

Facility Name & ID Number WINNING WHEELS

0024745 Report Period Beginning: 7/1/2004 Ending: 6/30/2005

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	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			5 Total	
		3 Medicaid Recipient	4 Private Pay	Other		
8	SNF	1,802	2,442	783	5,027	8
9	SNF/PED					9
10	ICF	23,386			23,386	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,188	2,442	783	28,413	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.30%

D. How many bed-hold days during this year were paid by the Department? 567 (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) _____

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

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

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

I. On what date did you start providing long term care at this location?
Date started 1/1/79

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 40 and days of care provided 783

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/05 Fiscal Year: 6/30/05

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

STATE OF ILLINOIS

Page 3

Facility Name & ID Number

WINNING WHEELS

0024745

Report Period Beginning:

7/1/2004

Ending:

6/30/2005

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	199,663	18,576	10,274	228,513	2,419	230,932		230,932		1
2	Food Purchase		211,677		211,677		211,677	(2,071)	209,606		2
3	Housekeeping	95,676	33,926		129,602	907	130,509		130,509		3
4	Laundry	75,225	11,978		87,203		87,203		87,203		4
5	Heat and Other Utilities			102,634	102,634		102,634	(6,637)	95,997		5
6	Maintenance	87,924	57,945	33,577	179,446	1,434	180,880	(250)	180,630		6
7	Other (specify):*										7
8	TOTAL General Services	458,488	334,102	146,485	939,075	4,760	943,835	(8,958)	934,877		8
	B. Health Care and Programs										
9	Medical Director			25,550	25,550		25,550		25,550		9
10	Nursing and Medical Records	1,241,154	215,165	3,983	1,460,302	(10,660)	1,449,642	(2,153)	1,447,489		10
10a	Therapy	221,643	8,517	210	230,370		230,370		230,370		10a
11	Activities	56,995	9,353	12,840	79,188		79,188		79,188		11
12	Social Services	70,457		1,825	72,282		72,282		72,282		12
13	CNA Training		1,702	3,170	4,872	16,558	21,430		21,430		13
14	Program Transportation	29,993	21,570		51,563	(33,818)	17,745		17,745		14
15	Other (specify):* COGN. REHAB	9,640			9,640		9,640		9,640		15
16	TOTAL Health Care and Programs	1,629,882	256,307	47,578	1,933,767	(27,920)	1,905,847	(2,153)	1,903,694		16
	C. General Administration										
17	Administrative			177,500	177,500		177,500	(20,731)	156,769		17
18	Directors Fees										18
19	Professional Services			53,055	53,055		53,055	1,008	54,063		19
20	Dues, Fees, Subscriptions & Promotions			34,317	34,317		34,317	(11,857)	22,460		20
21	Clerical & General Office Expenses	100,862	28,290	22,505	151,657		151,657	62,668	214,325		21
22	Employee Benefits & Payroll Taxes			343,412	343,412	(9,224)	334,188	39,944	374,132		22
23	Inservice Training & Education			1,375	1,375		1,375		1,375		23
24	Travel and Seminar			15,784	15,784		15,784	(4,457)	11,327		24
25	Other Admin. Staff Transportation							1,984	1,984		25
26	Insurance-Prop.Liab.Malpractice			45,361	45,361	(2,387)	42,974	552	43,526		26
27	Other (specify):*										27
28	TOTAL General Administration	100,862	28,290	693,309	822,461	(11,611)	810,850	69,111	879,961		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,189,232	618,699	887,372	3,695,303	(34,771)	3,660,532	58,000	3,718,532		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

WINNING WHEELS

#0024745

Report Period Beginning:

7/1/2004

Ending:

6/30/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			209,881	209,881	(15,727)	194,154	35,790	229,944			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			17,820	17,820		17,820	(3,699)	14,121			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			227,701	227,701	(15,727)	211,974	32,091	244,065			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					50,498	50,498		50,498			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	50,498	94,298		94,298			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,189,232	618,699	1,158,873	3,966,804		3,966,804	90,091	4,056,895			45

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

Facility Name & ID Number **WINNING WHEELS**

0024745

Report Period Beginning: **7/1/2004**

Ending: **6/30/2005**

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,071)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,637)	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	34,036	30		9
10	Interest and Other Investment Income	(4,506)	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	(2,154)	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	(9,461)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(7,997)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 1,210		\$	30

OHF 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	2	
		Amount	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)	88,881		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 88,881		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 90,091		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	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.	x		\$ 50,498	38	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	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 50,498		47

WINNING WHEELS

Report Period Beginning: 0024745
 7/1/2004
Ending: 6/30/2005

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	FLOWERS	\$ (202)	20	1
2	NON-ALLOWABLE CHAMBER DUES	(435)	20	2
3	RECOVERIES OF FIRE DAMAGE	(250)	6	3
4	EMPLOYEES WORKING @ OTHER FACILITIES	(2,153)	10	4
5	OUT OF STATE TRAVEL	(4,457)	24	5
6	GAIN ON VAN SALE	(500)	30	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	(7,997)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number **WINNING WHEELS**# **0024745**

