

Facility Name & ID Number WINNING WHEELS

0024745 Report Period Beginning: 7/1/2007 Ending: 6/30/2008

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	29,280	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	29,280	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Medicaid Recipient	4 Private Pay	Other		
8	SNF			467	467	8
9	SNF/PED					9
10	ICF	26,511	1,360		27,871	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,511	1,360	467	28,338	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.78%

D. How many bed-hold days during this year were paid by the Department? 655 (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 467

Medicare Intermediary ADMINISTRAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/08 Fiscal Year: 6/30/08

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

	Operating Expenses	Costs Per General Ledger				Reclassification 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	207,708	23,606	9,011	240,325		240,325	0	240,325		1
2	Food Purchase		238,021		238,021		238,021	(13,780)	224,241		2
3	Housekeeping	85,689	31,667		117,356		117,356	0	117,356		3
4	Laundry	98,085	18,311		116,396		116,396	0	116,396		4
5	Heat and Other Utilities			122,902	122,902		122,902	(7,605)	115,297		5
6	Maintenance	96,934	60,602	33,839	191,375	978	192,353	0	192,353		6
7	Other (specify):*				0		0	0	0		7
8	TOTAL General Services	488,416	372,207	165,752	1,026,375	978	1,027,353	(21,385)	1,005,968		8
	B. Health Care and Programs										
9	Medical Director			44,000	44,000		44,000	0	44,000		9
10	Nursing and Medical Records	1,383,457	193,152	8,298	1,584,907	(8,527)	1,576,380	0	1,576,380		10
10a	Therapy	100,669	2,455	98,567	201,691		201,691	0	201,691		10a
11	Activities	60,749	9,123	13,250	83,122		83,122	0	83,122		11
12	Social Services	79,150			79,150		79,150	0	79,150		12
13	CNA Training	26,207			26,207	17,960	44,167	0	44,167		13
14	Program Transportation	25,331	36,410		61,741		61,741	0	61,741		14
15	Other (specify):* COGNITIVE REHA	27,771			27,771		27,771	0	27,771		15
16	TOTAL Health Care and Programs	1,703,334	241,140	164,115	2,108,589	9,433	2,118,022	0	2,118,022		16
	C. General Administration										
17	Administrative			195,500	195,500		195,500	0	195,500		17
18	Directors Fees				0		0	0	0		18
19	Professional Services			53,450	53,450		53,450	0	53,450		19
20	Dues, Fees, Subscriptions & Promotions			42,560	42,560		42,560	(10,744)	31,816		20
21	Clerical & General Office Expenses	105,504	38,265	22,742	166,511		166,511	0	166,511		21
22	Employee Benefits & Payroll Taxes			357,296	357,296	(9,433)	347,863	0	347,863		22
23	Inservice Training & Education			7,091	7,091		7,091	0	7,091		23
24	Travel and Seminar			25,709	25,709		25,709	0	25,709		24
25	Other Admin. Staff Transportation				0		0	0	0		25
26	Insurance-Prop.Liab.Malpractice			63,980	63,980		63,980	0	63,980		26
27	Other (specify):*				0		0	0	0		27
28	TOTAL General Administration	105,504	38,265	768,328	912,097	(9,433)	902,664	(10,744)	891,920		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,297,254	651,612	1,098,195	4,047,061	978	4,048,039	(32,129)	4,015,910		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.

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										
	Depreciation			209,598	209,598	(978)	208,620	0	208,620		30
31	Amortization of Pre-Op. & Org.				0		0	0	0		31
32	Interest				0		0	0	0		32
33	Real Estate Taxes				0		0	0	0		33
34	Rent-Facility & Grounds				0		0	0	0		34
35	Rent-Equipment & Vehicles				0		0	0	0		35
36	Other (specify):*				0		0	0	0		36
37	TOTAL Ownership			209,598	209,598	(978)	208,620	0	208,620		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation				0		0	0	0		38
39	Ancillary Service Centers				0		0	0	0		39
40	Barber and Beauty Shops				0		0	0	0		40
41	Coffee and Gift Shops				0		0	0	0		41
42	Provider Participation Fee			43,920	43,920		43,920	0	43,920		42
43	Other (specify):*				0		0	0	0		43
44	TOTAL Special Cost Centers	0	0	43,920	43,920	0	43,920	0	43,920		44
	GRAND TOTAL COST										
45	(sum of lines 29, 37 & 44)	2,297,254	651,612	1,351,713	4,300,579	0	4,300,579	(32,129)	4,268,450		45

