FOR BHF USE

LL1

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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 THIRD 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 07/10/2010 to 06/30/2011 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) 12/12/2011 (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: 07/10/2010 Ending: 06/30/2011

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			258	258	8
9	SNF/PED					9
10	ICF	27,046	1,716		28,762	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,046	1,716	258	29,020	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 99.38%

D. How many bed-hold days during this year were paid by the Department?
665 (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 258

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

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

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

Tax Year: 06/30/2011 Fiscal Year: 06/30/2011

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

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/10/2010 Ending: 06/30/2011

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	236,530	37,586	10,824	284,940		284,940		284,940			1
2	Food Purchase		285,629		285,629		285,629	(8,294)	277,335			2
3	Housekeeping	118,167	37,571		155,738		155,738		155,738			3
4	Laundry	91,564	23,119		114,683		114,683		114,683			4
5	Heat and Other Utilities			126,694	126,694		126,694	(8,106)	118,588			5
6	Maintenance	119,831	71,726	30,071	221,628		221,628	2,115	223,743			6
7	Other (specify):*											7
8	**TOTAL General Services**	566,092	455,631	167,589	1,189,312		1,189,312	(14,285)	1,175,027			8
	B. Health Care and Programs											
9	Medical Director			24,298	24,298		24,298		24,298			9
10	Nursing and Medical Records	1,595,924	215,270	29,019	1,840,213	(21,922)	1,818,291		1,818,291			10
10a	Therapy	154,619	1,852	121,805	278,276		278,276	1,438	279,714			10a
11	Activities	61,857	8,549	15,660	86,066		86,066		86,066			11
12	Social Services	161,810			161,810		161,810		161,810			12
13	CNA Training			2,227	2,227	21,922	24,149	(3,705)	20,444			13
14	Program Transportation	55,079	35,470		90,549	(52,220)	38,329		38,329			14
15	Other (specify):* DENTAL SERVICES			270	270		270		270			15
16	**TOTAL Health Care and Programs**	2,029,289	261,141	193,279	2,483,709	(52,220)	2,431,489	(2,267)	2,429,222			16
	C. General Administration											
17	Administrative			203,160	203,160		203,160		203,160			17
18	Directors Fees											18
19	Professional Services			92,259	92,259		92,259		92,259			19
20	Dues, Fees, Subscriptions & Promotions			40,816	40,816		40,816	(16,297)	24,519			20
21	Clerical & General Office Expenses	125,512	44,962	24,110	194,584	(929)	193,655	81,990	275,645			21
22	Employee Benefits & Payroll Taxes			328,448	328,448		328,448	13,169	341,617			22
23	Inservice Training & Education			1,965	1,965		1,965		1,965			23
24	Travel and Seminar			17,802	17,802		17,802	(6,330)	11,472			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			40,226	40,226	(4,344)	35,882		35,882			26
27	Other (specify):*											27
28	**TOTAL General Administration**	125,512	44,962	748,786	919,260	(5,273)	913,987	72,532	986,519			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,720,893	761,734	1,109,654	4,592,281	(57,493)	4,534,788	55,980	4,590,768			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: 07/10/2010 Ending: 06/30/2011

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			207,764	207,764		207,764	(463)	207,301			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			5,783	5,783		5,783	(5,783)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			213,547	213,547		213,547	(6,246)	207,301			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					57,493	57,493		57,493			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	57,493	101,293		101,293			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,720,893	761,734	1,367,001	4,849,628		4,849,628	49,734	4,899,362			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 2011

Page 3, Schedule V

Line #		DR.	CR.
	RECLASSIFICATIONS		
13	CNA Training	$ 11,350	
10	Nursing & Medical Records		$ 11,350
	Nurse wages for training classes		
13	CNA Training	$ 10,572	
10	Nursing & Medical Records		$ 10,572
	Employee wages for attending training classes		
14	Transportation	$ 4,344	
26	Insurance		$ 4,344
	Transfer vehicle insurance premiums to transportation		
14	Transportation	$ 929	
21	Clerical & General Office		$ 929
	Transfer vehicle license fees to transportation		
38	Medically Necessary Transportation	$ 57,493	
14	Transportation		$ 57,493
	Transfer costs for medically necessary transportation		

