

Margel S. Peddicord, CPA
5300 Jaeger Dr.
Springfield, IL 62711
Phone 217-787-8554

ACCOUNTANT'S REPORT

The following schedules containing the financial statements and related disclosures of Winning Wheels, as of and for the year ended June 30, 2009, included in the accompanying prescribed form have been compiled by me:

XV Balance Sheet
XVI Changes in Equity
XVII Income Statement
XVIII Staffing & Salary Costs

My compilation was limited to presenting in the form prescribed by the state of Illinois Department of Healthcare and Family Services, information that is the representation of management. I have not audited or reviewed the financial statements and related disclosures referred to above, and accordingly, do not express an opinion or any other form of assurance on them.

The financial statements and related disclosures referred to above are presented in accordance with the state of Illinois' requirements which differ from generally accepted accounting principles. Accordingly, these financial statements' related disclosures are not designed for those who are not informed about such differences.

I did not compile or prepare Schedules I through XIV and XIX & XX. These schedules were prepared by representatives of Winning Wheels.

Margel S. Peddicord, CPA

January 21, 2010

Facility Name & ID Number WINNING WHEELS

0024745 Report Period Beginning: 07/01/2008 Ending: 06/30/2009

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	80	Skilled (SNF)	80	29,200	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	80	TOTALS	80	29,200	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other		Total
8	SNF			220	220	8
9	SNF/PED					9
10	ICF	26,373	1,702		28,075	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,373	1,702	220	28,295	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.90%

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

671 (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 01/01/1979

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 220

Medicare Intermediary Adminastar Federal/National Govt Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 06/30/2009 Fiscal Year: 06/30/2009

* 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	211,914	29,491	11,750	253,155		253,155	253,155		1	
2	Food Purchase		242,842		242,842		242,842	242,842		2	
3	Housekeeping	86,843	36,102		122,945		122,945	122,945		3	
4	Laundry	107,380	16,542		123,922		123,922	123,922		4	
5	Heat and Other Utilities			135,134	135,134		135,134	135,134		5	
6	Maintenance	96,335	69,044	28,997	194,376		194,376	977	195,353	6	
7	Other (specify):*									7	
8	TOTAL General Services	502,472	394,021	175,881	1,072,374		1,072,374	977	1,073,351	8	
	B. Health Care and Programs										
9	Medical Director			43,500	43,500		43,500	43,500		9	
10	Nursing and Medical Records	1,417,655	194,268	10,829	1,622,752	(33,117)	1,589,635	1,589,635		10	
10a	Therapy	89,787	1,940	193,957	285,684		285,684	285,684		10a	
11	Activities	40,820	8,794	15,907	65,521		65,521	65,521		11	
12	Social Services	105,417			105,417		105,417	105,417		12	
13	CNA Training		1,277	3,891	5,168	33,117	38,285	(8,489)	29,796	13	
14	Program Transportation	38,669	28,518		67,187		67,187	67,187		14	
15	Other (specify):* COGNITIVE REHA	33,500		160	33,660		33,660	33,660		15	
16	TOTAL Health Care and Programs	1,725,848	234,797	268,244	2,228,889		2,228,889	(8,489)	2,220,400	16	
	C. General Administration										
17	Administrative			200,848	200,848		200,848	200,848		17	
18	Directors Fees									18	
19	Professional Services			59,939	59,939		59,939	59,939		19	
20	Dues, Fees, Subscriptions & Promotions			33,940	33,940		33,940	(5,893)	28,047	20	
21	Clerical & General Office Expenses	97,754	30,824	23,601	152,179		152,179	152,179		21	
22	Employee Benefits & Payroll Taxes			396,905	396,905		396,905	396,905		22	
23	Inservice Training & Education			1,178	1,178		1,178	1,178		23	
24	Travel and Seminar			17,663	17,663		17,663	(4,375)	13,288	24	
25	Other Admin. Staff Transportation									25	
26	Insurance-Prop.Liab.Malpractice			46,656	46,656		46,656	46,656		26	
27	Other (specify):*									27	
28	TOTAL General Administration	97,754	30,824	780,730	909,308		909,308	(10,268)	899,040	28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,326,074	659,642	1,224,855	4,210,571		4,210,571	(17,780)	4,192,791	29	

