

Facility Name & ID Number WINNING WHEELS

0024745 Report Period Beginning: 7/1/2006 Ending: 6/30/2007

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 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		Medicaid Recipient	Private Pay	Other		
8	SNF	363	2,078	616	3,057	8
9	SNF/PED					9
10	ICF	25,004			25,004	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,367	2,078	616	28,061	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.10%

D. How many bed-hold days during this year were paid by the Department? 596 (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 616

Medicare Intermediary ADMINISTRAR FEDERAL

IV. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/07 Fiscal Year: 6/30/07

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
A. General Services											
1	Dietary	199,274	21,423	9,908	230,605	748	231,353		231,353		1
2	Food Purchase		220,211		220,211		220,211	(11,369)	208,842		2
3	Housekeeping	83,324	31,668		114,992	280	115,272		115,272		3
4	Laundry	98,259	12,459		110,718		110,718		110,718		4
5	Heat and Other Utilities			115,199	115,199		115,199	(7,190)	108,009		5
6	Maintenance	91,069	57,530	23,940	172,539	648	173,187	(300)	172,887		6
7	Other (specify):*										7
8	TOTAL General Services	471,926	343,291	149,047	964,264	1,676	965,940	(18,859)	947,081		8
B. Health Care and Programs											
9	Medical Director			28,500	28,500		28,500		28,500		9
10	Nursing and Medical Records	1,362,806	165,686	12,616	1,541,108	(26,547)	1,514,561	(8,798)	1,505,763		10
10a	Therapy	135,888	658	73,607	210,153		210,153		210,153		10a
11	Activities	55,399	10,264	12,860	78,523		78,523		78,523		11
12	Social Services	88,204			88,204		88,204		88,204		12
13	CNA Training		1,401		1,401	28,370	29,771		29,771		13
14	Program Transportation	19,782	27,785		47,567		47,567		47,567		14
15	Other (specify):* COGNITIVE REHA	34,557		735	35,292		35,292		35,292		15
16	TOTAL Health Care and Programs	1,696,636	205,794	128,318	2,030,748	1,823	2,032,571	(8,798)	2,023,773		16
C. General Administration											
17	Administrative			189,500	189,500		189,500		189,500		17
18	Directors Fees										18
19	Professional Services			53,144	53,144		53,144		53,144		19
20	Dues, Fees, Subscriptions & Promotions			36,240	36,240		36,240	(7,870)	28,370		20
21	Clerical & General Office Expenses	103,299	34,844	20,518	158,661		158,661		158,661		21
22	Employee Benefits & Payroll Taxes			351,687	351,687	(1,523)	350,164		350,164		22
23	Inservice Training & Education			5,604	5,604		5,604		5,604		23
24	Travel and Seminar			27,999	27,999	(1,328)	26,671	(6,526)	20,145		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			48,914	48,914		48,914		48,914		26
27	Other (specify):*										27
28	TOTAL General Administration	103,299	34,844	733,606	871,749	(2,851)	868,898	(14,396)	854,502		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,271,861	583,929	1,010,971	3,866,761	648	3,867,409	(42,053)	3,825,356		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:

7/1/2006

Ending:

6/30/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
30	D. Ownership			201,328	201,328	(648)	200,680		200,680			30
31	Depreciation											31
32	Amortization of Pre-Op. & Org.											32
33	Interest			(1,096)	(1,096)		(1,096)	(11,279)	(12,375)			33
34	Real Estate Taxes											34
35	Rent-Facility & Grounds											35
36	Rent-Equipment & Vehicles											36
36	Other (specify):*											36
37	TOTAL Ownership			200,232	200,232	(648)	199,584	(11,279)	188,305			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											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		43,800		43,800			44
45	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	2,271,861	583,929	1,255,003	4,110,793		4,110,793	(53,332)	4,057,461			45

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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(11,369)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,190)	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	(11,279)	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	(1,693)	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	(6,006)	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)	\$ (37,537)		\$	30

BHF USE ONLY							
48		49		50		51	
						52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

		1	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS)			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (37,537)		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