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/10/2010 Ending: 06/30/2011

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(10,653)	2		4
5	Telephone, TV & Radio in Resident Rooms	(8,106)	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	(5,783)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(375)	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	(15,448)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees	(3,705)	13		27
28	Yellow Page Advertising	(474)	20		28
29	Other-Attach Schedule PAGE 5A	(881)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (45,425)		$	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))**	$ (45,425)		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		$ 57,493	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)**			$ 57,493		47

WINNING WHEELS

ID# 0024745

Report Period Beginning: 07/10/2010

Ending: 06/30/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	NEW EQUIPMENT UNDER $2500	$ 2,359	2	1
2	NEW IMPROVEMENTS UNDER $2500	2,115	6	2
3	NEW EQUIPMENT UNDER $2500	1,438	10a	3
4	DEPRECIATION ON ASSETS UNDER $2500	(463)	30	4
5	OUT OF STATE TRAVEL	(6,330)	24	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**	(881)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WINNING WHEELS # 0024745 **Report Period Beginning:** 07/10/2010 **Ending:** 06/30/2011

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(8,294)	0	0	0	0	0	0	0	0	0	0	(8,294)	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	(8,106)	0	0	0	0	0	0	0	0	0	0	(8,106)	5
6	Maintenance	2,115	0	0	0	0	0	0	0	0	0	0	2,115	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(14,285)	0	0	0	0	0	0	0	0	0	0	(14,285)	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	1,438	0	0	0	0	0	0	0	0	0	0	1,438	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	(3,705)	0	0	0	0	0	0	0	0	0	0	(3,705)	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**	(2,267)	0	0	0	0	0	0	0	0	0	0	(2,267)	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	(16,297)	0	0	0	0	0	0	0	0	0	0	(16,297)	20
21	Clerical & General Office Expenses	0	81,990	0	0	0	0	0	0	0	0	0	81,990	21
22	Employee Benefits & Payroll Taxes	0	13,169	0	0	0	0	0	0	0	0	0	13,169	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(6,330)	0	0	0	0	0	0	0	0	0	0	(6,330)	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**	(22,627)	95,159	0	0	0	0	0	0	0	0	0	72,532	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(39,179)	95,159	0	0	0	0	0	0	0	0	0	55,980	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WINNING WHEELS # 0024745 **Report Period Beginning:** 07/10/2010 **Ending:** 06/30/2011

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	(463)	0	0	0	0	0	0	0	0	0	0	(463)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,783)	0	0	0	0	0	0	0	0	0	0	(5,783)	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**	(6,246)	0	0	0	0	0	0	0	0	0	0	(6,246)	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)**	(45,425)	95,159	0	0	0	0	0	0	0	0	0	49,734	45

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/10/2010 Ending: 06/30/2011

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
WINNING WHEELS, INC.	100%	STRIVE	PROPHETSTOWN	LYNDON PROGRESS	LYNDON	DAYTREATMENT
				CENTER		REHABILITATION
		BIG MEADOWS (BUILDING ONLY)	SAVANNA			
				LYNDON PLAY &	LYNDON	CHILD DAYCARE
		PINNACLE PLACE SLF	SAVANNA	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	$ 7,608	LYNDON PLAY AND LEARN CENTER	100.00%	$ 11,326	$ 3,718	1
2	V								2
3	V								3
4	V		ADMINISTRATIVE OVERHEAD						4
5	V	21	CLERICAL SALARIES		WINNING WHEELS, INC. (ADMINISTRATIVE FUND)	100.00%	81,990	81,990	5
6	V	22	BENEFITS		(SEE DETAILS, SCHEDULE VIII, PAGE 8)	100.00%	9,451	9,451	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 7,608			$ 102,767	$ * 95,159	14