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

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

Facility Name & ID Number

WINNING WHEELS

#0024745

Report Period Beginning:

07/01/2008

Ending:

06/30/2009

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	
	D. Ownership											
30	Depreciation			192,958	192,958		192,958		192,958			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			192,958	192,958		192,958		192,958			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 (sum of lines 29, 37 & 44)	2,326,074	659,642	1,461,613	4,447,329		4,447,329	(17,780)	4,429,549			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 FYE09
Prophetstown, IL 61277
IDPH #0024745

RECLASSIFICATIONS

Line #		DR.	CR.
13	CNA Training	\$ 11,872	
10	Nursing & Medical Records		\$ 11,872

Reclassify training wages

Regi Fortune wages for training classes

13	CNA Training	\$ 21,245	
10	Nursing & Medical Records		\$ 21,245

Reclassify training wages

Employee wages for attending training classes

ADJUSTMENTS

Page 5 line 29 Other Adjustments

24	Out of State Travel		(4,375)
6	Deferred Maintenance		977
13	Public Relations Expense		(5,893)
	Total	\$	<u>(9,291)</u>

BALANCE SHEET PAGE 17

9	OTHER CURRENT ASSETS		
	Depoit in Frontier Hollow	\$ 296,566	
	Deposit in Pinnacle Place	226,851	
	Investment in Al's Place	9,753	
	Total	\$	<u>533,170</u>

Facility Name & ID Number **WINNING WHEELS**

0024745

Report Period Beginning: **07/01/2008**

Ending: **06/30/2009**

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-	BHF USE	
			ence	ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				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				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				25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees	(8,489)	13		27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attached	(9,291)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (17,780)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (17,780)		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

BHF USE ONLY						
48		49		50		51
						52

WINNING WHEELS

ID# 0024745

Report Period Beginning: 07/01/2008

Ending: 06/30/2009

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	OUT OF STATE TRAVEL	\$ (4,375)	24	1
2	Public Relations Expense	(5,893)	20	2
3	Deferred Maintenance	977	6	3
4	CNA Training	(8,489)		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		(17,780)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WINNING WHEELS# 0024745

Report Period Beginning:

07/01/2008

Ending:

06/30/2009

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	977	0	0	0	0	0	0	0	0	0	0	977	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	977	0	977	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	(8,489)	0	0	0	0	0	0	0	0	0	0	(8,489)	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	(8,489)	0	(8,489)	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	(5,893)	0	0	0	0	0	0	0	0	0	0	(5,893)	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	(4,375)	0	0	0	0	0	0	0	0	0	0	(4,375)	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	(10,268)	0	(10,268)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(17,780)	0	(17,780)	29									

STATE OF ILLINOIS

Facility Name & ID Number WINNING WHEELS# 0024745

Report Period Beginning:

07/01/2008 Ending:

Summary B

06/30/2009

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	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	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)	(17,780)	0	0	0	0	0	0	0	0	0	0	(17,780)	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%	STRIVE	Prophetstown	Lyndon Play & Learn Center	Lyndon	Child Day Care
		Big Meadows (building 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:

07/01/2008

Ending:

06/30/2009

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: 07/01/2008

Ending: 6/30/2009

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

Facility Name & ID Number

WINNING WHEELS

0024745

Report Period Beginning:

07/01/2008

Ending:

06/30/2009

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

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

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

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill

1. Real Estate Tax accrual used on 2008 report.								
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.)								
3. Under or (over) accrual (line 2 minus line 1).								
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)								
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.)								
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.)								
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.								

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2004	_____	8
	2005	_____	9
	2006	_____	10
	2007	_____	11
	2008	_____	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2008	\$ _____	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:** 2008 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 2008 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2008.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2008 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 2009 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.

2008 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 2008 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 2008.