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

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

FYE08

Line #	(1)	DR.	CR.	Cost Report Line Line #
10	Nursing & Medical Records	9,433		10
22	Employee Benefits		9,433	22

Reclassify uniforms 5720 TB

	(2)			
6	Maintenance	978		6
30	Depreciation		978	30

	(4)			
13	CNA Training	17,960		13
10	Nursing & Medical Records		17,960	10

Reclassify class wages Training Salary & Bennies Regi Fortune
 +16% Fringe Ben

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	(13,780)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,605)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(3,391)	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	(7,353)	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)	\$ (32,129)		\$ 0	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)	\$ 0		36
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (32,129)		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						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: 7/1/2007

Ending: 6/30/2008

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
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			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	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WINNING WHEELS

0024745

Report Period Beginning:

7/1/2007

Ending:

6/30/2008

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	(13,780)	0	0	0	0	0	0	0	0	0	0	(13,780)	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	(7,605)	0	0	0	0	0	0	0	0	0	0	(7,605)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(21,385)	0	0	0	0	0	0	0	0	0	0	(21,385)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	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	0	0	0	0	0	0	0	0	0	0	0	0	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	(10,744)	0	0	0	0	0	0	0	0	0	0	(10,744)	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	0	0	0	0	0	0	0	0	0	0	0	0	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	(10,744)	0	0	0	0	0	0	0	0	0	0	(10,744)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(32,129)	0	0	0	0	0	0	0	0	0	0	(32,129)	29

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
WINNING WHEELS, INC.	100	S.T.R.I.V.E.	PROPHETSTOWN	LYNDON PLAY & LEARN CENTER	LYNDON	CHILD DAY CARE
		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

Facility Name & ID Number WINNING WHEELS # 0024745 Report Period Beginning: 7/1/2007 Ending: 6/30/2008

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: 7/1/2007 Ending: 5/30/2008

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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					\$	\$		\$	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

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		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						\$	\$			\$	1							
2											2							
3											3							
4											4							
5											5							
Working Capital																		
6											6							
7											7							
8											8							
9	TOTAL Facility Related					\$ 0	\$ 0			\$ 0	9							
B. Non-Facility Related*																		
10											10							
11											11							
12											12							
13											13							
14	TOTAL Non-Facility Related					\$ 0	\$ 0			\$ 0	14							
15	TOTALS (line 9+line14)					\$ 0	\$ 0			\$ 0	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 0 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 2007 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).		\$	0 3
4. Real Estate Tax accrual used for 2008 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.		\$	0 7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2003	8	
	2004	9	
	2005	10	
	2006	11	
	2007	12	
			FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2007 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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,

2007 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 Costs

Enter the tax index number and real estate tax assessed for 2007 on the lines provided below. Enter only the portion of total 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 2007.

(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		\$ <u>0.00</u>	\$ <u>0.00</u>

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 direct 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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008

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.

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 ground (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:

7/1/2007

Ending: 6/30/2008

XL 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		1979	1979	\$ 1,447,685	\$ 16,589	VAROUS	\$ 16,589		\$ 1,288,954	4
5		1979	1979	22,848		5			22,848	5
6		1985	1985	4,226		20			4,226	6
7		1987	1987	11,212		20			11,212	7
8										8
Improvement Type**										
9	TILE		1985	585	0	20	0	0	585	9
10	AIR CONDITIONER COMPRESSOR		1986	2,576	0	10	0	0	2,576	10
11	CON		1986	2,093	0	20	0	0	2,093	11
12	LAVATORIES		1987	780	0	20	0		780	12
13	PATIO		1987	3,089	0	20	0		3,089	13
14	TRACK CURTAIN SYSTEM		1987	1,306	0	20	0		1,306	14
15	CEDAR POST RAILS		1987	230	0	10	0		230	15
16	SHOWER DOORS		1987	350	0	15	0		350	16
17	BLACKTOP PATH		1987	5,946	124	20	124		5,946	17
18	BATH IMPROVEMENTS		1988	11,342	0	15	0		11,342	18
19	TV ANTENNA BOOSTER		1988	455	0	10	0		455	19
20	FAUCETS		1988	597	0	15	0		597	20
21	HEAT A/C UNIT		1988	2,869	0	15	0		2,869	21
22	MOTORS		1988	1,037	0	10	0		1,037	22
23	EMPLOYEE LOUNGE		1988	3,235	108	20	108		3,235	23
24	DOOR OPENERS		1988	3,505	0	15	0		3,505	24
25	BATH PARTITIONS		1988	764	0	10	0		764	25
26	BLACKTOP		1988	5,023	0	15	0		5,023	26
27	COUNTERTOP SHELVES		1988	1,678	0	15	0		1,678	27
28	FITNESS TRAIL		1988	945	0	5	0		945	28
29	PARKING LOT SEALER		1988	4,000	0	4	0		4,000	29
30	BACK ROOM RENOVATIONS		1988	30,717	0	15	0		30,717	30
31	SIGNAGE		1988	872	44	20	44		857	31
32	HEATERS MOTORS THERMOSTAT		1988	1,010	0	5	0		1,010	32
33	LANDSCAPING		1989	4,715	0	10	0		4,715	33
34	BLACKTOP ROCK & SEALING		1989	5,906	0	15	0	0	5,906	34
35	DRAPES		1989	1,083	0	10	0	0	1,083	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:

7/1/2007

Ending:

6/30/2008

XL OWNERSHIP COSTS (continued)

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

	1	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	\$ 0	8	\$ 0	\$	\$ 11,976	37
38	WATER SOFTENER	1990	5,858	0	12	0		5,858	38
39	SIGN	1990	3,700	0	12	0		3,700	39
40	PARKING LOT LIGHTS	1990	6,258	0	15	0		6,258	40
41	SHRUBS	1990	1,235	0	15	0		1,235	41
42	BATHROOM IMPROVEMENTS	1991	12,802	0	15	0		12,802	42
43	AUTOMATIC DOOR OPENERS	1991	4,455	0	10	0		4,455	43
44	REMODEL DINING ROOM	1992	34,562	1,728	20	1,728		27,649	44
45	REMODEL A & B WINGS	1992	18,929	946	20	946		14,828	45
46	HOTWATER BOILER	1992	4,272	119	15	119		4,272	46
47	RT CLINIC	1993	2,992	150	20	150		2,282	47
48	FLOWER BED	1993	1,142	0	10	0		1,142	48
49	KITCHEN LIGHTS & VENTS	1993	3,777	189	20	189		2,849	49
50	LAUNDRY ENGR. & ARCHITECT	1993	3,735	187	20	187		2,801	50
51	LAUNDRY WATER HEATER & CONDITIONER	1993	4,813	321	15	321		4,813	51
52	LOBBY & OFFICES BLINDS & VALANCES	1993	3,295	0	10	0		3,295	52
53	LAUNDRY ROOM	1993	28,023	1,401	20	1,401		20,550	53
54	INTERIOR SIGN	1994	900	0	11	0		900	54
55	RT CLINIC COUNTER TOPS	1994	1,283	64	20	64		930	55
56	REDECORATE LOBBY	1994	29,817	1,491	20	1,491		21,369	56
57	GAS WATER HEATER	1994	2,148	143	15	143		2,029	57
58	SHELTER ROOF	1994	514	34	15	34		482	58
59	REDECORATE OFFICE	1994	1,587	0	10	0		1,587	59
60	REDECORATE ROOMS & HALLS	1994	11,264	0	10	0		11,264	60
61	SHRUBS & PLANTS	1994	7,501	0	10	0		7,501	61
62	PATIO	1994	8,723	582	15	582		8,093	62
63	CARPETING	1994	680	0	5	0		680	63
64	COUNTER TOP	1994	1,241	62	20	62		858	64
65	DOOR ALARM SYSTEM	1994	6,962	0	7	0		6,962	65
66	DINING ROOM DECORATION	1995	1,870	0	10	0		1,870	66
67	ACCORDIAN DOORS	1995	12,071	604	20	604		8,098	67
68	AIR CONDITIONER	1995	3,575	0	10	0		3,575	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,824,639	\$ 24,884		\$ 24,884	\$ 0	\$ 1,630,894	70

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

Facility Name & ID Number WINNING WHEELS

0024745

Report Period Beginning:

7/1/2007

Ending:

6/30/2008

XL 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	\$ 24,884		\$ 24,884	\$	\$ 1,630,894	1
2	ROOF	1995	42,900	2,145	20	2,145		27,885	2
3	GARAGE	1995	27,086	1,354	20	1,354		17,155	3
4	SWING DOOR OPERATOR	1996	4,246	0	10	0		4,246	4
5	GARAGE WIRING	1996	3,384	226	15	226		2,820	5
6	CARPET	1996	811	0	5	0		811	6
7	GARAGE DOOR	1996	1,519	76	20	76		949	7
8	HEATER	1996	1,506	100	15	100		1,246	8
9	WALLPAPER	1996	471	0	10	0		471	9
10	CEILING TILE	1996	4,157	208	20	208		2,581	10
11	WALLPAPER BACK OFFICE	1996	587	0	10	0		587	11
12	FLOORING	1996	425	21	20	21		264	12
13	FLOOR TILING	1996	4,105	205	20	205		2,531	13
14	FLOOR GROUT	1996	237	12	20	12		145	14
15	STAIRS	1996	200	0	10	0		200	15
16	REMODEL KITCHEN	1996	13,551	678	20	678		8,300	16
17	CORNER PROTECTORS	1996	2,200	0	10	0		2,200	17
18	CARPET	1996	415	0	5	0		415	18
19	A/C COMPRESSOR	1996	6,500	0	10	0		6,500	19
20	CARPET	1996	415	0	5	0		415	20
21	BRICK	1996	768	38	20	38		445	21
22	CARAGE DOOR	1996	667	33	20	33		387	22
23	BLACKTOP	1996	8,260	551	15	551		6,378	23
24	DISPOSAL	1996	950	63	15	63		734	24
25	CARPET	1997	2,255	0	5	0		2,255	25
26	FAUCETS	1997	738	49	15	49		570	26
27	PAINTING	1997	1,948	0	10	0		1,948	27
28	TILING	1997	18,869	943	20	943		10,928	28
29	LANDSCAPING	1997	1,480	0	10	0		1,480	29
30	SOFFIT	1997	4,495	225	20	225		2,398	30
31	SOFFIT ADDITION	1997	952	48	20	48		527	31
32	A/C COMPRESSOR & CONTROLLER	1997	10,811	991	10	991		10,811	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,991,547	\$ 32,851		\$ 32,851	\$ 0	\$ 1,749,476	34

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

Facility Name & ID Number WINNING WHEELS

0024745

Report Period Beginning:

7/1/2007

Ending:

6/30/2008

XL 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 12B, Carried Forward		\$ 1,991,547	\$ 32,851		\$ 32,851	\$	\$ 1,749,476	1
2	DINING ROOM GLASS	1997	973	49	20	49		523	2
3	FOLDING ROOM WALL/DOORS	1998	5,099	255	20	255		2,677	3
4	FLOORING	1998	2,642	242	10	242		2,642	4
5	ALARM SYSTEM	1998	952	87	10	87		952	5
6	CABINETS	1998	7,745	387	20	387		4,002	6
7	3.5 TON A/C	1998	1,257	115	10	115		1,257	7
8	NATURE TRIAL LANDSCAPING	1998	18,965	1,897	10	1,897		18,333	8
9	HALLWAY PAINTING	1998	1,285	129	10	129		1,242	9
10	DUMPSTER PAD & FENCING	1998	1,873	0	5	0		1,873	10
11	FENCING	1998	2,375	119	20	119		1,098	11
12	GAZEBO	1999	8,200	410	20	410		3,793	12
13	FLOORING	1999	5,553	555	10	555		5,091	13
14	REMODEL DINING ROOM	1999	6,724	672	10	672		6,164	14
15	ABOVE GROUND TANK	1999	14,566	1,457	10	1,457		13,352	15
16	LANDSCAPING	1999	6,091	0	7	0		6,091	16
17	SECURITY SYSTEM UPGRADE	1999	5,472	0	7	0		5,472	17
18	GAZEBO INSTALLATION	1999	1,998	100	20	100		907	18
19	FRONT LIGHT FIXTURES	1999	4,507	451	10	451		3,831	19
20	STORM WATER PUMP	1999	2,404	0	7	0		2,404	20
21	PARKING LOT	1999	13,819	1,382	10	1,382		11,746	21
22	KITCHEN & DINING ROOM ROOF	1999	41,800	2,787	15	2,787		23,919	22
23	BREAKROOM FLOORING	2000	1,293	0	7	0		1,293	23
24	BUG BLOWER	2000	1,265	127	10	127		1,075	24
25	CARPET	2000	4,597	0	5	0		4,597	25
26	MULTI-SENSORY ROOM	2000	14,966	379	39.5	379		2,968	26
27	INDEPENDENT WAY GARDEN	2000	34,023	1,701	20	1,701		13,042	27
28	THERAPY ANNEX	2000	1,046,330	26,489	39.5	26,489		203,085	28
29	NURSE STATION	2001	17,475	448	39	448		3,137	29
30	DOCTOR OFFICE TILE	2001	822	82	82	82		534	30
31	ENTRYWAYS TILE	2001	1,022	102	102	102		665	31
32	DIETARY ROOM TILE	2001	1,064	106	106	106		692	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,268,704	\$ 73,379		\$ 73,379	\$ 0	\$ 2,097,934	34