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

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/10/2010 Ending: 06/30/2011

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	BOARD OF DIRECTORS							1
2	JOHN GUZZARDO - PRESIDENT	0%	N/A		N/A			2
3	DAVID MICKLEY - VICE-PRESIDENT	0%	N/A		N/A			3
4	KYLE GIBSON - TREASURER	0%	N/A		N/A			4
5	MARY ANN HILL - SECRETARY	0%	N/A		N/A			5
6	MEREDITH HAMMER	0%	N/A		N/A			6
7	CONNIE DEMARANVILLE	0%	N/A		N/A			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

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/10/2010 Ending: 06/30/2011

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		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: 07/10/2010 Ending: 6/30/2011

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 [X] NO [ ]

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

Name of Related Organization: WINNING WHEELS ADMINISTRATIVE FUNI
Street Address: 501 6TH AVE W
City / State / Zip Code: LYNDON, IL 61261
Phone Number: (815-778-3610
Fax Number: (815-778-4503

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	CLERICAL SALARIES	SALARIES/BENEFITS	6,332,151	7	$ 170,257	$ 170,257	3,049,342	$ 81,990	1
2	22	FICA	SALARIES/BENEFITS	6,332,151	7	9,969		3,049,342	4,801	2
3	22	WORKMAN'S COMP	SALARIES/BENEFITS	6,332,151	7	95		3,049,342	46	3
4	22	LIFE INSURANCE	SALARIES/BENEFITS	6,332,151	7	409		3,049,342	197	4
5	22	HEALTH INSURANCE	SALARIES/BENEFITS	6,332,151	7	3,051		3,049,342	1,469	5
6	22	403 B RETIREMENT	SALARIES/BENEFITS	6,332,151	7	1,588		3,049,342	765	6
7	22	DENTAL INSURANCE	SALARIES/BENEFITS	6,332,151	7	290		3,049,342	140	7
8	22	ST & LT DISABILITY INSURAN	SALARIES/BENEFITS	6,332,151	7	1,500		3,049,342	722	8
9	22	CHILD CARE	SALARIES/BENEFITS	6,332,151	7	2,328		3,049,342	1,121	9
10	22	OTHER	SALARIES/BENEFITS	6,332,151	7	394		3,049,342	190	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					$ 189,881	$ 170,257		$ 91,441	25

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/10/2010 Ending: 06/30/2011

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	FARMERS NATIONAL BANK		X	LINE OF CREDIT		04/27/2010	500,000		10/08/2011	4.9500	5,783	6
7												7
8												8
9	TOTAL Facility Related						$ 500,000	$			$ 5,783	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 500,000	$			$ 5,783	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:** 07/10/2010 **Ending:** 06/30/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 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 2011 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:		
	2006	8
	2007	9
	2008	10
	2009	11
	2010	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 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 2010 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 2010.

	(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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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: 07/10/2010 Ending: 06/30/2011