	(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 and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

Facility Name & ID Number WINNING WHEELS

0024745 Report Period Beginning:

07/01/2008 Ending:

06/30/2009

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (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: PRE-OPENING COSTS
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number WINNING WHEELS

0024745

Report Period Beginning:

07/01/2008

Ending:

06/30/2009

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	80		1979	1979	\$ 1,447,685	\$ 16,589	VARIOUS	\$ 16,589		\$ 1,305,541	4
5			1979	1979	22,848		5			22,848	5
6			1985	1985	4,226		20			4,226	6
7			1987	1987	13,305		20			13,305	7
8											8
	Improvement Type**										
9		TILE	1985		585		20			585	9
10		AIR CONDITIONER COMPRESSOR	1986		2,576		10			2,576	10
11		LAVATORIES	1987		780		20			780	11
12		PATIO	1987		3,089		20			3,089	12
13		TRACK CURTAIN SYSTEM	1987		1,306		20			1,306	13
14		CEDAR POST RAILS	1987		230		10			230	14
15		SHOWER DOORS	1987		350		15			350	15
16		BLACKTOP PATH	1987		5,946		20			5,946	16
17		BATH IMPROVEMENTS	1988		11,342		15			11,342	17
18		TV ANTENNA BOOSTER	1988		455		10			455	18
19		FAUCETS	1988		597		15			597	19
20		HEAT A/C UNIT	1988		2,869		15			2,869	20
21		MOTORS	1988		1,037		10			1,037	21
22		EMPLOYEE LOUNGE	1988		3,235		20			3,235	22
23		DOOR OPENERS	1988		3,505		15			3,505	23
24		BATH PARTITIONS	1988		764		10			764	24
25		BLACKTOP	1988		5,023		15			5,023	25
26		COUNTERTOP SHELVES	1988		1,678		15			1,678	26
27		FITNESS TRAIL	1988		945		5			945	27
28		PARKING LOT SEALER	1988		4,000		4			4,000	28
29		BACK ROOM RENOVATIONS	1988		30,717		15			30,717	29
30		SIGNAGE	1988		872	14	20	14		872	30
31		HEATERS MOTORS THERMOSTAT	1988		1,010		5			1,010	31
32		LANDSCAPING	1989		4,715		10			4,715	32
33		BLACKTOP ROCK & SEALING	1989		5,906		15			5,906	33
34		DRAPES	1989		1,083		10			1,083	34
35		BATHROOM REMODELING	1990		11,976		8			11,976	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number WINNING WHEELS

0024745

Report Period Beginning:

07/01/2008

Ending:

06/30/2009

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	WATER SOFTENER	1990	\$ 5,858	\$		\$	\$	\$ 5,858	37
38	SIGN	1990	3,700					3,700	38
39	PARKING LOT LIGHTS	1990	6,258					6,258	39
40	SHRUBS	1990	1,235					1,235	40
41	BATHROOM IMPROVEMENTS	1991	12,802					12,802	41
42	AUTOMATIC DOOR OPENERS	1991	4,455					4,455	42
43	REMODEL DINING ROOM	1992	34,562	1,728		1,728		29,377	43
44	REMODEL A & B WINGS	1992	18,929	946		946		15,774	44
45	HOT WATER BOILER	1992	4,272					4,272	45
46	RT CLINIC	1993	2,992	150		150		2,431	46
47	FLOWER BED	1993	1,142					1,142	47
48	KITCHEN LIGHTS & VENTS	1993	3,777	189		189		3,038	48
49	LAUNDRY ENGR. & ARCHITECT	1993	3,735	187		187		2,988	49
50	LAUNDRY WATER HEATER & CONDITIONER	1993	4,813					4,813	50
51	LOBBY & OFFICES BLINDS & VALANCES	1993	3,295					3,295	51
52	LAUNDRY ROOM	1993	28,023	1,401		1,401		21,951	52
53	INTERIOR SIGN	1994	900					900	53
54	RT CLINIC COUNTER TOPS	1994	1,283	64		64		994	54
55	REDECORATE LOBBY	1994	29,817	1,491		1,491		22,860	55
56	GAS WATER HEATER	1994	2,148	119		119		2,148	56
57	SHELTER ROOF	1994	514	31		31		514	57
58	REDECORATE OFFICE	1994	1,587					1,587	58
59	REDECORATE ROOMS & HALLS	1994	11,264					11,264	59
60	SHRUBS & PLANTS	1994	7,501					7,501	60
61	PATIO	1994	8,723	582		582		8,674	61
62	CARPETING	1994	680					680	62
63	COUNTER TOP	1994	1,241	62		62		920	63
64	DOOR ALARM SYSTEM	1994	6,962					6,962	64
65	DINING ROOM DECORATION	1995	1,870					1,870	65
66	ACCORDIAN DOORS	1995	12,071	604		604		8,701	66
67	AIR CONDITIONER	1995	3,575					3,575	67
68	ROOF	1995	42,900	2,145		2,145		30,030	68
69	GARAGE	1995	27,086	1,354		1,354		18,509	69
70	TOTAL (lines 4 thru 69)		\$ 1,894,625	\$ 27,656		\$ 27,656	\$	\$ 1,703,589	70

