

		FOR BHF USE					

LL1

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0024745

Facility Name: WINNING WHEELS

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

County: WHITESIDE

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

HFS ID Number:

Date of Initial License for Current Owners: 09/10/1979

Type of Ownership:

☒ VOLUNTARY, NON-PROFIT
☒ Charitable Corp.
☐ Trust
IRS Exemption Code 501(C)3

☐ PROPRIETARY ☐ GOVERNMENTAL
☐ Individual ☐ State
☐ Partnership ☐ County
☐ Corporation ☐ Other
☐ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other

In the event there are further questions about this report, please contact:
Name: MILT RUE Telephone Number: 815-537-5168
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2011 to 06/30/2012 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or
Administrator
of Provider

(Signed) 10/31/2012
(Date)

(Type or Print Name) MILT RUE

(Title) CFO

Paid
Preparer

(Signed) _____
(Date)

(Print Name and Title) _____

(Firm Name & Address) _____

(Telephone) () Fax # ()

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number WINNING WHEELS# 0024745 Report Period Beginning: 07/01/2011 Ending: 06/30/2012

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	<u>80</u>	Skilled (SNF)	<u>80</u>	<u>29,280</u>	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	<u>80</u>	TOTALS	<u>80</u>	<u>29,280</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			<u>583</u>	<u>583</u>	8
9	SNF/PED					9
10	ICF	<u>26,437</u>	<u>1,405</u>		<u>27,842</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>26,437</u>	<u>1,405</u>	<u>583</u>	<u>28,425</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 97.08%

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

648 (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)

NONE

F. Does the facility maintain a daily midnight census?

YESG. 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 09/10/1979

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 80 and days of care provided 583Medicare Intermediary CGS ADMINISTRATORS, LLC

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 06/30/2012 Fiscal Year: 06/30/2012

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total						
		1	2	3	4	5	6	7	8	9	10
	A. General Services										
1	Dietary	247,530	35,841	6,960	290,331		290,331		290,331		1
2	Food Purchase		165,265		165,265		165,265	(4,901)	160,364		2
3	Housekeeping	130,971	27,972		158,943		158,943		158,943		3
4	Laundry	58,318	25,382		83,700		83,700		83,700		4
5	Heat and Other Utilities			105,672	105,672		105,672	(9,341)	96,331		5
6	Maintenance	91,347	55,858	33,925	181,130		181,130	5,649	186,779		6
7	Other (specify):*										7
8	TOTAL General Services	528,166	310,318	146,557	985,041		985,041	(8,593)	976,448		8
	B. Health Care and Programs										
9	Medical Director			24,000	24,000		24,000		24,000		9
10	Nursing and Medical Records	1,557,864	211,884	9,355	1,779,103		1,779,103		1,779,103		10
10a	Therapy	121,915	11,399	194,818	328,132		328,132		328,132		10a
11	Activities	63,955	6,171	15,104	85,230		85,230		85,230		11
12	Social Services	163,321		2,156	165,477		165,477		165,477		12
13	CNA Training										13
14	Program Transportation	61,418	37,957		99,375	(55,317)	44,058		44,058		14
15	Other (specify):* DENTAL			102	102		102		102		15
16	TOTAL Health Care and Programs	1,968,473	267,411	245,535	2,481,419	(55,317)	2,426,102		2,426,102		16
	C. General Administration										
17	Administrative			210,073	210,073		210,073		210,073		17
18	Directors Fees										18
19	Professional Services			89,553	89,553		89,553		89,553		19
20	Dues, Fees, Subscriptions & Promotions			37,707	37,707		37,707	(20,614)	17,093		20
21	Clerical & General Office Expenses	113,419	39,455	21,928	174,802	(1,206)	173,596	87,544	261,140		21
22	Employee Benefits & Payroll Taxes			463,134	463,134		463,134	12,096	475,230		22
23	Inservice Training & Education										23
24	Travel and Seminar			11,186	11,186	(1,990)	9,196	(5,483)	3,713		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			51,251	51,251	(4,275)	46,976		46,976		26
27	Other (specify):*										27
28	TOTAL General Administration	113,419	39,455	884,832	1,037,706	(7,471)	1,030,235	73,543	1,103,778		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,610,058	617,184	1,276,924	4,504,166	(62,788)	4,441,378	64,950	4,506,328		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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			204,800	204,800		204,800	(1,180)	203,620			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			29,489	29,489		29,489	(14,552)	14,937			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			234,289	234,289		234,289	(15,732)	218,557			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					62,788	62,788		62,788			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			215,095	215,095		215,095		215,095			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			215,095	215,095	62,788	277,883		277,883			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	2,610,058	617,184	1,726,308	4,953,550		4,953,550	49,218	5,002,768			45

