

		FOR BHF USE				

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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 Facility ID Number: 0024745

Facility Name: WINNING WHEELS

Address: 701 EAST 3RD STREET PROPHETSTOWN 61277
 Number City Zip Code

County: WHITESIDE

Telephone Number: 815-537-5168 **Fax #** 815-537-5268

HFS ID Number: 23-7136038001

Date of Initial License for Current Owners: 9/10/79

Type of Ownership:

<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code <u>501 C(3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other	

In the event there are further questions about this report, please contact:
Name: DAVE HECKMAN **Telephone Number:** 815-778-3683

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/2005 to 6/30/2006 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) <u>JOHN SMITH</u>	
	(Title) <u>CFO</u>	
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: 7/1/2005 Ending: 6/30/2006

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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	720	2,867	405	3,992	8
9	SNF/PED					9
10	ICF	24,298			24,298	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,018	2,867	405	28,290	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.88%

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

597 (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 _____Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 6/30/06 Fiscal Year: 6/30/06

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

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 7/1/2005 Ending: 6/30/2006

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	200,757	23,457	10,485	234,699	2,159	236,858		236,858		1
2	Food Purchase		228,841		228,841		228,841	(10,927)	217,914		2
3	Housekeeping	83,162	32,235		115,397	810	116,207		116,207		3
4	Laundry	88,050	13,512		101,562		101,562		101,562		4
5	Heat and Other Utilities			116,302	116,302		116,302	(7,058)	109,244		5
6	Maintenance	93,631	54,845	35,711	184,187	1,434	185,621	(600)	185,021		6
7	Other (specify):*										7
8	TOTAL General Services	465,600	352,890	162,498	980,988	4,403	985,391	(18,585)	966,806		8
	B. Health Care and Programs										
9	Medical Director			25,000	25,000		25,000		25,000		9
10	Nursing and Medical Records	1,291,064	208,326	3,666	1,503,056	(13,281)	1,489,775	(1,782)	1,487,993		10
10a	Therapy	113,972	2,818	122,465	239,255		239,255		239,255		10a
11	Activities	65,453	11,619	12,840	89,912		89,912		89,912		11
12	Social Services	82,049			82,049		82,049		82,049		12
13	CNA Training		1,440	1,150	2,590	18,546	21,136		21,136		13
14	Program Transportation	21,802	29,579		51,381		51,381		51,381		14
15	Other (specify):*	8,540			8,540		8,540		8,540		15
16	TOTAL Health Care and Programs	1,582,880	253,782	165,121	2,001,783	5,265	2,007,048	(1,782)	2,005,266		16
	C. General Administration										
17	Administrative			183,500	183,500		183,500	(24,282)	159,218		17
18	Directors Fees										18
19	Professional Services			43,942	43,942		43,942	444	44,386		19
20	Dues, Fees, Subscriptions & Promotions			29,622	29,622		29,622	(8,343)	21,279		20
21	Clerical & General Office Expenses	109,756	26,221	21,925	157,902		157,902	71,278	229,180		21
22	Employee Benefits & Payroll Taxes			356,540	356,540	(8,234)	348,306	57,341	405,647		22
23	Inservice Training & Education			3,301	3,301		3,301		3,301		23
24	Travel and Seminar			30,755	30,755		30,755	(1,701)	29,054		24
25	Other Admin. Staff Transportation							2,906	2,906		25
26	Insurance-Prop.Liab.Malpractice			47,771	47,771		47,771		47,771		26
27	Other (specify):*										27
28	TOTAL General Administration	109,756	26,221	717,356	853,333	(8,234)	845,099	97,643	942,742		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,158,236	632,893	1,044,975	3,836,104	1,434	3,837,538	77,276	3,914,814		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:

7/1/2005

Ending:

6/30/2006

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			210,160	210,160	(10,676)	199,484	2,170	201,654			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			8,661	8,661		8,661	(3,933)	4,728			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			218,821	218,821	(10,676)	208,145	(1,763)	206,382			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					9,242	9,242		9,242			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	9,242	53,042		53,042			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,158,236	632,893	1,307,596	4,098,725		4,098,725	75,513	4,174,238			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: 7/1/2005