WINNING WHEELS

ID# 0024745

Report Period Beginning: 7/1/2006

Ending: 6/30/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	OUT OF STATE TRAVEL	\$ (6,526)	24	1
2	FLOWERS	(126)	20	2
3	EMPLOYEES @ OTHER FACILITIES	(8,798)	10	3
4				4
5	RECOVERY OF FIRE DAMAGE	(300)	6	5
6	NON-ALLOWABLE CHAMBER DUES	(45)	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	(15,795)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WINNING WHEELS# 0024745 Report Period Beginning:

7/1/2006

Ending:

6/30/2007

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	(11,369)	0	0	0	0	0	0	0	0	0	0	(11,369)	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	(7,190)	0	0	0	0	0	0	0	0	0	0	(7,190)	5
6	Maintenance	(300)	0	0	0	0	0	0	0	0	0	0	(300)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(18,859)	0	0	0	0	0	0	0	0	0	0	(18,859)	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	(8,798)	0	0	0	0	0	0	0	0	0	0	(8,798)	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	(8,798)	0	0	0	0	0	0	0	0	0	0	(8,798)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(7,870)	0	0	0	0	0	0	0	0	0	0	(7,870)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(6,526)	0	0	0	0	0	0	0	0	0	0	(6,526)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(14,396)	0	0	0	0	0	0	0	0	0	0	(14,396)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(42,053)	0	0	0	0	0	0	0	0	0	0	(42,053)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WINNING WHEELS# 0024745

Report Period Beginning:

7/1/2006 Ending:

6/30/2007

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

	Capital Expense	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)
	D. Ownership												
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(11,279)	0	0	0	0	0	0	0	0	0	0	(11,279) 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	(11,279)	0	0	0	0	0	0	0	0	0	0	(11,279) 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)	(53,332)	0	0	0	0	0	0	0	0	0	0	(53,332) 45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
WINNING WHEELS, INC.	100%	S.T.R.I.V.E.	PROPHETSTOWN	LYNDON PLAY & LEARN CENTER	LYNDON	CHILD DAYCARE
		BIG MEADOWS NURSING HOME-BLDG. ONLY	SAVANNA	FRONTIER HOLLOW APARTMENTS	PROPHETSTOWN	INDEPENDENT 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		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number **WINNING WHEELS**

0024745 Report Period Beginning: **7/1/2006**

Ending: **3/30/2007**

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number (_____) _____
 Fax Number (_____) _____

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

Facility Name & ID Number **WINNING WHEELS**

0024745

Report Period Beginning:

7/1/2006

Ending:

6/30/2007

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 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 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	\$	10/13/06	6.1500	\$ (1,096)	1
2												2
3												3
4												4
5												5
Working Capital												
6												6
7												7
8												8
9	TOTAL Facility Related				\$13,500.00		\$ 750,000	\$			\$ (1,096)	9
B. Non-Facility Related*												
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 750,000	\$			\$ (1,096)	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.)

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																							
1. Real Estate Tax accrual used on 2006 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 2007 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:	<table border="1"> <tr><td>2002</td><td>8</td></tr> <tr><td>2003</td><td>9</td></tr> <tr><td>2004</td><td>10</td></tr> <tr><td>2005</td><td>11</td></tr> <tr><td>2006</td><td>12</td></tr> </table>	2002	8	2003	9	2004	10	2005	11	2006	12	<table border="1"> <tr><th colspan="2">FOR BHF USE ONLY</th></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2006 \$</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5 \$</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6 \$</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION\$</td></tr> </table>	FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2006 \$	14	PLUS APPEAL COST FROM LINE 5 \$	15	LESS REFUND FROM LINE 6 \$	16	AMOUNT TO USE FOR RATE CALCULATION\$	
2002	8																						
2003	9																						
2004	10																						
2005	11																						
2006	12																						
FOR BHF USE ONLY																							
13	FROM R. E. TAX STATEMENT FOR 2006 \$																						
14	PLUS APPEAL COST FROM LINE 5 \$																						
15	LESS REFUND FROM LINE 6 \$																						
16	AMOUNT TO USE FOR RATE CALCULATION\$																						

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:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 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 2006 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 2006.

(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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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.