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

Page 3, Schedule V

Line #		DR.	CR.
	<u>RECLASSIFICATIONS</u>		
14	Transportation	\$ 4,275	
26	Insurance		\$ 4,275
	Transfer vehicle insurance premiums to transportation		
14	Transportation	\$ 1,206	
21	Clerical & General Office		\$ 1,206
	Transfer vehicle license fees to transportation		
38	Medically Necessary Transportation	\$ 62,788	
14	Transportation		\$ 62,788
	Transfer costs for medically necessary transportation		
14	Transportation	\$ 1,990	
24	Travel and Seminar		\$ 1,990
	Travel and Seminar for Nursing Staff		

		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	(4,901)	2		4
5	Telephone, TV & Radio in Resident Rooms	(9,341)	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	(14,552)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(350)	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	(17,765)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(387)	20		28
29	Other-Attach Schedule PAGE 5A	(3,126)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (50,422)		\$	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)	99,640	21 & 22	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 99,640		36
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 49,218		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.	X		\$ 62,788	14	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)			\$ 62,788		47

WINNING WHEELS

Report Period Beginning:
Ending:

ID# 0024745
07/01/2011
06/30/2012

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	NEW EQUIPMENT UNDER \$2500	\$ 5,649	6	1
2	DEPRECIATION ON ASSETS UNDER \$2500	(1,180)	30	2
3	OUT OF STATE TRAVEL	(5,483)	24	3
4	PAC PORTION OF IHCA DUES	(1,562)	20	4
5	CHAMBER OF COMMERCE DUES	(550)	20	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	(3,126)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WINNING WHEELS

0024745

Report Period Beginning:

07/01/2011

Ending:

06/30/2012

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	(4,901)	0	0	0	0	0	0	0	0	0	0	(4,901)	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	(9,341)	0	0	0	0	0	0	0	0	0	0	(9,341)	5
6	Maintenance	5,649	0	0	0	0	0	0	0	0	0	0	5,649	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(8,593)	0	0	0	0	0	0	0	0	0	0	(8,593)	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	(20,614)	0	0	0	0	0	0	0	0	0	0	(20,614)	20
21	Clerical & General Office Expenses	0	87,544	0	0	0	0	0	0	0	0	0	87,544	21
22	Employee Benefits & Payroll Taxes	0	12,096	0	0	0	0	0	0	0	0	0	12,096	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(5,483)	0	0	0	0	0	0	0	0	0	0	(5,483)	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	(26,097)	99,640	0	0	0	0	0	0	0	0	0	73,543	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(34,690)	99,640	0	0	0	0	0	0	0	0	0	64,950	29

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(1,180)	0	0	0	0	0	0	0	0	0	0	(1,180)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(14,552)	0	0	0	0	0	0	0	0	0	0	(14,552)	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	(15,732)	0	0	0	0	0	0	0	0	0	0	(15,732)	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)	(50,422)	99,640	0	0	0	0	0	0	0	0	0	49,218	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as 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 PROGRESS CENTER	LYNDON	DAY TREATMENT REHABILITATION
		BIG MEADOWS (BUILDING ONLY)	SAVANNA			
		PINNACLE PLACE SUPPORTIVE LIVING FACILITY	SAVANNA	LYNDON PLAY & LEARN CENTER	LYNDON	CHILD CARE
				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.

X 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	22	CHILDCARE BENEFITS	\$ 9,507	LYNDON PLAY AND LEARN CENTER	100.00%	\$ 10,181	\$ 674	1
2	V								2
3	V								3
4	V		ADMINISTRATIVE OVERHEAD						4
5	V	21	CLERICAL SALARIES		WINNING WHEELS, INC (ADMINISTRATIVE FUND)	100.00%	87,544	87,544	5
6	V	22	BENEFITS		(SEE DETAILS, SCHEDULE VIII, PAGE 8)		11,422	11,422	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 9,507			\$ 109,147	\$ * 99,640	14

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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	BOARD OF DIRECTORS							1
2	JOHN GUZZARDO - PRESIDENT	BOD						2
3	DAVID MICKLEY - VICE PRESIDENT	BOD						3
4	KYLE GIBSON - TREASURER	BOD						4
5	MARY ANN HILL - SECRETARY	BOD						5
6	MEREDITH HAMMER	BOD						6
7	CONNIE DEMARANVILLE	BOD						7
8	BILL SULLIVAN	BOD						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

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

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.)