Ending: 6/30/2006

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	(10,927)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,058)	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	(4,677)	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	(100)	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	(7,762)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (30,524)		\$	30

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)	106,037		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 106,037		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 75,513		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.			\$		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)			\$		47

BHF USE ONLY						
48		49		50		51
						52

WINNING WHEELS

ID# 0024745

Report Period Beginning: 7/1/2005

Ending: 6/30/2006

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	OUT OF STATE TRAVEL	\$ (1,701)	24	1
2	FLOWERS	(169)	20	2
3	EMPLOYEES @ OTHER FACILITIES	(1,782)	10	3
4	LOSS ON DISPOSAL OF EQUIPMENT	884	30	4
5	RECOVERY OF FIRE DAMAGE	(600)	6	5
6	NON-ALLOWABLE CHAMBER DUES	(335)	20	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	(3,703)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WINNING WHEELS

0024745

Report Period Beginning:

7/1/2005

Ending:

6/30/2006

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	(10,927)	0	0	0	0	0	0	0	0	0	0	(10,927)	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	(7,058)	0	0	0	0	0	0	0	0	0	0	(7,058)	5
6	Maintenance	(600)	0	0	0	0	0	0	0	0	0	0	(600)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(18,585)	0	0	0	0	0	0	0	0	0	0	(18,585)	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	(1,782)	0	0	0	0	0	0	0	0	0	0	(1,782)	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	(1,782)	0	0	0	0	0	0	0	0	0	0	(1,782)	16
	C. General Administration													
17	Administrative	0	0	0	(24,282)	0	0	0	0	0	0	0	(24,282)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	444	0	0	0	0	0	0	0	444	19
20	Fees, Subscriptions & Promotions	(8,366)	0	0	23	0	0	0	0	0	0	0	(8,343)	20
21	Clerical & General Office Expenses	0	0	70,990	288	0	0	0	0	0	0	0	71,278	21
22	Employee Benefits & Payroll Taxes	0	16,884	21,163	19,294	0	0	0	0	0	0	0	57,341	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(1,701)	0	0	0	0	0	0	0	0	0	0	(1,701)	24
25	Other Admin. Staff Transportation	0	0	0	2,906	0	0	0	0	0	0	0	2,906	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	(10,067)	16,884	92,153	(1,327)	0	97,643	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(30,434)	16,884	92,153	(1,327)	0	77,276	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WINNING WHEELS

0024745

Report Period Beginning:

7/1/2005 Ending:

6/30/2006

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	884	0	0	1,286	0	0	0	0	0	0	0	2,170	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,677)	0	0	744	0	0	0	0	0	0	0	(3,933)	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	(3,793)	0	0	2,030	0	(1,763)	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)	(34,227)	16,884	92,153	703	0	75,513	45						

Facility Name & ID Number WINNING WHEELS

0024745

Report Period Beginning:

7/1/2005

Ending:

6/30/2006

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		INDEPENDENT
				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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	22 DAYCARE BENEFITS	\$ 12,638	LYNDON PLAY & LEARN CENTER (DAYCARE)	100.00%	\$ 29,522	\$ 16,884	1
2	V							2
3	V	MANAGEMENT SERVICES	183,500	AMERICAN HEALTH ENTERPRISES, INC.	0.00%		(183,500)	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		\$ 196,138			\$ 29,522	\$ * (166,616)	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%	\$ 70,990	\$ 70,990	15
16	V	22	BENEFITS		ADMINISTRATION FUND ALLOCATION	100.00%	21,163	21,163	16
17	V				(SEE DETAILS, SCHEDULE VIII 8, PAGE 8A)				17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$				\$ 92,153	\$ * 92,153	39