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

Facility Name & ID Number WINNING WHEELS

0024745

Report Period Beginning:

07/01/2008

Ending:

06/30/2009

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,894,625	\$ 27,656		\$ 27,656	\$	\$ 1,703,589	1
2	SWING DOOR OPERATOR	1996	4,246		10			4,246	2
3	GARAGE WIRING	1996	3,384	226	15	226		3,046	3
4	CARPET	1996	811		5			811	4
5	GARAGE DOOR	1996	1,519	76	20	76		1,025	5
6	HEATER	1996	1,506	100	15	100		1,347	6
7	WALLPAPER	1996	471		10			471	7
8	CEILING TILE	1996	4,157	208	20	208		2,789	8
9	WALLPAPER BACK OFFICE	1996	587		10			587	9
10	FLOORING	1996	425	21	20	21		285	10
11	FLOOR TILING	1996	4,105	205	20	205		2,737	11
12	FLOOR GROUT	1996	237	12	20	12		157	12
13	STAIRS	1996	200		10			200	13
14	REMODEL KITCHEN	1996	13,551	678	20	678		8,977	14
15	CORNER PROTECTORS	1996	2,200		10			2,200	15
16	CARPET	1996	415		5			415	16
17	A/C COMPRESSOR	1996	6,500		10			6,500	17
18	CARPET	1996	415		5			415	18
19	BRICK	1996	768	38	20	38		483	19
20	CARAGE DOOR	1996	667	33	20	33		420	20
21	BLACKTOP	1996	8,260	551	15	551		6,929	21
22	DISPOSAL	1996	950	63	15	63		797	22
23	CARPET	1997	2,255		5			2,255	23
24	FAUCETS	1997	738	49	15	49		619	24
25	PAINTING	1997	1,948		10			1,948	25
26	TILING	1997	18,869	943	20	943		11,872	26
27	LANDSCAPING	1997	1,480		10			1,480	27
28	SOFFIT	1997	4,495	225	20	225		2,622	28
29	SOFFIT ADDITION	1997	952	48	20	48		575	29
30	A/C COMPRESSOR & CONTROLLER	1997	10,811		10			10,811	30
31	DINING ROOM GLASS	1997	973	49	20	49		572	31
32	FOLDING ROOM WALL/DOORS	1998	5,099	255	20	255		2,932	32
33	FLOORING	1998	2,642		10			2,642	33
34	TOTAL (lines 1 thru 33)		\$ 2,000,261	\$ 31,436		\$ 31,436	\$	\$ 1,786,754	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:

07/01/2008

Ending:

06/30/2009

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 2,000,261	\$ 31,436		\$ 31,436	\$	\$ 1,786,754	1
2	ALARM SYSTEM	1998	952		10			952	2
3	CABINETS	1998	7,745	387	20	387		4,389	3
4	3.5 TON A/C	1998	1,257		10			1,257	4
5	NATURE TRIAL LANDSCAPING	1998	18,965	632	10	632		18,965	5
6	HALLWAY PAINTING	1998	1,285	43	10	43		1,285	6
7	DUMPSTER PAD & FENCING	1998	1,873		5			1,873	7
8	FENCING	1998	2,375	119	20	119		1,217	8
9	GAZEBO	1999	8,200	410	20	410		4,203	9
10	FLOORING	1999	5,553	463	10	463		5,553	10
11	REMODEL DINING ROOM	1999	6,724	560	10	560		6,724	11
12	ABOVE GROUND TANK	1999	14,566	1,214	10	1,214		14,566	12
13	LANDSCAPING	1999	6,091		7			6,091	13
14	SECURITY SYSTEM UPGRADE	1999	5,472		7			5,472	14
15	GAZEBO INSTALLATION	1999	1,998	100	20	100		1,007	15
16	FRONT LIGHT FIXTURES	1999	4,507	451	10	451		4,282	16
17	STORM WATER PUMP	1999	2,404		7			2,404	17
18	PARKING LOT	1999	13,819	1,382	10	1,382		13,128	18
19	KITCHEN & DINING ROOM ROOF	1999	41,800	2,787	15	2,787		26,706	19
20	BREAKROOM FLOORING	2000	1,293		7			1,293	20
21	BUG BLOWER	2000	1,265	127	10	127		1,202	21
22	CARPET	2000	4,597		5			4,597	22
23	MULTI-SENSORY ROOM	2000	14,966	379	39.5	379		3,347	23
24	INDEPENDENT WAY GARDEN	2000	34,023	1,701	20	1,701		14,743	24
25	THERAPY ANNEX	2000	1,046,330	26,489	39.5	26,489		229,574	25
26	NURSE STATION	2001	17,475	448	39	448		3,585	26
27	DOCTOR OFFICE TILE	2001	822	82	10	82		617	27
28	ENTRYWAYS TILE	2001	1,022	102	10	102		767	28
29	DIETARY ROOM TILE	2001	1,064	106	10	106		798	29
30	ROOM TILE	2002	1,234	123	10	123		925	30
31	SHRUBS & PLANTS	2002	11,706	1,171	10	1,171		7,609	31
32	CERAMIC HALLWAY TILE	2003	4,687	469	10	469		2,578	32
33	UPGRADE WANDERGUARD & MAGNETIC	2004	7,606	380	20	380		1,870	33
34	TOTAL (lines 1 thru 33)		\$ 3,293,937	\$ 71,561		\$ 71,561	\$	\$ 2,180,333	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:

07/01/2008

Ending:

06/30/2009

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		\$ 3,293,937	\$ 71,561		\$ 71,561	\$	\$ 2,180,333	1
2	FENCE W/GATE PLUS INSTALLATION	2004	12,483	832	15	832		3,884	2
3	CONCRETE SIDEWALKS	2004	6,242	312	20	312		1,431	3
4	WALLCOVERING & CERAMIC	2005	4,642	464	10	464		2,089	4
5	DINING ROOM WINDOW	2005	1,732	87	20	87		354	5
6	A WING DAYROOM FLOORING	2005	2,475	248	10	248		866	6
7	FABRICATE ENTRANCE ARBOR W/PLANTER	2005	1,390	139	10	139		486	7
8	WINDOW TREATMENTS	2005	2,305	230	10	230		807	8
9	REAR ENTRANCE MATS	2005	2,681	383	7	383		1,340	9
10	WALL TRIM	2005	606	61	10	61		212	10
11	INSTALLATION OF CHAPEL WALL CARPET	2005	2,440	244	10	244		854	11
12	6 INSULATED WINDOWS	2006	1,520	76	20	76		266	12
13	BLACKTOP PARKING LOT	2006	3,400	680	5	680		1,700	13
14	CANVAS CANOPY	2007	3,260	326	10	326		815	14
15	RETILE 18 ROOM IN B WING	2007	12,594	630	20	630		1,522	15
16	GARAGE DOOR	2007	1,030	51	20	51		116	16
17	BOMANITE PATIO	2007	14,052	703	20	703		1,405	17
18	HUFCOR ACCORDION DOOR	2007	598	85	7	85		128	18
19	OFFICE BLINDS	2007	1,961	196	10	196		294	19
20	3 DUAL PURPOSE WINDOW UNITS	2008	4,264	609	7	609		914	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)		\$ 3,373,612	\$ 77,917		\$ 77,917	\$	\$ 2,199,816	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:

07/01/2008

Ending:

06/30/2009

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	\$ 561,653	\$ 76,566	\$ 76,566	\$		\$ 375,087	71
72	Current Year Purchases	33,297	2,406	2,406			2,406	72
73	Fully Depreciated Assets	854,175					854,175	73
74								74
75	TOTALS	\$ 1,449,125	\$ 78,972	\$ 78,972	\$		\$ 1,231,668	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	\$ 32,105	\$ 32,105	\$	5	\$ 212,279	76
77	TRANSPORT RESIDENTS	2009 FORD E250 VAN	2009	39,629	3,963	3,963		5	3,963	77
78	SNOW REMOVAL	2000 DODGE PICKUP	2001	28,254				5	28,254	78
79										79
80	TOTALS			\$ 327,849	\$ 36,068	\$ 36,068	\$		\$ 244,496	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)		\$ 5,174,086	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 192,957	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 192,957	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)		\$ 3,675,980	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

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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

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

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

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

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

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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	325	842	1,170	2,337
3	Classroom Wages (a)	8,149	8,333		16,482
4	Clinical Wages (b)		4,763		4,763
5	In-House Trainer Wages (c)	3,463	2,721	5,688	11,872
6	Transportation				
7	Contractual Payments		500	681	1,181
8	CNA Competency Tests		700	950	1,650
9	TOTALS	\$ 11,937	\$ 17,859	\$ 8,489	\$ 38,285
10	SUM OF line 9, col. 1 and 2 (e)	\$ 29,796			

- (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.

\$ 16,855

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	<u>11</u>
2. From other facilities (f)	<u>15</u>
DROP-OUTS	
1. From this facility	<u>14</u>
2. From other facilities (f)	<u>8</u>
TOTAL TRAINED	48

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	10a.3	hrs	\$		\$	20,232	\$		\$	20,232	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs				61,620				61,620	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	10a.3	hrs				109,154				109,154	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								2,951	10
11	Academic Education		hrs									11
12	Other (specify):											12
13	Other (specify):											13
14	TOTAL			\$		\$	191,006	\$		\$	193,957	14

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

Facility Name & ID Number **WINNING WHEELS**# **0024745**Report Period Beginning: **07/01/2008**

Ending:

06/30/2009**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **06/30/2009**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,246,274	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>4,887</u>)	699,880		3
4	Supply Inventory (priced at)	30,082		4
5	Short-Term Investments	930,538		5
6	Prepaid Insurance	44,597		6
7	Other Prepaid Expenses	27,225		7
8	Accounts Receivable (owners or related parties)	444,188		8
9	Other(specify): <u>See Attached</u>	533,170		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,955,954	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	23,500		13
14	Buildings, at Historical Cost	3,343,940		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,772,536		16
17	Accumulated Depreciation (book methods)	(3,643,677)		17
18	Deferred Charges	11,260		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(9,454)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Const. In Progress</u>	38,450		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,536,555	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,492,509	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 84,362	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	252,275		30
31	Accrued Taxes Payable (excluding real estate taxes)	33,555		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 370,192	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Advance</u>	7,777		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 7,777	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 377,969	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 5,114,540	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,492,509	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,100,948	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,100,948	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(24,204)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	37,796	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)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 13,592	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)		23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 5,114,540	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number WINNING WHEELS# 0024745Report Period Beginning: 07/01/2008Ending: 06/30/2009

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,327,216	1
2	Discounts and Allowances for all Levels	(6,000)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,321,216	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	7,881	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	13,733	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)	\$ 21,614	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	3,267	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,267	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc	605	28
28a	Transportation	76,423	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 77,028	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,423,125	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,072,374	31
32	Health Care	2,224,998	32
33	General Administration	913,199	33
B. Capital Expense			
34	Ownership	192,958	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)*	\$ 4,447,329	40
41	Income before Income Taxes (line 30 minus line 40)**	(24,204)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (24,204)	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.