YES☒

NO☐

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

Name of Related OrganizationWINNING WHEELS ADMINISTRATIVE FUNI

Street Address501 6TH AVE W

City / State / Zip CodeLYNDON, IL 61261

Phone Number(815-778-3610

Fax Number(815-778-4503

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	21	CLERICAL SALARIES	SALARIES/BENEFITS	6,198,278	7	\$176,221	\$176,221	3,079,200	\$87,544	1
2	22	FICA	SALARIES/BENEFITS	6,198,278	7	10,240		3,079,200	5,087	2
3	22	WORKMAN'S COMP	SALARIES/BENEFITS	6,198,278	7	379		3,079,200	188	3
4	22	LIFE INSURANCE	SALARIES/BENEFITS	6,198,278	7	430		3,079,200	214	4
5	22	HEALTH INSURANCE	SALARIES/BENEFITS	6,198,278	7	3,938		3,079,200	1,956	5
6	22	403 B RETIREMENT	SALARIES/BENEFITS	6,198,278	7	1,763		3,079,200	876	6
7	22	DENTAL INSURANCE	SALARIES/BENEFITS	6,198,278	7	360		3,079,200	179	7
8	22	ST & LT DISABILITY INSURANCE	SALARIES/BENEFITS	6,198,278	7	1,643		3,079,200	816	8
9	22	CHILD CARE	SALARIES/BENEFITS	6,198,278	7	3,711		3,079,200	1,844	9
10	22	OTHER	SALARIES/BENEFITS	6,198,278	7	527		3,079,200	262	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					\$199,212	\$176,221		\$98,966	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							\$				\$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	FARMERS NATIONAL BANK		X	LINE OF CREDIT		10/8/11	1,500,000	1,339,204	1/1/13	2.5400	29,489	6
7												7
8												8
9	TOTAL Facility Related						\$ 1,500,000	\$ 1,339,204			\$ 29,489	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$				\$	14
15	TOTALS (line 9+line14)						\$ 1,500,000	\$ 1,339,204			\$ 29,489	15

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

1. Real Estate Tax accrual used on 2011 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:		2007 8 2008 9 2009 10 2010 11 2011 12	FOR BHF USE ONLY	
			13 FROM R. E. TAX STATEMENT FOR 2011 \$	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.

2011 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 2011 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 2011.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 40,500

B. General Construction Type:

Exterior MASSONARY

Frame CONCRETE BLOCK

Number of Stories ONE

C. Does the Operating Entity?

X(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?

X(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

X 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:

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	BUILDING SITE	504,424	1973	\$ 23,500	1
2					2
3	TOTALS	504,424		\$ 23,500	3

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	NEW FRONT PARKING LOT	2009	\$ 67,321	\$ 4,488	15	\$ 4,488	\$	\$ 11,594	37
38	NEW FROOF ON MAIN BUILDING	2010	70,797	4,720	15	4,720		10,619	38
39	FLOORING	2010	4,995	714	7	714		1,070	39
40	PAINTING AND FLOORING	2011	10,906	1,558	7	1,558		2,337	40
41	LCD ANNUNCIATOR AT A WING NURSES STATION	2011	3,665	122	15	122		122	41
42	TILE IN SPA ROOM	2012	4,993	357	7	357		357	42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,530,901	\$ 81,508		\$ 81,508	\$	\$ 2,423,813	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$602,194	\$86,826	\$86,826	\$	7.26	\$372,574	71
72	Current Year Purchases	62,285	3,082	3,082		9.5	3,082	72
73	Fully Depreciated Assets	1,082,831				9.19	1,082,831	73
74								74
75	TOTALS	\$1,747,310	\$89,908	\$89,908	\$		\$1,458,487	75

D. Vehicle Costs. (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 VANS	VARIOUS	\$116,259	\$21,547	\$21,547	\$	6.67	\$41,606	76
77	TRANSPORT RESIDENTS	VARIOUS BUSES	VARIOUS	156,932	6,063	6,063		5	152,646	77
78	SNOW REMOVAL	2010 DODGE 2500	2010	32,157	4,594	4,594		7	11,485	78
79										79
80	TOTALS			\$305,348	\$32,204	\$32,204	\$		\$205,737	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$5,607,05981
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$203,62082
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$203,62083**
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)	\$4,088,03785