Report Period Beginning:

7/1/2004

Ending:

6/30/2005**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	(2,071)	0	0	0	0	0	0	0	0	0	0	(2,071)	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	(6,637)	0	0	0	0	0	0	0	0	0	0	(6,637)	5
6	Maintenance	(250)	0	0	0	0	0	0	0	0	0	0	(250)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(8,958)	0	0	0	0	0	0	0	0	0	0	(8,958)	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	(2,153)	0	0	0	0	0	0	0	0	0	0	(2,153)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(2,153)	0	0	0	0	0	0	0	0	0	0	(2,153)	16
	C. General Administration													
17	Administrative	0	0	0	(20,731)	0	0	0	0	0	0	0	(20,731)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	1,008	0	0	0	0	0	0	0	1,008	19
20	Fees, Subscriptions & Promotions	(12,252)	0	0	395	0	0	0	0	0	0	0	(11,857)	20
21	Clerical & General Office Expenses	0	0	59,967	2,701	0	0	0	0	0	0	0	62,668	21
22	Employee Benefits & Payroll Taxes	0	4,270	10,519	25,155	0	0	0	0	0	0	0	39,944	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(4,457)	0	0	0	0	0	0	0	0	0	0	(4,457)	24
25	Other Admin. Staff Transportation	0	0	0	1,984	0	0	0	0	0	0	0	1,984	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	552	0	0	0	0	0	0	0	552	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(16,709)	4,270	70,486	11,064	0	69,111	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(27,820)	4,270	70,486	11,064	0	58,000	29						

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
AMERICAN HEALTH ENTERPRISES	0.00	BIG MEADOWS, INC	SAVANNA	LYNDON PROGRESS		DAY TREATMENT
	0.00	PLEASANT VIEW	MORRISON	CENTER	LYNDON	REHABILITATION
WINNING WHEELS, INC.	100.00	S.T.R.I.V.E.	PROPHETSTOWN	LYNDON PLAY &		
		BIG MEADOWS NURSING HOME-BLDG. ONLY	SAVANNA	LEARN CENTER	LYNDON	CHILD DAYCARE
				FRONTIER HOLLOW		
				APARTMENTS	PROPHETSTOWN	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. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	22 DAYCARE BENEFITS	\$ 18,639	LYNDON PLAY & LEARN CENTER (DAYCARE)	100.00%	\$ 22,909	\$ 4,270	1
2	V							2
3	V	MANAGEMENT SERVICES	177,500	AMERICAN HEALTH ENTERPRISES, INC.	0.00%		(177,500)	3
4	V							4
5	V							5
6	V	ADMINISTRATIVE OVERHEAD		WINNING WHEELS, INC. (ADMINISTRATIVE FUND)	100.00%			6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 196,139			\$ 22,909	\$ * (173,230)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	21 CLERICAL SALARIES	\$	WINNING WHEELS, INC	100.00%	\$ 59,967	\$ 59,967
16	V	22 BENEFITS		ADMINISTRATIVE FUND ALLOCATION	100.00%	10,519	10,519
17	V			(SEE DETAILS, SCHEDULE VIII B, PG8A)			
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 70,486	\$ * 70,486

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	17	MANAGEMENT FEES	\$ 177,500	AMERICAN HEALTH ENTERPRISES, INC.	NONE	\$ 156,769	\$ (20,731)	15
16	V	22	BENEFITS		AHE, INC.		25,155	25,155	16
17	V	19			(SEE DETAILS SCHEDULE VII, PAGE 8)		1,008	1,008	17
18	V	20					395	395	18
19	V	21					2,701	2,701	19
20	V	25					1,984	1,984	20
21	V	26					552	552	21
22	V	30					2,254	2,254	22
23	V	32					807	807	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 177,500				\$ 191,625	\$ * 14,125	39

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

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 7/1/2004 Ending: 6/30/2005

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	AMERICAN HEALTH ENTERPRISES, INC.								\$	1
2	ALAN GAPINSKI	PRESIDENT	DIRECT MANAGEMENT							2
3	(100% OWNER - ANE, INC.)							MANAGEMENT		3
4								FEES		4
5	BIG MEADOWS, INC.			100.00	34,070	14	28.00	"	157,506	5
6	PLEASANT VIEW NURSING AND REHABILITATION			100.00	24,336	10	20.00	"	114,306	6
7	WINNING WHEELS, INC.				43,805	18	36.00	"	177,500	7
8	S.T.R.I.V.E.				12,170	5	10.00	"	109,750	8
9	OTHERS (NON-COST REPORTING)				7,300	3	6.00	"	136,012	9
10										10
11										11
12										12
13								TOTAL	\$ 695,074	13

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

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

Facility Name & ID Number WINNING WHEELS

0024745 Report Period Beginning: 7/1/2004

Ending: 7/30/2005

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

Name of Related Organization AMERICAN HEALTH ENTERPRISES, INC.
 Street Address 501 6TH AVENUE WEST
 City / State / Zip Code LYNDON, IL 61261
 Phone Number (815-778-3683
 Fax Number (815-778-4503