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: 07/10/2010 Ending: 06/30/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	80		1979	1979	$ 1,447,685	$ 13,800	23.35	$ 13,800	$	$ 1,333,838	4
5				1985	4,226		20			4,226	5
6				1986	13,305		20			13,305	6
7											7
8											8
	Improvement Type**										
9	REMODELING			1985	585		20			585	9
10	REMODELING			1986	2,576		10			2,576	10
11	REMODELING			1987	11,701		17.5			11,701	11
12	REMODELING			1988	68,047		12.6			68,047	12
13	REMODELING			1989	11,704		11.67			11,704	13
14	REMODELING			1990	29,027		12.4			29,027	14
15	REMODELING			1991	17,257		12.5			17,257	15
16	REMODELING			1992	57,762	2,674	18.33	2,674		54,772	16
17	REMODELING			1993	47,777	1,926	16.43	1,926		43,511	17
18	REMODELING			1994	72,619	1,617	13.17	1,617		68,287	18
19	REMODELING			1995	87,502	4,103	16	4,103		70,891	19
20	REMODELING			1996	55,375	2,057	14.05	2,057		49,106	20
21	REMODELING			1997	42,521	1,314	14.4	1,314		35,381	21
22	REMODELING			1998	39,818	642	11.88	642		35,579	22
23	REMODELING			1999	113,510	3,415	12.17	3,415		99,101	23
24	REMODELING			2000	1,102,474	28,569	20.17	28,569		311,959	24
25	REMODELING			2001	20,384	739	17.25	739		7,244	25
26	REMODELING			2002	12,940	1,294	10	1,294		11,122	26
27	REMODELING			2003	4,687	469	10	469		3,515	27
28	REMODELING			2004	26,331	1,525	18.33	1,525		10,233	28
29	REMODELING			2005	18,271	1,855	10.88	1,855		10,720	29
30	REMODELING			2006	4,920	756	12.5	756		3,478	30
31	CANVAS CANOPY			2007	3,260	326	10	326		1,467	31
32	RE-TILE 18 ROOMS-B WING			2007	12,594	630	20	630		2,781	32
33	GARAGE DOOR			2007	1,030	52	20	52		219	33
34	BOMANITE PATIO			2007	14,052	703	20	703		2,810	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/10/2010 Ending: 06/30/2011

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	CARPET HOUSE - CARPETING	2009	$ 5,594	$ 799	7	$ 799	$	$ 1,199	37
38	ANNEX DOOR ALERT TO NURSE'S STATIONS	2009	3,135	448	7	448		672	38
39	COVE CAP - 540 FEET	2009	1,044	149	7	149		224	39
40	ADVANCED DOOR CONTROL	2009	3,250	464	7	464		696	40
41	NEW FRONT PARKING LOT	2009	67,321	4,488	15	4,488		7,106	41
42	NEW ROOF ON MAIN BUILDING	2010	70,797	4,720	15	4,720		5,900	42
43	FLOORING	2010	4,995	357	7	357		357	43
44									44
45	DEFERRED MAINTENANCE ITEMS CAPITALIZED			1,438		1,438			45
46	(SEE PAGE 22)								46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,500,076	$ 81,329		$ 81,329	$	$ 2,330,596	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: 07/10/2010 Ending: 06/30/2011

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	$ 477,984	$ 72,214	$ 72,214	$	7.42	$ 274,659	71
72	Current Year Purchases	124,209	11,089	11,089		5.82	11,089	72
73	Fully Depreciated Assets	1,082,831	8,307	8,307		9.19	1,082,831	73
74								74
75	TOTALS	$ 1,685,024	$ 91,610	$ 91,610	$		$ 1,368,579	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	$ 155,246	$ 19,478	$ 19,478	$	5	$ 95,540	76
77	TRANSPORT RESIDENTS	VARIOUS BUSES	VARIOUS	156,932	10,290	10,290		5	146,583	77
78	SNOW REMOVAL	2010 DODGE 2500	2010	32,157	4,594	4,594		7	6,891	78
79										79
80	TOTALS			$ 344,335	$ 34,362	$ 34,362	$		$ 249,014	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)	$ 5,552,935	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 207,301	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 207,301	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)	$ 3,948,189	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	88,880	93
94			94
95		$ 127,330	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: 07/10/2010 Ending: 06/30/2011

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.	/2012	$
13.	/2013	$
14.	/2014	$

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: 07/10/2010 Ending: 06/30/2011

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	335	438	274	1,047
3	Classroom Wages (a)	4,099	4,020		8,119
4	Clinical Wages (b)	402	2,051		2,453
5	In-House Trainer Wages (c)	3,759	4,920	3,071	11,750
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests		420	360	780
9	TOTALS	$ 8,595	$ 11,849	$ 3,705	$ 24,149
10	SUM OF line 9, col. 1 and 2 (e)	$ 20,444			