Facility Name & ID Number WINNING WHEELS

0024745

Report Period Beginning: 07/01/2008

Ending: 06/30/2009

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	3,606	3,990	\$ 114,250	\$ 28.63	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,778	5,745	130,212	22.67	3
4	Licensed Practical Nurses	15,076	17,093	326,127	19.08	4
5	CNAs & Orderlies	68,606	71,891	786,275	10.94	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,867	9,794	128,828	13.15	8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	7,096	7,660	105,588	13.78	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,377	23,212	210,720	9.08	15
16	Dishwashers					16
17	Maintenance Workers	7,845	8,688	97,033	11.17	17
18	Housekeepers	8,437	8,993	77,092	8.57	18
19	Laundry	10,906	11,809	110,066	9.32	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	8,728	9,662	114,540	11.85	22
23	Office Manager					23
24	Clerical					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)	1,709	1,830	33,463	18.29	30
31	Medical Records	1,895	2,088	29,244	14.01	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Transportation</u>	5,695	6,181	62,636	10.13	33
34	TOTAL (lines 1 - 33)	174,621	188,636	\$ 2,326,074 *	\$ 12.33	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	294	\$ 11,750	1.3	35
36	Medical Director	240	24,000	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant	21	2,100	10.3	38
39	Pharmacist Consultant	52	2,600	10.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	35	1,750	11.3	44
45	Social Service Consultant				45
46	Other(specify) <u>CARF</u>	34	2,847	17.3	46
47	<u>Psychological Consultant</u>	20	2,950	10A.3	47
48	<u>Physiatrist Consultant</u>	156	19,500	9.3	48
49	TOTAL (lines 35 - 48)	852	\$ 67,497		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			51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)		\$	53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Tami Tegeler	Administrator		\$	Workers' Compensation Insurance	\$ 102,241	IDPH License Fee	\$ 1,990	
(Salary included in Management fees, Line 17, col 3)				Unemployment Compensation Insurance	8,291	Advertising: Employee Recruitment	5,529	
				FICA Taxes	174,009	Health Care Worker Background Check		
				Employee Health Insurance	38,780	(Indicate # of checks performed)	870	
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		IHCA	4,195	
				LIFE	5,059	CARF	1,280	
TOTAL (agree to Schedule V, line 17, col. 1)			\$	RETIREMENT	11,142	DUES, FEES, AND SUBSCRIPTIONS	6,842	
(List each licensed administrator separately.)			\$	DISABILITY	18,504	COMMUNITY RELATIONS/MARKETING	11,099	
				PHYSICALS	1,475	DONATIONS	2,136	
B. Administrative - Other				CHILDCARE	15,674	Less: Public Relations Expense	(5,893)	
Description			Amount	TUITION ASSISTANCE	3,270	Non-allowable advertising	()	
American Health Enterprises			\$ 198,000	EMPLOYEE MISC. BENEFITS	18,460	Yellow page advertising	()	
CARF Consulting			2,848					
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 396,905	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 28,048	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 200,848					
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
LVC, CPA	YEAR END AUDIT FEES		\$ 16,171			\$	Out-of-State Travel	\$ (4,375)
WARD, MURRAY, PACE	LEGAL FEES		1,755					
MDI ACHIEVE	SOFTWARE FEES		8,007					
JOHN PYSE CONSULTING	COMPUTER CONSULTING		24,386				In-State Travel	5,527
EHEALTH DATA SOLUTIONS	SOFTWARE FEES		2,700					
T6 BROADBAND	INTERNET EMAIL SERVER		735					
JCM CONSULTING	Software fees		625					
MIDWEST AUTOMATED TIME	TIME CLOCK MAINT.		730				Seminar Expense	12,136
SAGE Software	Financial software		1,856					
Network Solutions	Domain Reg. & hosting		1,603					
GoToMYPC	Computer Maint Fee		622					
Other computer & software			749				Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)			\$ 59,939	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	\$ 13,288
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications

**See instructions.

Winning Wheels, Inc.
2009 Cost Report
Travel and Seminars

Title Activity Seminar
Location Springfield, IL
Dates 8/19/2008
Attendees Karla Belzer
Cost \$ 185