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:

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

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	VAROUS	\$ 16,589		\$ 1,272,365
5		1979	1979	22,848		5			22,848
6		1985	1985	4,226		20			4,226
7		1987	1987	11,212	234	20	234		11,212
8									
	Improvement Type**								
9	TILE	1985		585		20			585
10	AIR CONDITIONER COMPRESSOR	1986		2,576		10			2,576
11	CON	1986		2,093	44	20	44		2,093
12	LAVATORIES	1987		780	23	20	23		780
13	PATIO	1987		3,089	129	20	129		3,089
14	TRACK CURTAIN SYSTEM	1987		1,306	54	20	54		1,306
15	CEDAR POST RAILS	1987		230		10			230
16	SHOWER DOORS	1987		350		15			350
17	BLACKTOP PATH	1987		5,946	297	20	297		5,822
18	BATH IMPROVEMENTS	1988		11,342		15			11,342
19	TV ANTENNA BOOSTER	1988		455		10			455
20	FAUCETS	1988		597		15			597
21	HEAT A/C UNIT	1988		2,869		15			2,869
22	MOTORS	1988		1,037		10			1,037
23	EMPLOYEE LOUNGE	1988		3,235	162	20	162		3,127
24	DOOR OPENERS	1988		3,505		15			3,505
25	BATH PARTITIONS	1988		764		10			764
26	BLACKTOP	1988		5,023		15			5,023
27	COUNTERTOP SHELVES	1988		1,678		15			1,678
28	FITNESS TRAIL	1988		945		5			945
29	PARKING LOT SEALER	1988		4,000		4			4,000
30	BACK ROOM RENOVATIONS	1988		30,717		15			30,717
31	SIGNAGE	1988		872	43	20	43		813
32	HEATERS MOTORS THERMOSTAT	1988		1,010		5			1,010
33	LANDSCAPING	1989		4,715		10			4,715
34	BLACKTOP ROCK & SEALING	1989		5,906		15			5,906
35	DRAPES	1989		1,083		10			1,083
36									

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

See Page 12A, Line 70 for total

**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:

7/1/2006

Ending:

6/30/2007

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 BATHROOM REMODELING	1990	\$ 11,976	\$	8	\$	\$	\$ 11,976	37	
38 WATER SOFTENER	1990	5,858		12			5,858	38	
39 SIGN	1990	3,700		12			3,700	39	
40 PARKING LOT LIGHTS	1990	6,258		15			6,258	40	
41 SHRUBS	1990	1,235		15			1,235	41	
42 BATHROOM IMPROVEMENTS	1991	12,802		15			12,802	42	
43 AUTOMATIC DOOR OPENERS	1991	4,455		10			4,455	43	
44 REMODEL DINING ROOM	1992	34,562	1,728	20	1,728		25,921	44	
45 REMODEL A & B WINGS	1992	18,929	946	20	946		13,881	45	
46 HOTWATER BOILER	1992	4,272	285	15	285		4,153	46	
47 RT CLINIC	1993	2,992	150	20	150		2,132	47	
48 FLOWER BED	1993	1,142		10			1,142	48	
49 KITCHEN LIGHTS & VENTS	1993	3,777	189	20	189		2,660	49	
50 LAUNDRY ENGR. & ARCHITECT	1993	3,735	187	20	187		2,615	50	
51 LAUNDRY WATER HEATER & CONDITIONER	1993	4,813	321	15	321		4,492	51	
52 LOBBY & OFFICES BLINDS & VALANCES	1993	3,295		10			3,295	52	
53 LAUNDRY ROOM	1993	28,023	1,401	20	1,401		19,149	53	
54 INTERIOR SIGN	1994	900		11			900	54	
55 RT CLINIC COUNTER TOPS	1994	1,283	64	20	64		866	55	
56 REDECORATE LOBBY	1994	29,817	1,491	20	1,491		19,878	56	
57 GAS WATER HEATER	1994	2,148	143	15	143		1,886	57	
58 SHELTER ROOF	1994	514	34	15	34		448	58	
59 REDECORATE OFFICE	1994	1,587		10			1,587	59	
60 REDECORATE ROOMS & HALLS	1994	11,264		10			11,264	60	
61 SHRUBS & PLANTS	1994	7,501		10			7,501	61	
62 PATIO	1994	8,723	581	15	581		7,511	62	
63 CARPETING	1994	680		5			680	63	
64 COUNTER TOP	1994	1,241	62	20	62		796	64	
65 DOOR ALARM SYSTEM	1994	6,962		7			6,962	65	
66 DINING ROOM DECORATION	1995	1,870		10			1,870	66	
67 ACCORDIAN DOORS	1995	12,071	603	20	603		7,494	67	
68 AIR CONDITIONER	1995	3,575		10			3,575	68	
69								69	
70 TOTAL (lines 4 thru 69)		\$ 1,824,639	\$ 25,760		\$ 25,760	\$	\$ 1,606,010	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:

7/1/2006

Ending:

6/30/2007**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	10
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12A, Carried Forward	\$ 1,824,639	\$ 25,760		\$ 25,760	\$	\$ 1,606,010		1
2	ROOF	1995 42,900	2,145	20	2,145		25,740		2
3	GARAGE	1995 27,086	1,354	20	1,354		15,800		3
4	SWING DOOR OPERATOR	1996 4,246		10			4,246		4
5	GARAGE WIRING	1996 3,384	226	15	226		2,595		5
6	CARPET	1996 811		5			811		6
7	GARAGE DOOR	1996 1,519	76	20	76		873		7
8	HEATER	1996 1,506	100	15	100		1,146		8
9	WALLPAPER	1996 471	4	10	4		471		9
10	CEILING TILE	1996 4,157	208	20	208		2,373		10
11	WALLPAPER BACK OFFICE	1996 587	5	10	5		587		11
12	FLOORING	1996 425	21	20	21		243		12
13	FLOOR TILING	1996 4,105	205	20	205		2,326		13
14	FLOOR GROUT	1996 237	12	20	12		134		14
15	STAIRS	1996 200	5	10	5		200		15
16	REMODEL KITCHEN	1996 13,551	678	20	678		7,622		16
17	CORNER PROTECTORS	1996 2,200	55	10	55		2,200		17
18	CARPET	1996 415		5			415		18
19	A/C COMPRESSOR	1996 6,500	596	10	596		6,500		19
20	CARPET	1996 415		5			415		20
21	BRICK	1996 768	38	20	38		406		21
22	CARAGE DOOR	1996 667	33	20	33		353		22
23	BLACKTOP	1996 8,260	551	15	551		5,828		23
24	DISPOSAL	1996 950	63	15	63		670		24
25	CARPET	1997 2,255		5			2,255		25
26	FAUCETS	1997 738	49	15	49		520		26
27	PAINTING	1997 1,948	179	10	179		1,948		27
28	TILING	1997 18,869	943	20	943		9,985		28
29	LANDSCAPING	1997 1,480	136	10	136		1,480		29
30	SOFFIT	1997 4,495	225	20	225		2,173		30
31	SOFFIT ADDITION	1997 952	48	20	48		480		31
32	A/C COMPRESSOR & CONTROLLER	1997 10,811	541	10	541		9,820		32
33									33
34	TOTAL (lines 1 thru 33)	\$ 1,991,547	\$ 34,256		\$ 34,256	\$	\$ 1,716,625		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:

7/1/2006

Ending:

6/30/2007**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	\$ 1,991,547	\$ 34,256		\$ 34,256		\$ 1,716,625		1
2	DINING ROOM GLASS	973	49	20	49		475		2
3	FOLDING ROOM WALL/DOORS	5,099	255	20	255		2,422		3
4	FLOORING	2,642	132	10	132		2,399		4
5	ALARM SYSTEM	952	48	10	48		865		5
6	CABINETS	7,745	387	20	387		3,615		6
7	3.5 TON A/C	1,257	126	10	126		1,142		7
8	NATURE TRIAL LANDSCAPING	18,965	1,897	10	1,897		16,436		8
9	HALLWAY PAINTING	1,285	129	10	129		1,114		9
10	DUMPSTER PAD & FENCING	1,873		5			1,873		10
11	FENCING	2,375	119	20	119		980		11
12	GAZEBO	8,200	410	20	410		3,383		12
13	FLOORING	5,553	555	10	555		4,535		13
14	REMODEL DINING ROOM	6,724	672	10	672		5,492		14
15	ABOVE GROUND TANK	14,566	1,457	10	1,457		11,896		15
16	LANDSCAPING	6,091		7			6,091		16
17	SECURITY SYSTEM UPGRADE	5,472		7			5,472		17
18	GAZEBO INSTALLATION	1,998	100	20	100		807		18
19	FRONT LIGHT FIXTURES	4,507	451	10	451		3,380		19
20	STORM WATER PUMP	2,404	172	7	172		2,404		20
21	PARKING LOT	13,819	1,382	10	1,382		10,364		21
22	KITCHEN & DINING ROOM ROOF	41,800	2,787	15	2,787		21,132		22
23	BREAKROOM FLOORING	1,293	92	7	92		1,293		23
24	BUG BLOWER	1,265	126	10	126		949		24
25	CARPET	4,597		5			4,597		25
26	MULTI-SENSORY ROOM	14,966	379	39.5	379		2,589		26
27	INDEPENDENT WAY GARDEN	34,023	1,701	20	1,701		11,341		27
28	THERAPY ANNEX	1,046,330	26,489	39.5	26,489		176,596		28
29	NURSE STATION	17,475	448	39	448		2,688		29
30	DOCTOR OFFICE TILE	822	82	82	82		452		30
31	ENTRYWAYS TILE	1,022	102	102	102		562		31
32	DIETARY ROOM TILE	1,064	106	106	106		585		32
33									33
34	TOTAL (lines 1 thru 33)	\$ 3,268,704	\$ 74,909		\$ 74,909		\$ 2,024,554		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	\$ 3,268,704	\$ 74,909		\$ 74,909		\$ 2,024,554		1
2	ROOM TILE	1,234	123	10	123		679		2
3	SHRUBS & PLANTS	11,706	1,171	10	1,171		5,268		3
4	CERAMIC HALLWAY TILE	4,687	469	10	469		1,640		4
5	UPGRADE WANDERGUARD & MAGNETIC	7,606	380	20	380		1,109		5
6	FENCE W/GATE PLUS INSTALLATION	12,483	832	15	832		2,219		6
7	CONCRETE SIDEWALKS	6,242	312	20	312		806		7
8	WALLCOVERING & CERAMIC	4,642	464	10	464		1,160		8
9	DINING ROOM WINDOW	1,732	87	20	87		180		9
10	A WING DAYROOM FLOORING	2,475	248	10	248		371		10
11	FABRICATE ENTRANCE ARBOR W/PLANTER	1,390	139	10	139		209		11
12	WINDOW TREATMENTS	2,305	230	10	230		346		12
13	REAR ENTRANCE MATS	2,681	383	7	383		575		13
14	WALL TRIM	606	61	10	61		91		14
15	INSTALLATION OF CHAPEL WALL CARPET	2,440	244	10	244		366		15
16	6 INSULATED WINDOWS	1,520	76	20	76		114		16
17	BLACKTOP PARKING LOT	3,400	340	5	340		340		17
18	CANVAS CANOPY	3,260	163	10	163		163		18
19	RETILE 18 ROOM IN B WING	12,594	262	20	262		262		19
20	GARAGE DOOR	1,030	13	20	13		13		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)	\$ 3,352,737	\$ 80,906		\$ 80,906		\$ 2,040,465		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	\$ 630,469	\$ 76,194	\$ 76,194		VARIOUS	\$ 417,006	71
72	Current Year Purchases	97,079	7,883	7,883		VARIOUS	7,883	72
73	Fully Depreciated Assets	629,842				VARIOUS	629,842	73
74								74
75	TOTALS	\$ 1,357,390	\$ 84,078	\$ 84,078	\$		\$ 1,054,731	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	\$ 259,966	\$ 32,871	\$ 32,871		5	\$ 142,473	76
77	SNOW REMOVAL	2000 DODGE PICKUP	2001	28,254	2,825	2,825		5	28,254	77
78	MEDICAL NECESSARY TRANSPORT									78
79										79
80	TOTALS			\$ 288,220	\$ 35,697	\$ 35,697	\$		\$ 170,727	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,021,847	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 200,680	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 200,680	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,265,923	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	ENVIROMENTAL STUDY	\$ 38,450	92
93			93
94			94
95		\$ 38,450	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: 7/1/2006

Ending: 6/30/2007

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. _____/2008 \$ _____

13. _____/2009 \$ _____

14. _____/2010 \$ _____

* 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.)