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

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	17	ADMINISTRATIVE	DIRECT COST	1	\$ 69,667	\$ 69,667	1	\$ 69,667	1
2	17	ADMINISTRATIVE	GROSS REVENUE	11,849,297	5	255,101	4,045,832	87,102	2
3	22	BENEFITS	DIRECT COST	1	25,155		1	25,155	3
4									4
5	19	DATA PROCESSING	GROSS REVENUE	11,849,297	5	1,295	4,045,832	442	5
6	19	ACCOUNTING	GROSS REVENUE	11,849,297	5	1,657	4,045,832	566	6
7	20	DUES, FEES, SUBSCRIPTIONS	GROSS REVENUE	11,849,297	5	1,157	4,045,832	395	7
8	21	SUPPLIES, PHONE	GROSS REVENUE	11,849,297	5	7,912	4,045,832	2,701	8
9	24	TRAINING, SEMINAR	GROSS REVENUE	11,849,297	5	0	4,045,832	0	9
10	25	ADMIN. TRANSPORTATION	GROSS REVENUE	11,849,297	5	5,810	4,045,832	1,984	10
11	26	INSURANCE	GROSS REVENUE	11,849,297	5	1,618	4,045,832	552	11
12	32	INTEREST VEHICLES	GROSS REVENUE	11,849,297	5	2,363	4,045,832	807	12
13	30	DEPRECIATION VEHICLES	GROSS REVENUE	11,849,297	5	6,600	4,045,832	2,254	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				\$ 378,335	\$ 324,768		\$ 191,625	25

Facility Name & ID Number WINNING WHEELS

0024745 Report Period Beginning: 7/1/2004

Ending: 7/30/2005

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

Name of Related Organization WINNING WHEELS, INC. (ADMIN. FUND)
 Street Address 501 6TH AVENUE WEST
 City / State / Zip Code LYNDON, IL 61261
 Phone Number (815-778-3610
 Fax Number (815-778-4503

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

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	ADMINISTRATIVE SALARIES	GROSS REVENUE	6,395,084	9	\$ 92,961	\$ 4,125,316	\$ 59,967	1
2	22	FICA	GROSS REVENUE	6,395,084	9	6,611	4,125,316	4,265	2
3	22	WORKER'S COMP	GROSS REVENUE	6,395,084	9	165	4,125,316	106	3
4	22	HEALTH/DENTAL INSURANCE	GROSS REVENUE	6,395,084	9	2,976	4,125,316	1,920	4
5	22	RETIREMENT	GROSS REVENUE	6,395,084	9	1,500	4,125,316	968	5
6	22	DISABILITY INSURANCE	GROSS REVENUE	6,395,084	9	1,209	4,125,316	780	6
7	22	CHILD CARE	GROSS REVENUE	6,395,084	9	3,590	4,125,316	2,316	7
8	22	LIFE INSURANCE	GROSS REVENUE	6,395,084	9	255	4,125,316	164	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					\$ 109,267	\$ 92,961	\$ 70,486	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10	11						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	FARMERS NATIONAL BANK	X		MORTGAGE	\$13,500.00	10/13/00	\$ 750,000	\$ 202,253	10/13/06	6.1500	\$ 17,820	1						
2												2						
3	AMCORE BANK-HOME	X		VEHICLE	\$624.50	1/2001	30,000	6,210	10/2005	9.0000	807	3						
4	OFFICE ALLOCATION											4						
5												5						
Working Capital																		
6												6						
7												7						
8												8						
9	TOTAL Facility Related				\$14,124.50		\$ 780,000	\$ 208,463			\$ 18,627	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 780,000	\$ 208,463			\$ 18,627	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ NONE Line # _____

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

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

Facility Name & ID Number **WINNING WHEELS**# **0024745** Report Period Beginning: **7/1/2004** Ending: **6/30/2005****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1.	Real Estate Tax accrual used on 2004 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 2005 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:		2000	_____	8	
		2001	_____	9	
		2002	_____	10	
		2003	_____	11	
		2004	_____	12	
		FOR OHF USE ONLY			
		13	FROM R. E. TAX STATEMENT FOR 2004	\$	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 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 2004 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 2004.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
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 & 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 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number WINNING WHEELS# 0024745 Report Period Beginning:7/1/2004 Ending:6/30/2005**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 40,500 B. General Construction Type: Exterior MASONARY Frame CONCRETE BLOCK Number of Stories ONEC. Does the Operating Entity? (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? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: 1979Nature of Costs: PRE-OPENING COSTS

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number WINNING WHEELS

0024745

Report Period Beginning:

7/1/2004

Ending:

6/30/2005

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9		
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	80	1979	1979	\$ 1,526,858	\$ 16,809	VARIOUS	\$ 50,845	\$ 34,036	\$ 1,318,355	4
5		1979	1979	22,848		5				5
6		1979	1979	3,826		20			3,826	6
7		1985	1985	4,226	153	20	153		4,226	7
8		1987	1987	11,212	561	20	561		10,418	8
Improvement Type**										
9	TILE	1985		585	29	20	29		576	9
10	KITCHEN AIR CONDITIONER	1986		1,367		10			1,367	10
11	AIR CONDITIONER COMPRESSOR	1986		2,576		10			2,576	11
12	CON	1986		2,093	105	20	105		1,945	12
13	LAVATORIES	1987		780	39	20	39		718	13
14	PATIO	1987		3,089	154	20	154		2,806	14
15	TRACK CURTAIN SYSTEM	1987		1,306	65	20	65		1,186	15
16	CEDAR POST RAILS	1987		230		10			230	16
17	SHOWER DOORS	1987		350		15			350	17
18	BLACKTOP	1987		5,946	297	20	297		5,228	18
19	BATH IMPROVEMENTS	1988		11,342		15			11,342	19
20	TV ANTENNA BOOSTER	1988		455		10			455	20
21	FAUCETS	1988		597		15			597	21
22	HEAT A/C UNIT	1988		2,869		15			2,869	22
23	MOTORS	1988		1,037		10			1,037	23
24	EMPLOYEE LOUNGE	1988		3,235	162	20	162		2,804	24
25	DOOR OPENERS	1988		3,505		15			3,505	25
26	BATH PARTITIONS	1988		764		10			764	26
27	BLACKTOP	1988		5,023		15			5,023	27
28	COUNTERTOP SHELVES	1988		1,678		15			1,678	28
29	FITNESS TRAIL	1988		945		5			945	29
30	PARKING LOT SEALER	1988		4,000		4			4,000	30
31	BACK ROOM RENOVATONS	1988		30,717		15			30,717	31
32	SIGNAGE	1988		872	44	20	44		726	32
33	HEATER MOTORS THERMOSTAT	1988		1,010		5			1,010	33
34	LANDSCAPING	1989		4,715		10			4,715	34
35	BLACKTOP ROCK & SEALING	1989		5,906	66	15	66		5,906	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

STATE OF ILLINOIS

Page 12A

Facility Name & ID Number WINNING WHEELS

0024745

Report Period Beginning:

7/1/2004

Ending:

6/30/2005

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	DRAPES	1989	\$ 1,083	\$	10	\$	\$	\$ 1,083		37
38	BATHROOM REMODELING	1990	11,976		8			11,976		38
39	WATER SOFTENER	1990	5,858		12			5,858		39
40	SIGN	1990	3,700		12			3,700		40
41	PARKING LOT LIGHTS	1990	6,258	351	15	351		6,258		41
42	SHRUBS	1990	1,235	76	15	76		1,235		42
43	CARPET	1990	2,669		5			2,669		43
44	BATHROOM IMPROVEMENTS	1991	12,802	853	15	853		12,162		44
45	WANDERGUARD	1991	2,772		7			2,772		45
46	AUTOMATIC DOOR OPENERS	1991	4,455		10			4,455		46
47	REMODELING DINING ROOM	1992	34,562	1,728	20	1,728		22,465		47
48	REMODELING A & B WINGS	1992	18,929	946	20	946		11,988		48
49	HOT WATER BOILER	1992	4,272	285	15	285		3,584		49
50	RT CLINIC	1993	2,992	150	20	150		1,833		50
51	FLOWER BED	1993	1,142		10			1,142		51
52	KITCHEN LIGHTS & VENT	1993	3,777	189	20	189		2,282		52
53	LAUNDRY ENGR. & ARCHITECT	1993	3,735	187	20	187		2,241		53
54	LAUNDRY WATER HEATER & CONDITIONER	1993	4,813	321	15	321		3,850		54
55	LOBBY & OFFICE BLINDS & VALANCES	1993	3,295		10			3,295		55
56	LAUNDRY ROOM	1993	28,023	1,401	20	1,401		16,347		56
57	INTERIOR SIGN	1994	900	82	11	82		900		57
58	RT CLINIC COUNTER TOPS	1994	1,283	64	20	64		738		58
59	REDECORATE LOBBY	1994	29,817	1,491	20	1,491		16,896		59
60	GAS WATER HEATER	1994	2,148	143	15	143		1,600		60
61	SHELTER ROOF	1994	514	34	15	34		379		61
62	REDECORATE OFFICE	1994	1,587	66	10	66		1,587		62
63	REDECORATE ROOMS & HALLS	1994	11,264	563	10	563		11,264		63
64	SHRUBS & PLANTS	1994	7,501	438	10	438		7,501		64
65	PATIO	1994	8,723	582	15	582		6,348		65
66	CARPETING	1994	680		5			680		66
67	COUNTER TOP	1994	1,241	62	20	62		672		67
68	DOOR ALARM SYSTEM	1994	6,962		7			6,962		68
69										69
70	TOTAL (lines 4 thru 69)		\$ 1,896,930	\$ 28,496		\$ 62,532	\$ 34,036	\$ 1,608,622		70

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

STATE OF ILLINOIS

Page 12B

Facility Name & ID Number WINNING WHEELS

0024745

Report Period Beginning:

7/1/2004

Ending:

6/30/2005

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12A, Carried Forward	\$ 1,896,930	\$ 28,496		\$ 62,532	\$ 34,036	\$ 1,608,622		1
2	DECORATION DINING ROOM	1995 1,870	187	10	187		1,870		2
3	ACCORDIAN DOORS	1995 12,071	604	20	604		6,287		3
4	AIR CONDITIONER	1995 3,575	179	10	179		3,426		4
5	ROOF	1995 42,900	2,145	20	2,145		21,450		5
6	GARAGE	1995 27,086	1,354	20	1,354		13,092		6
7	SWING DOOR OPERATOR	1996 4,246	212	10	212		3,821		7
8	GARAGE WIRING	1996 3,384	226	15	226		2,143		8
9	CARPET	1996 811		5			811		9
10	GARAGE DOOR	1996 1,519	76	20	76		721		10
11	HEATER	1996 1,506	100	15	100		945		11
12	WALLPAPER	1996 471	24	10	24		420		12
13	CEILING TILE	1996 4,157	208	20	208		1,957		13
14	WALLPAPER BACK OFFICE	1996 587	29	10	29		524		14
15	FLOORING	1996 425	21	20	21		200		15
16	FLOOR TILING	1996 4,105	205	20	205		1,916		16
17	FLOOR GROUT	1996 237	12	20	12		110		17
18	STAIRS	1996 200	10	10	10		175		18
19	REMODEL KITCHEN	1996 13,551	678	20	678		6,267		19
20	CORNER PROTECTORS	1996 2,200	110	10	110		1,925		20
21	CARPET	1996 415		5			415		21
22	A/C COMPRESSOR	1996 6,500	650	10	650		5,579		22
23	CARPET	1996 415		5			415		23
24	BRICK	1996 768	38	20	38		330		24
25	GARAGE DOOR	1996 667	33	20	33		286		25
26	BLACKTOP	1996 8,260	551	15	551		4,728		26
27	DISPOSAL	1996 950	63	15	63		543		27
28	CARPET	1997 2,255		5			2,255		28
29	FAUCETS	1997 738	49	15	49		422		29
30	PAINTING	1997 1,948	195	10	195		1,672		30
31	TILING	1997 18,869	943	20	943		8,098		31
32	LANDSCAPING	1997 1,480	148	10	148		1,270		32
33									33
34	TOTAL (lines 1 thru 33)	\$ 2,065,096	\$ 37,546		\$ 71,582	\$ 34,036	\$ 1,702,695		34

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

STATE OF ILLINOIS

Page 12C

Facility Name & ID Number WINNING WHEELS

0024745

Report Period Beginning:

7/1/2004

Ending:

6/30/2005

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12B, Carried Forward	\$ 2,065,096	\$ 37,546		\$ 71,582	\$ 34,036	\$ 1,702,695		1
2	SOFFIT	1997 4,495	225	20	225		1,723		2
3	SOFFIT ADDITION	1997 952	48	20	48		385		3
4	A/C COMPRESSOR & CONTROLLER	1997 10,811	1,081	10	1,081		8,198		4
5	DINING ROOM GLASS	1997 973	49	20	49		377		5
6	FOLDING ROOM WALL/DOORS	1998 5,099	255	20	255		1,912		6
7	FLOORING	1998 2,642	264	10	264		2,003		7
8	ALARM SYSTEM	1998 952	95	10	95		722		8
9	CABINETS	1998 7,745	387	20	387		2,840		9
10	3.5 TON A/C	1998 1,257	126	10	126		890		10
11	NATURE TRAIL LANDSCAPING	1998 18,965	1,896	10	1,896		12,643		11
12	HALLWAY PAINTING	1998 1,285	128	10	128		857		12
13	DUMPSTER PAD & FENCING	1998 1,873		5			1,873		13
14	FENCING	1999 2,375	119	20	119		742		14
15	GAZEBO	1999 8,200	410	20	410		2,563		15
16	FLOORING	1999 5,553	555	10	555		3,425		16
17	REMODEL DINING ROOM	1999 6,724	672	10	672		4,147		17
18	ABOVE GROUND TANK	1999 14,566	1,457	10	1,457		8,982		18
19	LANDSCAPING	1999 6,091	870	7	870		5,366		19
20	SECURITY SYSTEM UPGRADE	1999 5,472	782	7	782		4,756		20
21	GAZEBO INSTALLATION	1999 1,998	100	20	100		608		21
22	FRONT LIGHT FIXTURES	1999 4,507	451	10	451		2,479		22
23	STORM WATER PUMP	1999 2,404	343	7	343		1,889		23
24	PARKING LOT	1999 13,819	1,382	10	1,382		7,601		24
25	KITCHEN & DINING AREA ROOF	1999 41,800	2,787	15	2,787		15,559		25
26	BREAKROOM FLOORING	2000 1,293	185	7	185		1,016		26
27	BUG BLOWER	2000 1,265	127	10	127		696		27
28	CARPET	2000 4,597	919	5	919		4,597		28
29	MULTI-SENSORY ROOM	2000 14,966	379	39.5	379		1,831		29
30	INDEPENDENT WAY GARDEN	2000 34,023	1,701	20	1,701		7,939		30
31	THERAPY ANNEX	2000 1,046,329	26,489	39.5	26,489		123,617		31
32	NURSE STATION	2001 17,475	448	39	448		1,792		32
33									33
34	TOTAL (lines 1 thru 33)	\$ 3,355,602	\$ 82,276		\$ 116,312	\$ 34,036	\$ 1,936,723		34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 3,355,602	\$ 82,276		\$ 116,312	\$ 34,036	\$ 1,936,723	1
2	DOCTOR OFFICE TILE	2001	822	82	10	82		288	2
3	ENTRYWAYS TILE	2001	1,022	102	10	102		358	3
4	DIETARY ROOM TILE	2001	1,064	106	10	106		372	4
5	ROOM TILE	2002	1,234	123	10	123		432	5
6	SHRUBS & PLANTS	2002	11,706	1,171	10	1,171		2,927	6
7	CERAMIC HALLWAY TILE	2003	4,687	469	10	469		703	7
8	UPGRADE WANDERGUARD & MAGNETIC DOORS	2004	7,606	349	20	349		349	8
9	FENCE W/GATE PLUS INSTALLATION	2004	12,483	555	15	555		555	9
10	CONCRETE SIDEWALKS	2004	6,242	182	20	182		182	10
11	WALLCOVERING & CERAMIC	2005	4,642	232	10	232		232	11
12	DINING ROOM WINDOW	2005	1,732	7	20	7		7	12
13									13
14	DEFERRED MAINTENANCE ITEMS CAPITALIZED			1,434	5		(1,434)		14
15	(SEE PAGE 22)								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	TOTAL (lines 1 thru 33)		\$ 3,408,842	\$ 87,088		\$ 119,690	\$ 32,602	\$ 1,943,128	34