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

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 7/1/2005 Ending: 6/30/2006

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	\$ 183,500	AMERICAN HEALTH ENTERPRISES, INC.	NONE	\$ 159,218	\$ (24,282)	15
16	V	22 BENEFITS		AMERICAN HEALTH ENTERPRISES, INC.		19,294	19,294	16
17	V	19		(SEE DETAILS, SCHEDULE VII, PAGE 8)		444	444	17
18	V	20				23	23	18
19	V	21				288	288	19
20	V	25				2,906	2,906	20
21	V	26				0		21
22	V	30				1,286	1,286	22
23	V	32				744	744	23
24	V					460	460	24
25	V					1,657	1,657	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		\$ 183,500			\$ 186,320	\$ * 2,820	39

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

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 7/1/2005 Ending: 6/30/2006

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 - AHE, INC.)							MANAGEMENT		3
4								FEES		4
5	BIG MEADOWS, INC.			100.00	35,560	14	28	"	162,563	5
6	PLEASANT VIEW NURSING & REHABILITATION			100.00	25,400	10	20	"	116,983	6
7	WINNING WHEELS, INC.				45,720	18	36	"	201,500	7
8	S.T.R.I.V.E.				12,700	5	10	"	112,750	8
9	OTHERS (NON-COST REPORTING)				7,620	3	6	"	139,750	9
10										10
11										11
12										12
13								TOTAL	\$ 733,546	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: 7/1/2005

Ending: 7/30/2006

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	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	ADMINISTRATIVE	DIRECT COST	1	1	\$ 69,680	\$ 69,680	1	\$ 69,680	1
2	17	ADMINISTRATIVE	GROSS REVENUE	12,046,542	5	264,500	264,500	4,077,983	89,538	2
3	22	BENEFITS	DIRECT COST	1	5	19,294		1	19,294	3
4										4
5	19	DATA PROCESSING	GROSS REVENUE	12,046,542	5	1,311		4,077,983	444	5
6	19	ACCOUNTING	GROSS REVENUE	12,046,542	5	68		4,077,983	23	6
7	20	DUES, FEES, SUBSCRIPTIONS	GROSS REVENUE	12,046,542	5	851		4,077,983	288	7
8	21	SUPPLIES, PHONE	GROSS REVENUE	12,046,542	5	8,583		4,077,983	2,906	8
9	24	TRAINING, SEMINAR	GROSS REVENUE	12,046,542	5	0		4,077,983	0	9
10	25	ADMIN. TRANSPORTATON	GROSS REVENUE	12,046,542	5	3,798		4,077,983	1,286	10
11	26	INSURANCE	GROSS REVENUE	12,046,542	5	2,199		4,077,983	744	11
12	32	INTEREST VEHICLES	GROSS REVENUE	12,046,542	5	1,358		4,077,983	460	12
13	30	DEPRECIATION VEHICLES	GROSS REVENUE	12,046,542	5	4,895		4,077,983	1,657	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					\$ 376,537	\$ 334,180		\$ 186,320	25

Facility Name & ID Number WINNING WHEELS

0024745

Report Period Beginning:

7/1/2005

Ending: 7/30/2006

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. FEE)
 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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	21	ADMINISTRATIVE SALARIES	GROSS REVENUE	6,388,807	9	\$ 70,212	\$ 4,077,983	\$ 44,816	1
2	22	FICA	GROSS REVENUE	6,388,807	9	9,090	4,077,983	5,802	2
3	22	WORKMENS COMP.	GROSS REVENUE	6,388,807	9	261	4,077,983	167	3
4	22	HEALTH/DENTAL INSURANCE	GROSS REVENUE	6,388,807	9	5,572	4,077,983	3,557	4
5	22	RETIREMENT	GROSS REVENUE	6,388,807	9	2,615	4,077,983	1,669	5
6	22	DISABILITY INSURANCE	GROSS REVENUE	6,388,807	9	1,725	4,077,983	1,101	6
7	22	CHILD CARE	GROSS REVENUE	6,388,807	9	271	4,077,983	173	7
8	22	LIFE INSURANCE	GROSS REVENUE	6,388,807	9		4,077,983		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					\$ 89,746	\$	\$ 57,285	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	FARMERS NATIONAL BANK	X	MORTGAGE	\$13,500.00	10/13/00	\$ 750,000	\$ 48,265	10/13/06	6.1500	\$ 8,661	1									
2											2									
3	AMCORE BANK-HOME	X	VEHICLES	\$624.50	1/2001	30,000		10/2005	9.0000	460	3									
4											4									
5											5									
Working Capital																				
6											6									
7											7									
8											8									
9	TOTAL Facility Related			\$14,124.50		\$ 780,000	\$ 48,265			\$ 9,121	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	\$ 48,265			\$ 9,121	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.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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.