Title ARN Certification
Location Glenview, IL
Dates 8/20/2008
Attendees Sue Jacobs
Cost \$ 215

Title Best Care II
Location Hinsdale, IL
Dates 2/26/2009
Attendees Tami Tegeler
Cost \$ 140

Title Brain Injury Conference
Location Chicago, IL
Dates 11/10/2008
Attendees Tami Tegeler, Diane Dynes, Sheri Kenworthy
Cost \$ 1,876

Title CARF Seminar
Location Chicago, IL
Dates 9/7/08 - 9/9/08
Attendees Tami Tegeler
Cost \$ 475

Title CMS Quality of Life
Location Peoria, IL
Dates 6/19/2009
Attendees Diane Dynes
Cost \$ 101

Winning Wheels, Inc.
2009 Cost Report
Travel and Seminars

Title Food Service Training
Location Springfield, IL
Dates 1/26/2009
Attendees Valerie Armstrong
Cost \$ 115

Title F309 Provider/Surveyor
Location Peoria, IL
Dates 3/3/2009
Attendees Tami Tegeler
Cost \$ 95

Title IHCA Convention
Location Peoria, IL
Dates 9/8/08 - 9/11/08
Attendees Tami Tegeler, John Smith, Karla Belzer,
Mary Burgess, Valerie Armstrong, Shari
Kenworthy
Cost \$ 2,852

Winning Wheels, Inc.
2009 Cost Report
Travel and Seminars

Title IHCA Meeting
Location Springfield, IL
Dates 7/10/2008
Attendees Sue Jacobs
Cost \$ 188

Title IHCA Meeting
Location Springfield, IL
Dates 2/9/2009
Attendees Sue Jacobs
Cost \$ 178

Title NARHA Conference
Location Willowbrook, IL
Dates 2/21/09 - 2/22/09
Attendees Karla Belzer
Cost \$ 491

Title Rehab Conference
Location Davenport, IA (within 50 miles)
Dates 11/5/2008
Attendees Gayla Bohms, Sheri Kenworthy, Mary Burgess
Cost \$ 308

Title Sanitary and Safe Kitchen
Location Westmont, IL
Dates 8/8/2008
Attendees Valerie Armstrong
Cost \$ 129

Title Sanitation Refresher
Location Sterling, IL
Dates 5/2/2009
Attendees Valerie Armstrong
Cost \$ 100

Winning Wheels, Inc.
2009 Cost Report
Travel and Seminars

Title SLF Web conference
Location Springfield, IL
Dates 11/5/2008
Attendees Tami Tegeler
Cost \$ 25

Title LSN Teleseminar
Location Springfield, IL
Dates 5/29/2009
Attendees Tami Tegeler
Cost \$ 115

Title Audio Seminar
Location Springfield, IL
Dates 5/11/2009
Attendees Tami Tegeler
Cost \$ 99

Winning Wheels, Inc.
2009 Cost Report
Travel and Seminars

Title	Thinking Outside the Circle		
Location	Springfield, IL		
Dates	8/19/2008		
Attendees	Karla Belzer		
Cost		\$	75
	Reimbursed Employee Travel/Mileage	\$	5,527
	Total	\$	13,288

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1		\$		\$								
2	Painting	1/2005	1,592	5	319	318	319	318	159			
3	Painting	1/2007	3,295	5		329	659	659	659	330	0	
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS		\$ 4,887		\$ 319	\$ 647	\$ 978	\$ 977	\$ 818	\$ 659	\$ 330	\$

Facility Name & ID Number WINNING WHEELS# 0024745Report Period Beginning: 07/01/2008 Ending: 06/30/2009**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. IHCA \$4,195
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 7 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 24,181 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 43,800
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ NONE Has any meal income been offset against related costs? YES Indicate the amount. \$ 13,733
- (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. \$ 76,423
c. What percent of all travel expense relates to transportation of nurses and patients? _____
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 CPAs
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? NA
Attach invoices and a summary of services for all architect and appraisal fees.