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

Facility Name & ID Number WINNING WHEELS

0024745

Report Period Beginning:

7/1/2007

Ending:

6/30/2008

XL 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 12C, Carried Forward		\$ 3,268,704	\$ 73,379		\$ 73,379	\$	\$ 2,097,934	1
2	ROOM TILE	2002	1,234	123	10	123		802	2
3	SHRUBS & PLANTS	2002	11,706	1,171	10	1,171		6,438	3
4	CERAMIC HALLWAY TILE	2003	4,687	469	10	469		2,109	4
5	UPGRADE WANDERGUARD & MAGNETIC	2004	7,606	380	20	380		1,489	5
6	FENCE W/GATE PLUS INSTALLATION	2004	12,483	832	15	832		3,052	6
7	CONCRETE SIDEWALKS	2004	6,242	312	20	312		1,118	7
8	WALL COVERING & CERAMIC	2005	4,642	464	10	464		1,625	8
9	DINING ROOM WINDOW	2005	1,732	87	20	87		267	9
10	A WING DAYROOM FLOORING	2005	2,475	248	10	248		619	10
11	FABRICATE ENTRANCE ARBOR W/PLANTER	2005	1,390	139	10	139		348	11
12	WINDOW TREATMENTS	2005	2,305	231	10	231		576	12
13	REAR ENTRANCE MATS	2005	2,681	383	7	383		958	13
14	WALL TRIM	2005	606	61	10	61		152	14
15	INSTALLATION OF CHAPEL WALL CARPET	2005	2,440	244	10	244		610	15
16	6 INSULATED WINDOWS	2006	1,520	76	20	76		190	16
17	BLACKTOP PARKING LOT	2006	3,400	680	5	680		1,020	17
18	CANVAS CANOPY	2007	3,260	326	10	326		489	18
19	RETILE 18 ROOM IN B WING	2007	12,594	630	20	630		892	19
20	GARAGE DOOR	2007	1,030	52	20	52		64	20
21	BOMANITE PATIO	2007	14,052	703	20	703		703	21
22	HUF COR ACCORDION DOOR	2007	598	43	7	43		43	22
23	OFFICE BLINDS	2007	1,961	98	10	98		98	23
24	3 DUAL PURPOSE WINDOW UNITS	2008	4,264	305	7	305		305	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)		\$ 3,373,612	\$ 81,433		\$ 81,433	\$ 0	\$ 2,121,900	34

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

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	\$ 514,476	\$ 74,228	\$ 74,228	\$ 0		\$ 294,967	71
72	Current Year Purchases	47,176	3,555	3,555	0		3,555	72
73	Fully Depreciated Assets	854,175			0		854,175	73
74					0			74
75	TOTALS	\$ 1,415,827	\$ 77,783	\$ 77,783	\$ 0		\$ 1,152,697	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	\$ 37,700	\$ 37,700	\$ 0	5	\$ 180,173	76
77	SNOW REMOVAL	2000 DODGE PICKUP	2001	28,254	0	0	0	5	28,254	77
78							0			78
79							0			79
80	TOTALS			\$ 288,220	\$ 37,700	\$ 37,700	\$ 0		\$ 208,427	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)	\$ 5,089,898	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 208,620	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 208,620	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 0	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,483,024	85