<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			
	1	2	3	4
	Drop-outs	Completed	Contract	Total
1 Community College Tuition	\$	\$	\$	\$
2 Books and Supplies				
3 Classroom Wages (a)	394	1,007		1,401
4 Clinical Wages (b)				
5 In-House Trainer Wages (c)	418	7,509	20,443	28,370
6 Transportation				
7 Contractual Payments				
8 CNA Competency Tests				
9 TOTALS	\$ 812	\$ 8,516	\$ 20,443	\$ 29,771
10 SUM OF line 9, col. 1 and 2 (e)	\$ 9,328			

C. CONTRACTUAL INCOME

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

\$ 12,720

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	10
2. From other facilities (f)	22
DROP-OUTS	
1. From this facility	1
2. From other facilities (f)	11
TOTAL TRAINED	44

- (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.)

1	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	2 hrs	\$ 41		\$	\$	2	\$ 41	1
2	Licensed Speech and Language Development Therapist	10a, 1	15 hrs	556				15	556	2
3	Licensed Recreational Therapist	11, 1	##### hrs	26,506				1,966	26,506	3
4	Licensed Physical Therapist	10a, 1	861 hrs	32,256				861	32,256	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			\$ 59,359		\$	\$	2,844	\$ 59,359	14

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

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

	1	2	
	Operating	After Consolidation*	
A. Current Assets			
1	Cash on Hand and in Banks	\$ 327,415	\$ 373,526
2	Cash-Patient Deposits		
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 911208/101497)	809,711	1,233,239
4	Supply Inventory (priced at COST)	28,901	43,939
5	Short-Term Investments	1,238,406	2,352,961
6	Prepaid Insurance	15,985	17,902
7	Other Prepaid Expenses	8,470	22,080
8	Accounts Receivable (owners or related parties)	504,744	900,741
9	Other(specify): ATTACHED	815,919	817,075
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,749,550	\$ 5,761,462
B. Long-Term Assets			
11	Long-Term Notes Receivable		
12	Long-Term Investments	(2,990)	(2,990)
13	Land	23,500	319,861
14	Buildings, at Historical Cost	3,329,889	8,013,340
15	Leasehold Improvements, at Historical Cos		151,205
16	Equipment, at Historical Cost	1,645,611	2,314,203
17	Accumulated Depreciation (book methods)	(3,243,075)	(4,970,920)
18	Deferred Charges	3,761	3,914
19	Organization & Pre-Operating Costs	22,848	22,848
20	Accumulated Amortization - Organization & Pre-Operating Costs	(22,848)	(22,848)
21	Restricted Funds		
22	Other Long-Term Assets (specify):		
23	Other(specify): CONSTRUCTION IN PROGRE	38,450	42,027
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,795,146	\$ 5,870,639
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,544,696	\$ 11,632,102

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26	Accounts Payable	\$ 44,785	\$ 113,619
27	Officer's Accounts Payable		
28	Accounts Payable-Patient Deposits		
29	Short-Term Notes Payable		68,262
30	Accrued Salaries Payable	100,103	150,725
31	Accrued Taxes Payable (excluding real estate taxes)	26,984	41,376
32	Accrued Real Estate Taxes(Sch.IX-B)		6,049
33	Accrued Interest Payable		
34	Deferred Compensation		
35	Federal and State Income Taxes		
Other Current Liabilities(specify):			
36	DUE TO OTHER FUNDS	395,999	900,741
37			
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 567,871	\$ 1,280,772
D. Long-Term Liabilities			
39	Long-Term Notes Payable		
40	Mortgage Payable		1,669,840
41	Bonds Payable		
42	Deferred Compensation		
Other Long-Term Liabilities(specify):			
43	PA ADVANCE FOR DAY TREATMENT	7,691	49,028
44			
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 7,691	\$ 1,718,868
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 575,562	\$ 2,999,640
47	TOTAL EQUITY(page 18, line 24)	\$ 4,969,134	\$ 8,632,463
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,544,696	\$ 11,632,102

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,255,870	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,255,870	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(165,818)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	289,931	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	(410,849)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (286,736)	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)	\$ 4,969,134	24 *

* This must agree with page 17, line 47.