C. CONTRACTUAL INCOME

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

$ 4,165

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	6
2. From other facilities (f)	3
DROP-OUTS	
1. From this facility	7
2. From other facilities (f)	2
TOTAL TRAINED	18

(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

STATE OF ILLINOIS
0024745 Report Period Beginning: 07/10/2010 Ending: 06/30/2011

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	$	816	$ 40,805	$	816	$ 40,805	1
2	Licensed Speech and Language Development Therapist	10a.1	1881	hrs	61,359				1,881	61,359	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a.3		hrs		1,887	80,350		1,887	80,350	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)	10a.3		hrs		13	650		13	650	10
11	Academic Education			hrs							11
12	Other (specify):										12
13	Other (specify):										13
14	TOTAL				$ 61,359	2,716	$ 121,805	$	4,597	$ 183,164	14

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

STATE OF ILLINOIS

Facility Name & ID Number WINNING WHEELS **#** 0024745 **Report Period Beginning:** 07/10/2010 **Ending:** 06/30/2011

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 06/30/2011 **(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	$ 167,030	$ 219,629	1
2	Cash-Patient Deposits	20,540	23,533	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 24,182)	271,970	447,872	3
4	Supply Inventory (priced at COST)	30,359	42,149	4
5	Short-Term Investments	22,486	22,486	5
6	Prepaid Insurance	7,065	7,065	6
7	Other Prepaid Expenses	25,246	25,246	7
8	Accounts Receivable (owners or related parties)	707,013	2,191,849	8
9	Other(specify): PG17_SUPPORT	446,472	446,472	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,698,181	$ 3,426,301	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	23,500	231,451	13
14	Buildings, at Historical Cost	3,500,077	7,513,417	14
15	Leasehold Improvements, at Historical Cost		43,361	15
16	Equipment, at Historical Cost	2,035,271	2,352,722	16
17	Accumulated Depreciation (book methods)	(3,960,362)	(5,485,950)	17
18	Deferred Charges	22,166	33,115	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		1,731,431	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CONSTR IN PROGRESS	127,330	148,921	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,747,982	$ 6,568,468	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,446,163	$ 9,994,769	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 63,584	$ 63,584	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	20,540	23,533	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	209,721	209,721	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,714	10,714	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	560	560	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	WORK COMP INSURANCE	2,000	2,000	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 307,119	$ 310,112	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,503,580	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	PUBLIC AID ADVANCE	7,691	7,691	43
44	RESERVE FUND	2,419	2,419	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 10,110	$ 1,513,690	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 317,229	$ 1,823,802	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,128,934	$ 8,170,967	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,446,163	$ 9,994,769	48

***(See instructions.)**

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

FYE 2011

BALANCE SHEET PAGE 17

Line #		
9	OTHER CURRENT ASSETS	
	Depoit in Frontier Hollow	$ 388,464
	Deposit in Pinnacle Place	$ 97,601
	Investment in Al's Place Limited Partnership	$ (39,593)
	Total	$ 446,472

Facility Name & ID Number WINNING WHEELS # 0024745 **Report Period Beginning:** 07/10/2010 **Ending:** 06/30/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 8,739,948	1
2	Restatements (describe):		2
3	ADJUST TO AUDITED FUND BALANCE	(270,298)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 8,469,650	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(316,068)	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)	17,385	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (298,683)	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)**	$ 8,170,967	24 *

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

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/10/2010 Ending: 06/30/2011

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	$ 4,444,602	1
2	Discounts and Allowances for all Levels	(11,239)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,433,363	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	15,047	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	10,653	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)**	$ 25,700	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	16,566	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 16,566	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	TRANSPORTATION	55,688	28
28a	MISCELLANEOUS	2,243	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 57,931	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,533,560	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,189,312	31
32	Health Care	2,483,709	32
33	General Administration	919,260	33
	B. Capital Expense		
34	Ownership	213,547	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)***	$ 4,849,628	40
41	**Income before Income Taxes (line 30 minus line 40)****	(316,068)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (316,068)	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: 07/10/2010 Ending: 06/30/2011