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

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

G. Construction-in-Progress

	Description	Cost	
92	NEW PROJECT	\$ 38,450	92
93			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

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 amortize _____
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. _____/2009 \$ _____

13. _____/2010 \$ _____

14. _____/2011 \$ _____

* 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		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$		\$	\$ 0
2	Books and Supplies		0		0
3	Classroom Wages (a)		4,281		21,926
4	Clinical Wages (b)		0		0
5	In-House Trainer Wages (c)		2,300	15,660	0
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests			0	0
9	TOTALS	\$	6,581	\$ 37,586	\$ 0
10	SUM OF line 9, col. 1 and 2 (e)	\$	44,167		

- (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

C. CONTRACTUAL INCOME

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

\$ 21,240

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	16
2. From other facilities (f)	20
DROP-OUTS	
1. From this facility	8
2. From other facilities (f)	10
TOTAL TRAINED	54

- (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	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$	374	\$ 15,403	\$	374	\$ 15,403	1
2	Licensed Speech and Language Development Therapist		hrs		1,107	42,210		1,107	42,210	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		1,436	40,354		1,436	40,354	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	600					600	10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$ 600	2,917	\$ 97,967	\$	2,917	\$ 98,567	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	\$ 523,193	\$ 556,826	1
2 Cash-Patient Deposits			2
3 Accounts & Short-Term Notes Receivable- Patients (less allowance 896921-65913)	845,598	1,403,061	3
4 Supply Inventory (priced at COST)	24,549	39,641	4
5 Short-Term Investments	1,334,582	2,493,854	5
6 Prepaid Insurance	(4,950)	(1,649)	6
7 Other Prepaid Expenses	3,694	13,154	7
8 Accounts Receivable (owners or related parties)	601,949	1,789,367	8
9 Other(specify): ATTACHED	915,647	915,647	9
10 TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,244,262	\$ 7,209,902	10
B. Long-Term Assets			
11 Long-Term Notes Receivable			11
12 Long-Term Investments	1,365	1,365	12
13 Land	23,500	319,861	13
14 Buildings, at Historical Cost	3,343,940	7,362,592	14
15 Leasehold Improvements, at Historical Cost		179,437	15
16 Equipment, at Historical Cost	1,699,610	3,032,532	16
17 Accumulated Depreciation (book methods)	(3,451,696)	(5,326,417)	17
18 Deferred Charges	2,784	(34,290)	18
19 Organization & Pre-Operating Costs	22,848	22,848	19
20 Accumulated Amortization - Organization & Pre-Operating Costs	(22,848)	(22,848)	20
21 Restricted Funds			21
22 Other Long-Term Assets (specify):			22
23 Other(specify): CONSTRUCTION IN PROGRE	38,450	70,561	23
24 TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,657,953	\$ 5,605,642	24
25 TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,902,216	\$ 12,815,544	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26 Accounts Payable	\$ 168,787	\$ 250,209	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits			28
29 Short-Term Notes Payable		72,128	29
30 Accrued Salaries Payable	121,090	180,665	30
31 Accrued Taxes Payable (excluding real estate taxes)	111	7,266	31
32 Accrued Real Estate Taxes(Sch.IX-B)	0	5,767	32
33 Accrued Interest Payable			33
34 Deferred Compensation			34
35 Federal and State Income Taxes			35
Other Current Liabilities(specify):			
36 DUE TO OTHER FUNDS	503,590	1,789,367	36
37			37
38 TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 793,577	\$ 2,305,402	38
D. Long-Term Liabilities			
39 Long-Term Notes Payable			39
40 Mortgage Payable	0	1,599,648	40
41 Bonds Payable			41
42 Deferred Compensation			42
Other Long-Term Liabilities(specify):			
43			43
44 ADVANCE	7,691	49,028	44
45 TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 7,691	\$ 1,648,676	45
46 TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 801,268	\$ 3,954,078	46
47 TOTAL EQUITY(page 18, line 24)	\$ 5,100,948	\$ 8,861,466	47
48 TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,902,216	\$ 12,815,544	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,969,134	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,969,134	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(71,501)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	203,315	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		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 131,814	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 0	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 5,100,948	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Facility Name & ID Number WINNING WHEELS

