Date Travel	11/10/2009		
Location	Lisle, IL		
Title of Seminar	MDS		
Sponsor	MDS		
Total Cost		$	136
10			
Name & Title	Tami Tegeler, Administrator		
	Mary Burgess, Director of Rehab		
	Neal Gapinski, Regional Administrator		
	Milt Rue, CFO		
Date Travel	11/11/2009		
Location	Springfield, IL		
Title of Seminar	MDS		
Sponsor	IHCA		
Total Cost		$	625
11			
Name & Title	Mary Burgess, Director of Rehab		
Date Travel	11/12/2009		
Location	Webinar		
Title of Seminar	Long Term Care Consequences		
Sponsor	Tramatic Brain Assoc.		
Total Cost		$	45
12			
Name & Title	Tami Tegeler, Administrator		
Date Travel	11/25/2009		
Location	Chicago, IL		
Title of Seminar	BIA of IL		
Sponsor	BIA of IL		
Total Cost		$	1,000
13			
Name & Title	Amber Temple, Human Resources		
Date Travel	12/8/2009		
Location	Clinton, IA		
Title of Seminar	LSN Conference		
Sponsor	LSN		
Total Cost		$	103
14			
Name & Title	Tami Tegeler, Administrator		
Date Travel	2/10/2010		
Location	Westmont, IL		
Title of Seminar	Pathway Health Annual conference		
Sponsor	LTC		
Total Cost		$	387
15			
Name & Title	Tami Tegeler, Administrator		
	Kathy VanderSlice, DON		
Date Travel	2/16/2010		
Location	Lisle, IL		
Title of Seminar	Risk Management		
Sponsor	MPIC		
Total Cost		$	130
16			
Name & Title	Chris Burks, Social Worker		
	Courtney Hubner, Speech Therapy		
Date Travel	03/3 - 03/05/10		
Location	Des Moines, IA		
Title of Seminar	BIA Conference		
Sponsor	BIA of IA		
Total Cost		$	636
17			
Name & Title	Amy Ryan, RN		
Date Travel	4/4/2010		
Location	Springfield, IL		
Title of Seminar	DON Resources for Success		
Sponsor	LTCNA		
Total Cost		$	179
18			
Name & Title	Valorie Armstrong, Dietary Manager		
Date Travel	4/8-4/9/10		
Location	Rock Island, IL		
Title of Seminar	State Meeting		
Sponsor	IDMS		
Total Cost		$	183
19			
Name & Title	Sandy Harper, RN		
Date Travel	04/06-04/07/10		
Location	Springfield, IL		
Title of Seminar	IHCA		
Sponsor	IHCA		
Total Cost		$	427
20			
Name & Title	Regi Fortune, RN		
Date Travel	4/16/2010		
Location	Springfield, IL		
Title of Seminar	CNA-instructors Conference		
Sponsor	LLCC		
Total Cost		$	340
21			
Name & Title	Toni Whitcher, LPN		
Date Travel	4/22/2010		
Location	Webinar		
Title of Seminar	Understanding Personalities		
Sponsor	IBP Seminars		
Total Cost		$	160
22			
Name & Title	Tami Tegeler, Administrator		
Date Travel	4/26/2010		
Location	Webinar		
Title of Seminar	Brain Injury and Substance Abuse		
Sponsor	Care International		
Total Cost		$	240
23			
Name & Title	Tami Tegeler, Administrator		
	Mary Burgess, Director of Rehab		
Date Travel	05/03-05/04/10		
Location	Wisconsin Dells, WI		
Title of Seminar	Wisconsin Conference		
Sponsor	BIA of WI		
Total Cost		$	1,291
24			
Name & Title	Tami Tegeler, Administrator		
	Mary Burgess, Director of Rehab		
	Neal Gapinski, Regional Administrator		
	Karyn Sommers-Buck		
Date Travel	6/15/2010		
Location	Peoria, IL		
Title of Seminar	MDS 3.0		
Sponsor	IHCA		
Total Cost		$	762
	Total Seminars	**$**	**14,235**
	Employee mileage reimbursement	$	4,158
	Less: Out of State Travel and Seminars	$	(4,653)
	Total Travel and Seminars	**$**	**13,740**

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/01/2009 Ending: 06/30/2010

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2	PAINTING	01/2005	1,592	5	318	319	318	159					
3	PAINTING	01/2007	3,295	5	329	659	659	659	659	330			
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 4,887		$ 647	$ 978	$ 977	$ 818	$ 659	$ 330	$	$	$

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. **ILL HEALTH CARE ASSOC. $4,195**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? _____

(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? **5.54 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **34,197** 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 **X** NO

(10) 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.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **43,800**
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? **YES** 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. $ **16,883**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **YES** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **54,745**
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? **N/A**
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: **WIPFLI LLP**

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

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

Winning Wheels, Inc.
701 East Third Street
Prophetstown, IL 61277
IDPH #0024745

FYE 2010

Page 23, Schedule XX
Question 12

SALARY COSTS ALLOCATED TO MULTIPLE LINES ON SCHEDULE V

Several nursing employees participated in CNA training and their wages were split between lines 10 and 13 on Schedule V.