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	\$ 3,853,718	1
2	Discounts and Allowances for all Levels	(6,000)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,847,718	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	15,951	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	11,369	14
15	Telephone, Television and Radic		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)	\$ 27,320	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	11,279	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 11,279	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	TRANSPORTATION	54,765	28
28a	MISCELLANEOUS-SCHEDULE ATTACHED	3,892	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 58,657	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,944,975	30

2

Expenses		Amount	
A. Operating Expenses			
31	General Services	964,264	31
32	Health Care	2,030,748	32
33	General Administration	871,749	33
B. Capital Expense			
34	Ownership	200,232	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)*	\$ 4,110,793	40
41	Income before Income Taxes (line 30 minus line 40)**	(165,818)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (165,818)	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

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	1,807	2,231	\$ 59,753	\$ 26.78	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,792	9,702	217,180	22.39	3
4	Licensed Practical Nurses	12,801	14,031	249,747	17.80	4
5	CNAs & Orderlies	67,777	74,427	781,485	10.50	5
6	CNA Trainees	3,338	3,338	28,370	8.50	6
7	Licensed Therapist	822	878	32,853	37.42	7
8	Rehab/Therapy Aides	7,209	7,956	103,035	12.95	8
9	Activity Director	1,838	1,966	26,506	13.48	9
10	Activity Assistants	2,730	2,881	28,893	10.03	10
11	Social Service Workers	5,738	6,256	88,204	14.10	11
12	Dietician					12
13	Food Service Supervisor	1,589	1,837	20,046	10.91	13
14	Head Cook	5,842	6,381	58,514	9.17	14
15	Cook Helpers/Assistants	15,386	16,536	120,714	7.30	15
16	Dishwashers					16
17	Maintenance Workers	8,039	9,134	91,069	9.97	17
18	Housekeepers	9,190	10,390	83,324	8.02	18
19	Laundry	10,254	11,386	98,259	8.63	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,050	2,178	20,822	9.56	23
24	Clerical	5,898	6,484	82,477	12.72	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	1,787	1,998	26,271	13.15	31
32	Other Health Care COGNITIVE REH	1,885	2,019	34,557	17.12	32
33	Other(specify) TRANSPORTATI	1,866	2,125	19,782	9.31	33
34	TOTAL (lines 1 - 33)	175,638	194,134	\$ 2,271,861 *	\$ 11.70	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	220	\$ 9,908	1,3	35
36	Medical Director	65	6,500	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	1,413	42,378	10a,3	40
41	Occupational Therapy Consultant	594	17,812	10a,3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	276	11,054	10,3	43
44	Activity Consultant	31	860	11,3	44
45	Social Service Consultant	24	2,400	12,3	45
46	Other(specify) EQUESTRIAN THEI	480	12,000	11,3	46
47	PHYSIATRIST CONSULTANT	176	22,000	9,3	47
48	LAB & X-RAY	78	2,333	10,3	48
49	TOTAL (lines 35 - 48)	3,405	\$ 129,644		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	231	6,403	10,3	51
52	Certified Nurse Assistants/Aides	90	1,444	10,3	52
53	TOTAL (lines 50 - 52)	321	\$ 7,847		53

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	
													Amount of Expense Amortized Per Year
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	
1	PAINTING	7/2000	\$ 6,373	5 YRS	\$ 1,274	\$ 1,275	\$	\$	\$	\$	\$	\$	
2	PAINTING	1/2005	1,592	5 YRS		159	319	318	319	318	159		
3	PAINTING	1/2007	3,295	5 YRS				329	659	659	659	659	330
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 11,260		\$ 1,274	\$ 1,434	\$ 319	\$ 647	\$ 978	\$ 977	\$ 818	\$ 659	\$ 330

Facility Name & ID Number WINNING WHEELS# 0024745Report Period Beginning: 7/1/2006Ending: 6/30/2007**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 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. \$ 23,195 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 _____ NO X
- (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 benefit on Schedule V. \$ NONE Has any meal income been offset against related costs? YES Indicate the amount. \$ 11,369
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? YES If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 55,177
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 \$5,000, have legal invoices and a summary of service performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.