0024745

Report Period Beginning: 7/1/2007

Page 19
Ending: 6/30/2008

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,039,070	1
2	Discounts and Allowances for all Levels	6,000	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,033,070	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)	\$ 0	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	50,478	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	13,780	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)	\$ 64,258	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	55,654	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 55,654	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	TRANSPORTATION	66,547	28
28a	MISC.	9,549	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 76,096	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,229,078	30

Expenses		Amount	
A. Operating Expenses			
31	General Services	1,026,375	31
32	Health Care	2,108,589	32
33	General Administration	912,097	33
B. Capital Expense			
34	Ownership	209,598	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	43,920	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,300,579	40
41	Income before Income Taxes (line 30 minus line 40)**	(71,501)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (71,501)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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.

	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	1,652	2,052	\$ 54,607	\$ 26.61	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,005	7,851	183,717	23.40	3
4	Licensed Practical Nurses	14,828	16,032	291,862	18.20	4
5	CNAs & Orderlies	69,111	73,720	824,128	11.18	5
6	CNA Trainees	2,952	2,952	26,207	8.88	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,673	7,574	100,669	13.29	8
9	Activity Director	1,670	1,702	24,339	14.30	9
10	Activity Assistants	1,938	2,034	28,856	14.19	10
11	Social Service Workers	5,819	6,400	86,704	13.55	11
12	Dietician					12
13	Food Service Supervisor	1,486	1,871	21,085	11.27	13
14	Head Cook	1,992	2,152	22,043	10.24	14
15	Cook Helpers/Assistants	17,353	18,703	164,580	8.80	15
16	Dishwashers					16
17	Maintenance Workers	7,390	8,707	96,934	11.13	17
18	Housekeepers	8,791	9,390	85,689	9.13	18
19	Laundry	9,063	9,925	98,085	9.88	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	1,947	2,067	36,703	17.76	22
23	Office Manager	1,964	2,120	21,215	10.01	23
24	Clerical	4,028	4,405	47,586	10.80	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	1,911	2,089	29,143	13.95	31
32	Other Health Care COGNITIVE REH	1,353	1,526	27,771	18.20	32
33	Other(specify) TRANSPORTATI	2,358	2,578	25,331	9.83	33
34	TOTAL (lines 1 - 33)	171,284	185,850	\$ 2,297,254 *	\$ 12.36	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	248	\$ 9,011	1,3	35
36	Medical Director	260	26,000	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	1,436	40,354	10a,3	40
41	Occupational Therapy Consultant	374	15,403	10a,3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1,107	42,210	10a,3	43
44	Activity Consultant	25	1,250	11,3	44
45	Social Service Consultant	6	600	10a,3	45
46	Other(specify) Equestrian Therapy	480	12,000	11,3	46
47	Physiatrist Consultant	144	18,000	9,3	47
48	Lab & Xray	146	4,391	10,3	48
49	TOTAL (lines 35 - 48)	4,274	\$ 171,619		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	40	1,113	10,3	51
52	Certified Nurse Assistants/Aides	23	395	10,3	52
53	TOTAL (lines 50 - 52)	63	\$ 1,508		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	Amount of Expense Amortized Per Year									
				5	6	7	8	9	10	11	12	13	
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	
1	PAINTING	7/2000	\$ 6,373	5 YRS	\$ 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		\$ 1,434	\$ 319	\$ 647	\$ 978	\$ 977	\$ 818	\$ 659	\$ 330	

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL HEALTH CARE ASSOC \$4195
- (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. \$ 23,369 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. \$ 43,920
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. \$ 13,780
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? YES
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. \$ 66,547
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, VANOSDOL 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? NO If no, please explain. Not Complete
- (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 services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

WINNING WHEELS, INC
Report Period Beginning:
Travel and Seminar Analysis
Acct #

7/1/2007 Ending 6/30/2008

9140-00	TRAVEL & SEMINAR		
	Seminars	19301	
	Instate travel	1838	
	Other	1480	\$22,619.00
	Total		
	Per Schedule V line 24		\$22,619.00

**Facility Names & Addresses
for Which Winning Wheels Trained CNA's**

Big Meadows Nursing Home
1000 Longmoor Avenue
Savanna, IL 61270

Pleasant View Nursing Home
500 N. Jackson St.
Morrison, IL 61270

Promise Jobs Iowa at Work
315 Fifth Avenue South
Clinton, IA 52732