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

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	\$ 615,630	\$ 74,723	\$ 74,723	\$	VARIOUS	\$ 385,341	71
72	Current Year Purchases	77,279	6,583	6,583		VARIOUS	6,583	72
73	Fully Depreciated Assets	557,896				VARIOUS	557,896	73
74								74
75	TOTALS	\$ 1,250,805	\$ 81,306	\$ 81,306	\$		\$ 949,820	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	VARIOUS	\$ 283,071	\$ 35,836	\$ 35,836	\$	VARIOUS	\$ 185,269	76
77	SNOW REMOVAL	2000 DODGE PICKUP		28,254	5,651	5,651		5	19,778	77
78	MEDICAL NECESSARY TRANSPORT					(14,293)	(14,293)	VARIOUS		78
79	RELATED ORGANIZATION ALLOCATION & GAIN ON SALE -\$500					1,754	1,754	5		79
80	TOTALS			\$ 311,325	\$ 41,487	\$ 28,948	\$ (12,539)		\$ 205,047	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)	\$ 4,994,472	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 209,881	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 229,944	83**
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 20,063	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,097,995	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	REMODELING ENTRY &	\$	92
93	HALLWAY	19,473	93
94			94
95		\$ 19,473	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	\$ _____
13.	/2007	\$ _____
14.	/2008	\$ _____

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<input checked="" type="checkbox"/> YES	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
	<input type="checkbox"/> NO	IN-HOUSE PROGRAM <input checked="" type="checkbox"/>	IN-HOUSE PROGRAM <input checked="" type="checkbox"/>
		IN OTHER FACILITY <input type="checkbox"/>	IN OTHER FACILITY <input type="checkbox"/>
		COMMUNITY COLLEGE <input type="checkbox"/>	HOURS PER CNA <u>48</u>
		HOURS PER CNA <u>96</u>	

B. EXPENSES

ALLOCATION OF COSTS (d)

	Facility			
	1 Drop-outs	2 Completed	3 Contract	4 Total
1 Community College Tuition	\$	\$	\$	\$
2 Books and Supplies	40	420	1,242	1,702
3 Classroom Wages (a)	478	6,513		6,991
4 Clinical Wages (b)		3,672		3,672
5 In-House Trainer Wages (c)	244	4,383	11,931	16,558
6 Transportation				
7 Contractual Payments		755	525	1,280
8 CNA Competency Tests		550	1,340	1,890
9 TOTALS	\$ 762	\$ 16,293	\$ 15,038	\$ 32,093
10 SUM OF line 9, col. 1 and 2 (e)	\$ 17,055			

C. CONTRACTUAL INCOME

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

\$ 14,544

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	9
2. From other facilities (f)	22
DROP-OUTS	
1. From this facility	1
2. From other facilities (f)	5
TOTAL TRAINED	37