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	3,950	4,266	$ 129,543	$ 30.37	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,989	10,756	246,857	22.95	3
4	Licensed Practical Nurses	14,196	15,350	319,979	20.85	4
5	CNAs & Orderlies	72,903	77,360	871,090	11.26	5
6	CNA Trainees	1,119	1,119	10,572	9.45	6
7	Licensed Therapist	1,843	1,923	62,717	32.61	7
8	Rehab/Therapy Aides	6,085	6,971	91,902	13.18	8
9	Activity Director					9
10	Activity Assistants	4,009	4,368	61,857	14.16	10
11	Social Service Workers	9,735	10,422	161,810	15.53	11
12	Dietician					12
13	Food Service Supervisor	1,274	1,442	23,397	16.23	13
14	Head Cook	3,946	4,346	50,496	11.62	14
15	Cook Helpers/Assistants	17,507	18,430	162,637	8.82	15
16	Dishwashers					16
17	Maintenance Workers	9,467	10,377	119,831	11.55	17
18	Housekeepers	11,931	12,951	118,167	9.12	18
19	Laundry	7,776	8,604	91,564	10.64	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	3,572	3,992	78,742	19.72	22
23	Office Manager	1,932	2,152	25,241	11.73	23
24	Clerical	1,746	1,976	21,529	10.90	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	1,337	1,484	17,883	12.05	31
32	Other Health Care(specify)					32
33	Other(specify) TRANSPORTATI	3,796	4,203	55,079	13.10	33
34	TOTAL (lines 1 - 33)	188,113	202,492	$ 2,720,893 *	$ 13.44	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		$		35
36	Medical Director	195	24,298	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant	12	600	10.3	38
39	Pharmacist Consultant	28	1,260	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				46
47	PHYSIATRIST CONSULTANT	200	25,000	10.3	47
48	LAB		1,950	10.3	48
49	TOTAL (lines 35 - 48)	435	$ 53,108		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	9	209	10.3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	9	$ 209		53

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/10/2010 Ending: 06/30/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
TAMI TEGELER	ADMINISTRATOR		$
NEAL GAPINSKI	INTERIM ADMIN		
(SALARIES INCLUDED IN ADMINISTRATIVE - OTHER)			
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
AMERICAN HEALTH ENTERPRISES	$ 201,000
BENEFIT PLANNING CONSULTANTS	2,160
TOTAL (agree to Schedule V, line 17, col. 3)	$ 203,160
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
JOHN PYSE CONSULTING	COMPUTER CONSULTIN	$ 47,554
MDI ACHIEVE	SOFTWARE FEES	9,702
SAGE SOFTWARE	FINANCIAL SOFTWARE	4,107
EHEALTH DATA SOLUTIONS	SOFTWARE FEES	2,025
MIDWEST AUTOMATED TIME	TIME CLOCK MAINTENANC	730
GOTOMYPC	REMOTE ACCESS SOFTWAR	1,859
WIPFLI	FINANCIAL AUDIT FEES	21,575
WARD, MURRAY, PACE, JOHNSC	LEGAL SERVICES	505
IVANS	MEDICARE TRANSMIT SOFT	927
JCM CONSULTING	EMPLOYEE EVALUATION S	500
MARTIN, HOOD, FRIESE, & ASSC	403(B) AUDIT FEES	2,375
MISC	SOFTWARE FEES	400
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 92,259