2005 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 2005 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 2005.

(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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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:

7/1/2005 Ending:

6/30/2006

X. BUILDING AND GENERAL INFORMATION:

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

C. 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: 1979

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>BUILDING SITE</u>	<u>504,424</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:

7/1/2005

Ending:

6/30/2006

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 BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	80		1979	1979	\$ 1,447,685	\$ 16,589	VARIOUS	\$ 16,589		\$ 1,255,776	4
5			1979	1979	22,848		5				5
6			1979	1979			20				6
7			1985	1985	4,226		20			4,226	7
8			1987	1987	11,212	561	20	561		10,978	8
	Improvement Type**										
9		TILE	1985		585	10	20	10		585	9
10		KITCHEN AIR CONDITIONER	1986				10				10
11		AIR CONDITIONER COMPRESSOR	1986		2,576		10			2,576	11
12		CON	1986		2,093	105	20	105		2,049	12
13		LAVATORIES	1987		780	39	20	39		757	13
14		PATIO	1987		3,089	154	20	154		2,960	14
15		TRACK CURTAIN SYSTEM	1987		1,306	65	20	65		1,251	15
16		CEDAR POST RAILS	1987		230		10			230	16
17		SHOWER DOORS	1987		350		15			350	17
18		BLACKTOP PATH	1987		5,946	297	20	297		5,525	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		2,966	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 RENOVATIONS	1988		30,717		15			30,717	31
32		SIGNAGE	1988		872	44	20	44		770	32
33		HEATERS 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		15			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

Facility Name & ID Number WINNING WHEELS

0024745

Report Period Beginning:

7/1/2005

Ending:

6/30/2006

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		15			6,258	41
42	SHRUBS	1990	1,235		15			1,235	42
43	CARPET	1990			5				43
44	BATHROOM IMPROVEMENTS	1991	12,802	640	15	640		12,802	44
45	WANDERGUARD	1991			7				45
46	AUTOMATIC DOOR OPENERS	1991	4,455		10			4,455	46
47	REMODEL DINING ROOM	1992	34,562	1,728	20	1,728		24,193	47
48	REMODEL A & B WINGS	1992	18,929	946	20	946		12,935	48
49	HOTWATER BOILER	1992	4,272	285	15	285		3,869	49
50	RT CLINIC	1993	2,992	150	20	150		1,982	50
51	FLOWER BED	1993	1,142		10			1,142	51
52	KITCHEN LIGHTS & VENTS	1993	3,777	189	20	189		2,471	52
53	LAUNDRY ENGR. & ARCHITECT	1993	3,735	187	20	187		2,428	53
54	LAUNDRY WATER HEATER & CONDITIONER	1993	4,813	321	15	321		4,171	54
55	LOBBY & OFFICES BLINDS & VALANCES	1993	3,295		10			3,295	55
56	LAUNDRY ROOM	1993	28,023	1,401	20	1,401		17,748	56
57	INTERIOR SIGN	1994	900		11			900	57
58	RT CLINIC COUNTER TOPS	1994	1,283	64	20	64		802	58
59	REDECORATE LOBBY	1994	29,817	1,491	20	1,491		18,387	59
60	GAS WATER HEATER	1994	2,148	143	15	143		1,743	60
61	SHELTER ROOF	1994	514	34	15	34		414	61
62	REDECORATE OFFICE	1994	1,587		10			1,587	62
63	REDECORATE ROOMS & HALLS	1994	11,264		10			11,264	63
64	SHRUBS & PLANTS	1994	7,501		10			7,501	64
65	PATIO	1994	8,723	582	15	582		6,930	65
66	CARPETING	1994	680		5			680	66
67	COUNTER TOP	1994	1,241	62	20	62		734	67
68	DOOR ALARM SYSTEM	1994	6,962		7			6,962	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,807,123	\$ 26,249		\$ 26,249	\$	\$ 1,545,067	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:

7/1/2005

Ending:

6/30/2006

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		\$ 1,807,123	\$ 26,249		\$ 26,249	\$	\$ 1,545,067	1
2	DINING ROOM DECORATION	1995	1,870		10			1,870	2
3	ACCORDIAN DOORS	1995	12,071	604	20	604		6,891	3
4	AIR CONDITIONER	1995	3,575	149	10	149		3,575	4
5	ROOF	1995	42,900	2,145	20	2,145		23,595	5
6	GARAGE	1995	27,086	1,354	20	1,354		14,446	6
7	SWING DOOR OPERATOR	1996	4,246	425	10	425		4,246	7
8	GARAGE WIRING	1996	3,384	226	15	226		2,369	8
9	CARPET	1996	811		5			811	9
10	GARAGE DOOR	1996	1,519	76	20	76		797	10
11	HEATER	1996	1,506	100	15	100		1,046	11
12	WALLPAPER	1996	471	47	10	47		467	12
13	CEILING TILE	1996	4,157	208	20	208		2,165	13
14	WALLPAPER BACK OFFICE	1996	587	59	10	59		582	14
15	FLOORING	1996	425	21	20	21		221	15
16	FLOOR TILING	1996	4,105	205	20	205		2,121	16
17	FLOOR GROUT	1996	237	12	20	12		122	17
18	STAIRS	1996	200	20	10	20		195	18
19	REMODEL KITCHEN	1996	13,551	678	20	678		6,945	19
20	CORNER PROTECTORS	1996	2,200	220	10	220		2,145	20
21	CARPET	1996	415		5			415	21
22	A/C COMPRESSOR	1996	6,500	325	10	325		5,904	22
23	CARPET	1996	415		5			415	23
24	BRICK	1996	768	38	20	38		368	24
25	CARAGE DOOR	1996	667	33	20	33		320	25
26	BLACKTOP	1996	8,260	551	15	551		5,277	26
27	DISPOSAL	1996	950	63	15	63		607	27
28	CARPET	1997	2,255		5			2,255	28
29	FAUCETS	1997	738	49	15	49		471	29
30	PAINTING	1997	1,948	97	10	97		1,769	30
31	TILING	1997	18,869	943	20	943		9,041	31
32	LANDSCAPING	1997	1,480	74	10	74		1,344	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,975,289	\$ 34,971		\$ 34,971	\$	\$ 1,647,862	34

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

Facility Name & ID Number WINNING WHEELS

0024745

Report Period Beginning:

7/1/2005

Ending:

6/30/2006

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		\$ 1,975,289	\$ 34,971		\$ 34,971	\$	\$ 1,647,862	1
2	SOFFIT	1997	4,495	225	20	225		1,948	2
3	SOFFIT ADDITION	1997	952	48	20	48		432	3
4	A/C COMPRESSOR & CONTROLLER	1997	10,811	1,081	10	1,081		9,280	4
5	DINING ROOM GLASS	1997	973	49	20	49		426	5
6	FOLDING ROOM WALL/DOORS	1998	5,099	255	20	255		2,167	6
7	FLOORING	1998	2,642	264	10	264		2,267	7
8	ALARM SYSTEM	1998	952	95	10	95		817	8
9	CABINETS	1998	7,745	387	20	387		3,227	9
10	3.5 TON A/C	1998	1,257	126	10	126		1,016	10
11	NATURE TRIAL LANDSCAPING	1998	18,965	1,897	10	1,897		14,540	11
12	HALLWAY PAINTING	1998	1,285	129	10	129		985	12
13	DUMPSTER PAD & FENCING	1998	1,873		5			1,873	13
14	FENCING	1998	2,375	119	20	119		861	14
15	GAZEBO	1999	8,200	410	20	410		2,973	15
16	FLOORING	1999	5,553	555	10	555		3,980	16
17	REMODEL DINING ROOM	1999	6,724	672	10	672		4,819	17
18	ABOVE GROUND TANK	1999	14,566	1,457	10	1,457		10,439	18
19	LANDSCAPING	1999	6,091	725	7	725		6,091	19
20	SECURITY SYSTEM UPGRADE	1999	5,472	717	7	717		5,472	20
21	GAZEBO INSTALLATION	1999	1,998	100	20	100		707	21
22	FRONT LIGHT FIXTURES	1999	4,507	451	10	451		2,930	22
23	STORM WATER PUMP	1999	2,404	343	7	343		2,232	23
24	PARKING LOT	1999	13,819	1,382	10	1,382		8,983	24
25	KITCHEN & DINING ROOM ROOF	1999	41,800	2,787	15	2,787		18,346	25
26	BREAKROOM FLOORING	2000	1,293	185	7	185		1,201	26
27	BUG BLOWER	2000	1,265	126	10	126		822	27
28	CARPET	2000	4,597		5			4,597	28
29	MULTI-SENSORY ROOM	2000	14,966	379	39.5	379		2,210	29
30	INDEPENDENT WAY GARDEN	2000	34,023	1,701	20	1,701		9,640	30
31	THERAPY ANNEX	2000	1,046,330	26,489	39.5	26,489		150,106	31
32	NURSE STATION	2001	17,475	448	39	448		2,240	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,265,796	\$ 78,573		\$ 78,573	\$	\$ 1,925,489	34

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

Facility Name & ID Number WINNING WHEELS

0024745

Report Period Beginning:

7/1/2005

Ending:

6/30/2006

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		\$ 3,265,796	\$ 78,573		\$ 78,573	\$	\$ 1,925,489	1
2	DOCTOR OFFICE TILE	2001	822	82	10	82		370	2
3	ENTRYWAYS TILE	2001	1,022	102	10	102		460	3
4	DIETARY ROOM TILE	2001	1,064	106	10	106		479	4
5	ROOM TILE	2002	1,234	123	10	123		555	5
6	SHRUBS & PLANTS	2002	11,706	1,171	10	1,171		4,097	6
7	CERAMIC HALLWAY TILE	2003	4,687	469	10	469		1,172	7
8	UPGRADE WANDERGUARD & MAGNETIC	2004	7,606	380	20	380		729	8
9	FENCE W/GATE PLUS INSTALLATION	2004	12,483	832	15	832		1,387	9
10	CONCRETE SIDEWALKS	2004	6,242	312	20	312		494	10
11	WALLCOVERING & CERAMIC	2005	4,642	464	10	464		696	11
12	DINING ROOM WINDOW	2005	1,732	87	20	87		94	12
13	A WING DAYROOM FLOORING	2005	2,475	124	10	124		124	13
14	FABRICATE ENTRANCE ARBOR W/PLANTER	2005	1,390	70	10	70		70	14
15	WINDOW TREATMENTS	2005	2,305	115	10	115		115	15
16	REAR ENTRANCE MATS	2005	2,681	191	7	191		191	16
17	WALL TRIM	2005	606	30	10	30		30	17
18	INSTALLATION OF CHAPEL WALL CARPET	2005	2,440	122	10	122		122	18
19	6 INSULATED WINDOWS	2006	1,520	38	20	38		38	19
20									20
21									21
22	DEFERRED MAINTENANCE ITEMS CAPITALIZED			319	5	319			22
23	(SEE PAGE 22)								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)		\$ 3,332,453	\$ 83,710		\$ 83,710	\$	\$ 1,936,712	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 596,133	\$ 81,202	\$ 81,202	\$	VARIOUS	\$ 377,235	71
72	Current Year Purchases	76,838	6,079	6,079		VARIOUS	6,079	72
73	Fully Depreciated Assets	587,340				VARIOUS	587,340	73
74								74
75	TOTALS	\$ 1,260,311	\$ 87,281	\$ 87,281	\$		\$ 970,654	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	\$ 245,259	\$ 33,518	\$ 33,518	\$	VARIOUS	\$ 180,976	76
77	SNOW REMOVAL	2000 DODGE PICKUP	2001	28,254	5,651	5,651		5	25,428	77
78	MEDICAL NECESSARY TRANSPORT					(10,676)	(10,676)	VARIOUS		78
79	RELATED ORGANIZATION ALLOCATION & LOSS ON SALE					2,170	2,170	VARIOUS		79
80	TOTALS			\$ 273,513	\$ 39,169	\$ 30,663	\$ (8,506)		\$ 206,404	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)		\$ 4,889,777	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 210,160	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 201,654	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ (8,506)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 3,113,770	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number WINNING WHEELS