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)			
					Units	Cost						
1	Licensed Occupational Therapist	10a,1	2027	hrs	\$ 61,102		\$	\$		2,027	\$ 61,102	1
2	Licensed Speech and Language Development Therapist	10a,1	1513	hrs	36,421					1,513	36,421	2
3	Licensed Recreational Therapist	11,1	2079	hrs	29,385					2,079	29,385	3
4	Licensed Physical Therapist	10a,1	1978	hrs	48,053					1,978	48,053	4
5	Physician Care			visits								5
6	Dental Care			visits								6
7	Work Related Program			hrs								7
8	Habilitation			hrs								8
9	Pharmacy			# of prescripts								9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs								10
11	Academic Education			hrs								11
12	Exceptional Care Program											12
13	Other (specify):											13
14	TOTAL				\$ 174,961		\$	\$		7,597	\$ 174,961	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

Page 17

Facility Name & ID Number WINNING WHEELS

0024745

Report Period Beginning: 7/1/2004

Ending:

6/30/2005

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2005

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 364,458	\$ 365,057	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 93937/118726)	758,276	1,161,594	3
4	Supply Inventory (priced at COST)	34,054	51,883	4
5	Short-Term Investments	1,564,791	2,692,654	5
6	Prepaid Insurance	19,214	22,981	6
7	Other Prepaid Expenses	14,478	36,390	7
8	Accounts Receivable (owners or related parties)	248,589	1,049,319	8
9	Other(specify): ATTACHED	681,837	689,836	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,685,697	\$ 6,069,714	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	4,298	4,298	12
13	Land	23,500	282,861	13
14	Buildings, at Historical Cost	3,385,994	7,704,019	14
15	Leasehold Improvements, at Historical Cost		151,205	15
16	Equipment, at Historical Cost	1,562,130	2,210,903	16
17	Accumulated Depreciation (book methods)	(3,097,994)	(4,396,778)	17
18	Deferred Charges	1,433	3,691	18
19	Organization & Pre-Operating Costs	22,848	22,848	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(22,848)	(22,848)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CONSTRUCTION IN PROGRE	19,473	54,943	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,898,834	\$ 6,015,142	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,584,531	\$ 12,084,856	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 149,145	\$ 265,247	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	153,850	212,625	29
30	Accrued Salaries Payable	165,934	254,419	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,544	12,964	31
32	Accrued Real Estate Taxes(Sch.IX-B)		6,590	32
33	Accrued Interest Payable	1,342	1,342	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	DUE TO OTHER FUNDS		1,049,319	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 478,816	\$ 1,802,506	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	48,403	1,847,901	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	PA ADVANCE FOR DAY TREATMENT	7,691	49,028	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 56,093	\$ 1,896,929	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 534,909	\$ 3,699,435	46
47	TOTAL EQUITY(page 18, line 24)	\$ 5,049,622	\$ 8,385,421	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,584,531	\$ 12,084,856	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,215,180	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,215,180	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	201,847	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	163,369	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) INTERFUND TRANSFERS	(530,774)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (165,558)	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)	\$ 5,049,622	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number WINNING WHEELS

0024745

Report Period Beginning: 7/1/2004

Ending: 6/30/2005

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,084,596	1
2	Discounts and Allowances for all Levels	(6,000)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,078,596	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	24,330	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,073	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)	\$ 26,403	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	4,506	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,506	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	TRANSPORTATION	57,317	28
28a	MISCELLANEOUS ATTACHED	1,829	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 59,146	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,168,651	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	939,075	31
32	Health Care	1,933,767	32
33	General Administration	822,461	33
B. Capital Expense			
34	Ownership	227,701	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)*	\$ 3,966,804	40
41	Income before Income Taxes (line 30 minus line 40)**	201,847	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 201,847	43

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

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

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

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

Facility Name & ID Number **WINNING WHEELS**

0024745

Report Period Beginning: **7/1/2004**

Ending:

6/30/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,800	2,072	\$ 50,673	\$ 24.46	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,394	12,362	253,663	20.52	3
4	Licensed Practical Nurses	10,294	11,305	198,068	17.52	4
5	CNAs & Orderlies	60,382	66,403	701,212	10.56	5
6	CNA Trainees	1,248	1,248	10,663	8.54	6
7	Licensed Therapist	4,960	5,518	145,576	26.38	7
8	Rehab/Therapy Aides	5,585	6,189	76,067	12.29	8
9	Activity Director	1,896	2,079	29,385	14.13	9
10	Activity Assistants	1,986	2,214	27,610	12.47	10
11	Social Service Workers	4,827	5,513	70,457	12.78	11
12	Dietician					12
13	Food Service Supervisor	1,655	1,835	18,001	9.81	13
14	Head Cook	9,104	9,874	82,408	8.35	14
15	Cook Helpers/Assistants	12,453	13,486	99,254	7.36	15
16	Dishwashers					16
17	Maintenance Workers	7,874	8,722	87,924	10.08	17
18	Housekeepers	12,054	12,929	95,676	7.40	18
19	Laundry	8,135	8,945	75,225	8.41	19
20	Administrator					20
21	Assistant Administrator	1,872	2,080	46,419	22.32	21
22	Other Administrative					22
23	Office Manager	1,848	1,939	16,706	8.62	23
24	Clerical	3,870	4,142	37,737	9.11	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	1,984	2,176	26,875	12.35	31
32	Other Health C: <u>COGNITIVE REH</u>	767	837	9,640	11.52	32
33	Other(specify) <u>TRANSPORTATI</u>	3,337	3,618	29,993	8.29	33
34	TOTAL (lines 1 - 33)	168,325	185,486	\$ 2,189,232 *	\$ 11.80	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	228	\$ 10,274	1,3	35
36	Medical Director	30	3,000	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	48	2,400	10,3	39
40	Physical Therapy Consultant	8	210	10a,3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	21	840	11,3	44
45	Social Service Consultant	18	1,825	12,3	45
46	Other(specify) <u>EQUESTRIAN THE</u>	480	12,000	11,3	46
47	<u>PHYSIATRIST CONSULTANT</u>	180	22,550	9,3	47
48	<u>LAB</u>	20	403	10,3	48
49	TOTAL (lines 35 - 48)	1,033	\$ 53,502		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	66	1,180	10,3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	66	\$ 1,180		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
ELIZABETH GOODMAN			\$	Workers' Compensation Insurance	\$ 48,097	IDPH License Fee	\$ 200	
(SALARY - \$69,667- INCLUDED IN MANAGEMENT FEES-LINE 17, COL. 3)				Unemployment Compensation Insurance	2,400	Advertising: Employee Recruitment	10,248	
				FICA Taxes	169,837	Health Care Worker Background Check		
				Employee Health Insurance	38,598	(Indicate # of checks performed 106)	1,063	
				Employee Meals		CARF FEES - 1280, IHCA Dues - 4250	5,530	
				Illinois Municipal Retirement Fund (IMRF)*		DUES, FEES, & SUBSCRIPTIONS	5,459	
				LIFE INSURANCE	4,548	COMMUNITY RELATIONS/MRKTING	9,663	
				RETIREMENT	9,918	CONTRIBUTIONS	2,154	
				DISABILITY INSURANCE	26,376	HOME OFFICE ALLOCATION	395	
				PHYSICALS	1,221	NON-ALLOWABLE DUES	(435)	
				CHILD CARE	25,225	Less: Public Relations Expense	(11,220)	
				EMPLOYEE MISC. BENEFITS	22,757	Non-allowable advertising	(597)	
				HOME OFFICE ALLOCATION	25,155	Yellow page advertising	()	
						TOTAL (agree to Sch. V,	\$ 22,460	
TOTAL (agree to Schedule V, line 17, col. 1)			\$	TOTAL (agree to Schedule V,	\$ 374,132	line 20, col. 8)		
(List each licensed administrator separately.)				line 22, col.8)				
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
AMERICAN HEALTH ENTERPRISES			\$ 177,500			\$	Out-of-State Travel	\$ (4,457)
							In-State Travel	
							EMPLOYEE MILEAGE REIMBURSEMEN	1,646
							Seminar Expense	14,138
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 177,500				Entertainment Expense	()
(Attach a copy of any management service agreement)							(agree to Sch. V,	
C. Professional Services				TOTAL			TOTAL	
Vendor/Payee	Type		Amount			\$	line 24, col. 8)	\$ 11,327
LVC, CPA'S	YEAR END AUDIT FEES		\$ 11,150					
BDK, LLP	MEDICARE COST REPORT		2,450					
MISC. ATTORNEYS	LEGAL FEES		228					
JOHN PYSE CONSULTING	COMPUTER CONSULTANT		24,512					
CREATIVE SOLUTIONS	MEDICAL RECORDS SOFTW		4,317					
MAS 90	SOFTWARE MAINT. FEES		2,768					
UNISOFT	MENU SOFTWARE		972					
ACHIEVE	SOFTWARE MAINT. FEES		2,966					
MIDWEST AUTOMATED TIME	TIME CLOCK MAINT.		730					
E-HEALTH DATA SOLUTIONS	SOFTWARE FEES		2,700					
MISC. SOFTWARE VENDORS	SOFTWARE MAINT. FEES		262					
TOTAL (agree to Schedule V, line 19, column 3)			\$					
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 53,055					

* Attach copy of IMRF notifications

**See instructions.

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	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	PAINTING	7/2000	\$ 6,373	5 YRS	\$ 1,274	\$ 1,275	\$ 1,274	\$ 1,275	\$	\$	\$	\$
2	PAINTING	1/2005	1,592	5 YRS				159	318	318	319	319
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS		\$ 7,965		\$ 1,274	\$ 1,275	\$ 1,274	\$ 1,434	\$ 318	\$ 318	\$ 319	\$ 319

Facility Name & ID Number WINNING WHEELS# 0024745Report Period Beginning: 7/1/2004Ending: 6/30/2005**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. ILLINOIS HEALTHCARE ASSOC.-\$4250
- (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 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 25,524 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? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ NONE Has any meal income been offset against related costs? YES Indicate the amount. \$ 2,073
- (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. \$ 53,491
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: LINDGREN, CALLIHAN, VAN OSDOL, CPA'S The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? YES If no, please explain. _____
- (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 \$2500, have legal invoices and a summary of services performed been attached to this cost report? NO
Attach invoices and a summary of services for all architect and appraisal fees.