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 46
Unemployment Compensation Insurance	15,120
FICA Taxes	207,047
Employee Health Insurance	33,293
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
LIFE INSURANCE	9,726
RETIREMENT	12,785
DENTAL	3,532
DISABILITY	21,899
CHILD CARE	12,447
TUITION / TRAINING / LICENSES	4,465
MISC. EMPLOYEE BENEFITS	21,257
TOTAL (agree to Schedule V, line 22, col.8)	$ 341,617

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	$ 829
Advertising: Employee Recruitment	9,337
Health Care Worker Background Check	2,300
(Indicate # of checks performed 72)	
Patient Background Checks 74	1,000
ASSOCIATION DUES	4,201
CARF	1,413
IHCA	4,195
NEWSPAPERS / MAGAZINES	1,244
MARKETING / ADVERTISING	16,297
Less: Public Relations Expense	(12,152)
Non-allowable advertising	(3,671)
Yellow page advertising	(474)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 24,519

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ (6,330)
In-State Travel	3,746
Seminar Expense	14,056
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 11,472

**See instructions.

WINNING WHEELS - 24745
Report Period Beginning – 7/1/2010
Report Period Ending – 6/30/2011
DETAIL SCHEDULE V-LINE 24

1

Names & Titles	Karen Goodell, RN		
Dates of Seminar	August 8 - 18, 2010		
Location	Springfield, IL		
Title of Seminar	Restorative Nursing		
Sponsor	Azer Clinic		
Cost		$	997

2

Name & Title	Tami Tegeler, Administrator		
	Valorie Armstrong, Dietary Manager		
	Hope Anderson, CNA		
	Mary Burgess, Director of Rehab		
	Ashley Clayton, CNA		
Dates of Seminar	September 13 - 16, 2010		
Location	Peoria, IL		
Title	Annual Convention		
Sponsor	IHCA		
Cost		$	2,257

3

Name & Title	Jill Smith, Director of Admissions		
	Kathy Vanderslice, Director of Nursing		
Date of Seminar	September 23 - 24, 2010		
Location	Ankeny, IA		
Title of Seminar	Annual Fall Conference		
Sponsor	On with Life		
Total Cost		$	332

4

Name & Title	Kathy Vanderslice, Director of Nursing		
Date of Seminar	October 12, 2010		
Location	St. Charles, IL		
Title of Seminar	Falls and Safety		
Sponsor	NHRMA		
Total Cost		$	118

5

Name & Title	Gayla Bohms, Social Worker		
Date of Seminar	October 20 - 23, 2011		
Location	St. Charles, MO		
Title of Seminar	Brain Injury Conference		
Sponsor	BIA of Missouri		
Total Cost		$	443

6

Name & Title	Valorie Armstrong, Dietary Manager		
Date of Seminar	October 21 - 22, 2011		
Location	Peoria, IL		
Title of Seminar	Dietary Managers meeting		
Sponsor	IL Dietary Managers Association		
Total Cost		$	157

7

Name & Title	Jill Smith, Director of Admissions		
Date of Seminar	October 25, 2010		
Location	Oakbrook, IL		
Title of Seminar	Brain Injury Conference		
Sponsor	BIA of Illinois		
Total Cost		$	199

8

Name & Title	Toni Williar, Activiry Director		

WINNING WHEELS - 24745
Report Period Beginning – 7/1/2010
Report Period Ending – 6/30/2011
DETAIL SCHEDULE V-LINE 24

	Erica Kershaw, Activity Director		
Date of Seminar	October 27 - 29, 2010		
Location	Peoria, IL		
Title of Seminar	Annual Activity Professionals Seminar		
Sponsor	IL Activity Professionals Association		
Total Cost		$	302

9

Name & Title	Tammy Schmidt, CNA		
	Megan Ingram, CNA		
	Mary Locey, CNA		
Date of Seminar	November 4, 2010		
Location	Galesburg, IL		
Title of Seminar	Restorative Nursing		
Sponsor	Azer Clinic		
Total Cost		$	330