0024745

Report Period Beginning: 7/1/2005

Ending: 6/30/2006

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

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.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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

* 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.

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.)

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)	405	1,035		1,440
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)	273	4,909	13,364	18,546
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests		1,150		1,150
9	TOTALS	\$ 678	\$ 7,094	\$ 13,364	\$ 21,136
10	SUM OF line 9, col. 1 and 2 (e)	\$ 7,772			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	7
2. From other facilities (f)	16
DROP-OUTS	
1. From this facility	1
2. From other facilities (f)	8
TOTAL TRAINED	32

- (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	Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5					
					Units	Cost				
1	Licensed Occupational Therapist	10a, 1	1092 hrs	\$ 31,006		\$		1,092	\$ 31,006	1
2	Licensed Speech and Language Development Therapist	10a, 1	731 hrs	17,841				731	17,841	2
3	Licensed Recreational Therapist	11, 1	1976 hrs	29,300				1,976	29,300	3
4	Licensed Physical Therapist	10a, 1	918 hrs	16,070				918	16,070	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$ 94,217		\$	\$	4,717	\$ 94,217	14

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

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

Ending:

6/30/2006**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 6/30/2006

(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	\$ 362,570	\$ 363,170	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>1107010/86056</u>)	1,020,954	1,388,929	3
4	Supply Inventory (priced at <u>COST</u>)	34,007	49,563	4
5	Short-Term Investments	1,193,977	2,232,901	5
6	Prepaid Insurance	16,694	19,967	6
7	Other Prepaid Expenses	7,748	27,429	7
8	Accounts Receivable (owners or related parties)	803,695.95	1,225,300	8
9	Other(specify): <u>ATTACHED</u>	709,438	717,439	9
	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,149,085	\$ 6,024,698	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	3,266	3,266	12
13	Land	23,500	302,861	13
14	Buildings, at Historical Cost	3,309,605	7,806,559	14
15	Leasehold Improvements, at Historical Cost		151,205	15
16	Equipment, at Historical Cost	1,533,824	2,176,153	16
17	Accumulated Depreciation (book methods)	(3,113,769)	(4,613,686)	17
18	Deferred Charges	1,115	2,070	18
19	Organization & Pre-Operating Costs	22,848	22,848	19
	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): <u>CONSTRUCTION IN PROGRE</u>	21,050	23,878	23
	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,778,590	\$ 5,852,306	24
	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,927,675	\$ 11,877,004	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 75,324	\$ 134,475	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	48,265	112,842	29
30	Accrued Salaries Payable	91,080	141,707	30
	Accrued Taxes Payable (excluding real estate taxes)	25,850	38,022	31
32	Accrued Real Estate Taxes(Sch.IX-B)		6,457	32
33	Accrued Interest Payable	1,991	1,991	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>DUE TO OTHER FUNDS</u>	421,604	1,225,300	36
37				37
	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 664,114	\$ 1,660,794	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,736,772	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>PA ADVANCE FOR DAY TREATMENT</u>	7,691	49,028	43
44				44
	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 7,691	\$ 1,785,800	45
	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 671,805	\$ 3,446,594	46
47	TOTAL EQUITY (page 18, line 24)	\$ 5,255,870	\$ 8,430,410	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,927,675	\$ 11,877,004	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,049,622	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,049,622	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	23,058	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	91,695	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) INTRACOMPANY TRANSFER	91,495	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 206,248	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)	\$ 5,255,870	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number WINNING WHEELS

0024745

Report Period Beginning: 7/1/2005

Ending: 6/30/2006

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	\$ 4,027,197	1
2	Discounts and Allowances for all Levels	(6,000)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,021,197	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	21,600	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	10,927	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)	\$ 32,527	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	4,677	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,677	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	TRANSPORTATION	61,395	28
28a	MISCELLANEOUS-SCHEDULE ATTACHED	1,987	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 63,382	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,121,783	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	980,988	31
32	Health Care	2,001,783	32
33	General Administration	853,333	33
B. Capital Expense			
34	Ownership	218,821	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)*	\$ 4,098,725	40
41	Income before Income Taxes (line 30 minus line 40)**	23,058	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 23,058	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: **7/1/2005**

Ending:

6/30/2006

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	1,869	2,197	\$ 56,159	\$ 25.56	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,309	8,784	176,504	20.09	3
4	Licensed Practical Nurses	13,236	14,624	273,910	18.73	4
5	CNAs & Orderlies	63,685	70,078	737,923	10.53	5
6	CNA Trainees	2,174	2,174	18,546	8.53	6
7	Licensed Therapist	2,293	2,741	64,917	23.68	7
8	Rehab/Therapy Aides	3,887	4,258	49,055	11.52	8
9	Activity Director	1,844	1,976	29,300	14.83	9
10	Activity Assistants	2,818	3,036	36,153	11.91	10
11	Social Service Workers	5,795	6,055	82,049	13.55	11
12	Dietician					12
13	Food Service Supervisor	1,628	1,875	19,411	10.35	13
14	Head Cook	7,410	8,009	69,566	8.69	14
15	Cook Helpers/Assistants	14,128	15,126	111,780	7.39	15
16	Dishwashers					16
17	Maintenance Workers	8,231	9,055	93,631	10.34	17
18	Housekeepers	9,403	10,382	83,162	8.01	18
19	Laundry	9,256	10,298	88,050	8.55	19
20	Administrator					20
21	Assistant Administrator	1,872	2,160	49,673	23.00	21
22	Other Administrative					22
23	Office Manager	2,190	2,256	21,072	9.34	23
24	Clerical	3,767	4,115	39,011	9.48	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,966	2,191	28,022	12.79	31
32	Other Health Care <u>COGNITIVE REH</u>	507	507	8,540	16.84	32
33	Other(specify) <u>TRANSPORTATI</u>	2,208	2,472	21,802	8.82	33
34	TOTAL (lines 1 - 33)	167,476	184,369	\$ 2,158,236 *	\$ 11.71	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	233	\$ 10,485	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		44,851	10a,3	40
41	Occupational Therapy Consultant		48,597	10a,3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant		27,217	10a,3	43
44	Activity Consultant	21	840	11,3	44
45	Social Service Consultant		1,800	12,3	45
46	Other(specify) <u>EQUESTRIAN THE</u>	480	12,000	11,3	46
47	<u>PHYSIATRIST CONSULTANT</u>	176	22,000	9,3	47
48	<u>LAB</u>		666	10,3	48
49	TOTAL (lines 35 - 48)	988	\$ 173,856		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	59	1,434	10,3	51
52	Certified Nurse Assistants/Aides	18	296	10,3	52
53	TOTAL (lines 50 - 52)	77	\$ 1,730		53

Facility Name & ID Number WINNING WHEELS

Report Period Beginning: 7/1/2005

Ending:

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2003	6 FY2004	7 FY2005	8 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 FY2011
1	PAINTING	7/2000	\$ 6,373	5 YRS	\$ 1,275	\$ 1,274	\$ 1,275	\$	\$	\$	\$	\$	\$
2	PAINTING	1/2005	1,592	5 YRS			159	319	318	319	318	159	
3													
4													
5													
6													
7													
8													
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13													
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15													
16													
17													
18													
19													
20	TOTALS		\$ 7,965		\$ 1,275	\$ 1,274	\$ 1,434	\$ 319	\$ 318	\$ 319	\$ 318	\$ 159	\$

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 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 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 23,826 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. \$ 10,927
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? YES If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 54,117
- 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? NO
- (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? YES
Attach invoices and a summary of services for all architect and appraisal fees.