10

Name & Title	Mike Lombardo, Riding Instructor		
Date of Seminar	January 19 - 22, 2011		
Location	Ponder, TX		
Title of Seminar	Riding Unlimited		
Sponsor	NARHA		
Total Cost		$	1,378

11

Name & Title	Courtney Huber, Speech Therapist		
	Mary Burgess, Director of Rehab		
Date of Seminar	March 9 - 11, 2011		
Location	Des Moines, IA		
Title of Seminar	Brain Injury Conference		
Sponsor	BIA of Iowa		
Total Cost		$	1,340

12

Name & Title	Jean Luett, Riding Instructor		
Date of Seminar	April 16 - 17, 2011		
Location	Madison, WI		
Title of Seminar	Midwest Horse Fair		
Sponsor	NARHA		
Total Cost		$	460

13

Name & Title	Chris Burks, Social Worker		
Date of Seminar	May 5, 2011		
Location	Skokie, IL		
Title of Seminar	Brain Injury Seminar		
Sponsor	BIA of Illinois		
Total Cost		$	423

14

Name & Title	Jill Smith, Director of Admissions		
	Kathy Vanderslice, Director of Nursing		
	Megan Swan, RN		
	Chris Burks, Social Worker		
Date of Seminar	May 9 - 10, 2011		
Location	Wisconsin Dells, WI		
Title of Seminar	Brain Injury Conference		
Sponsor	BIA of WI		
Total Cost		$	2,438

15

Name & Title	Jean Luett, Riding Instructor		

WINNING WHEELS - 24745
Report Period Beginning – 7/1/2010
Report Period Ending – 6/30/2011
DETAIL SCHEDULE V-LINE 24

Date of Seminar	May 25, 2011		
Location	Rockford, IL		
Title of Seminar	BIA stroke and Alzheimers		
Sponsor	Institute of Natural Resources		
Total Cost		$	84
16			
Name & Title	Rachael Kalebaugh, Riding Instructor Sally Masscho, Riding Instructor Jean Luett, Riding Instructor Kay Richmond, Director of WHOA		
Date of Seminar	June 1, 2011		
Location	online		
Title of Seminar	Certified Instructor Seminar and Training		
Sponsor	NARHA		
Total Cost		$	597
17			
Name & Title	Courtney Huber, Speech Therapist		
Date of Seminar	June 22 - 23, 2011		
Location	Atlanta, GA In-state option not available, so we had to do an out of state seminar		
Title of Seminar	Preparing for successful accredidation in Medical Rehab		
Sponsor	CARF		
Total Cost		$	1,719
18			
Name & Title	Erin Beauchamp, Dietary		
Date of Seminar	June 5, 2011		
Location	Sterling, IL		
Title of Seminar	Food Service Certification Seminar		
Sponsor	CGH Medical Center		
Total Cost		$	100
19			
Name & Title	Sally Masscho, Riding Instructor Kay Richmond, Director of WHOA		
Date of Seminar	June 30, 2011		
Location	Augusta, MI		
Title of Seminar	Certified Instructor Seminar and Training		
Sponsor	CHEFF Therapeutic Riding Center		
Total Cost		$	382
	Total Seminars	**$**	**14,056**
	Employee mileage reimbursement	$	3,746
	Less: Out of State Travel and Seminars	$	(6,330)
	Total Travel and Seminars	**$**	**11,472**

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 07/10/2010 Ending: 06/30/2011

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	320			
4	PAINTING	06/2011	10,097	7					721	1,442	1,442	1,442	1,442
5	FLOORING	06/2011	809	7					58	116	116	116	116
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 15,793		$ 647	$ 978	$ 977	$ 818	$ 1,438	$ 1,878	$ 1,558	$ 1,558	$ 1,558

Facility Name & ID Number WINNING WHEELS **#** 0024745 **Report Period Beginning:** 07/10/2010 **Ending:** 06/30/2011

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. **IL 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? **7**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **31,508** 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. $ **10,653**

(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. $ **55,688**
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? 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 2011

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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.