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	RENOVATION/EXPANSION	220,549	94
95		\$258,999	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. /2013\$
13. /2014\$
14. /2015\$

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	1	2	3	4	5	6	7	8		
	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	10a.3	hrs	\$	844	\$ 56,428	\$	844	\$ 56,428	1
2	Licensed Speech and Language Development Therapist	10a.1 & 10a.3	655 hrs	22,141	114	14,307		769	36,448	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs		2,167	124,083		2,167	124,083	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$ 22,141	3,125	\$ 194,818	\$	3,780	\$ 216,959	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.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 196,137	\$ 199,004	1
2	Cash-Patient Deposits	20,186	22,861	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (67,614)	1,348,992	1,715,941	3
4	Supply Inventory (priced at COST)	31,133	41,258	4
5	Short-Term Investments	30	30	5
6	Prepaid Insurance	17,664	17,664	6
7	Other Prepaid Expenses	16,081	16,081	7
8	Accounts Receivable (owners or related parties)	1,098,390	1,138,213	8
9	Other(specify): PG17_Support	434,219	434,219	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,162,832	\$ 3,585,271	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	23,500	231,451	13
14	Buildings, at Historical Cost	3,508,735	7,529,747	14
15	Leasehold Improvements, at Historical Cost		52,673	15
16	Equipment, at Historical Cost	2,064,219	2,397,503	16
17	Accumulated Depreciation (book methods)	(4,089,681)	(5,765,867)	17
18	Deferred Charges	22,166	33,115	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		1,771,235	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CONSTR IN PROGRESS	258,999	280,590	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,787,938	\$ 6,530,447	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,950,770	\$ 10,115,718	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 345,261	\$ 345,261	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	20,186	22,861	28
29	Short-Term Notes Payable	1,339,204	1,499,204	29
30	Accrued Salaries Payable	208,057	208,057	30
31	Accrued Taxes Payable (excluding real estate taxes)	104,636	104,636	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	104	104	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	WORK COMP INSURANCE	12,536	12,536	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,029,984	\$ 2,192,659	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,459,956	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	PUBLIC AID ADVANCE	7,691	7,691	43
44	RESERVE FUND	4,742	4,742	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 12,433	\$ 1,472,389	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,042,417	\$ 3,665,048	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,908,353	\$ 6,450,670	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,950,770	\$ 10,115,718	48

*(See instructions.)

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

FYE 2012

BALANCE SHEET PAGE 17

Line #

9	OTHER CURRENT ASSETS
	Depoit in Frontier Hollow
	Deposit in Pinnacle Place
	Investment in Al's Place Limited Partnership
	Total

\$	392,662
\$	97,601
\$	(56,044)
\$	434,219

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 8,170,967	1
2	Restatements (describe):		2
3	RECONCILE TO AUDIT	(333,905)	3
4	WRITE OFF DUE FROM SUBSIDIARY	(1,439,013)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 6,398,049	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	30,004	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		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) SUBSIDIARY COMPANIES		15
16	Other (describe) NET INCOME (LOSS)	22,617	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 52,621	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)	\$ 6,450,670	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **WINNING WHEELS**# **0024745**Report Period Beginning: **07/01/2011**Ending: **06/30/2012**

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		2
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,925,310	1
2	Discounts and Allowances for all Levels	(12,000)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,913,310	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	6,767	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	4,901	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)	\$ 11,668	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	14,552	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 14,552	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	TRANSPORTATION	42,835	28
28a	MISCELLANEOUS	1,189	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 44,024	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,983,554	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	985,041	31
32	Health Care	2,481,419	32
33	General Administration	1,037,706	33
	B. Capital Expense		
34	Ownership	234,289	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	215,095	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,953,550	40
41	Income before Income Taxes (line 30 minus line 40)**	30,004	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 30,004	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 4,260,748	44
45	Private Pay - Net Inpatient Revenue	286,360	45
46	Medicare - Net Inpatient Revenue	366,202	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,913,310	49

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

** Does this agree with taxable income (loss) per Federal Income

Tax Return? N/A 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.

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	2,988	3,566	\$ 110,777	\$ 31.06	1
2	Assistant Director of Nursing	1,612	1,636	39,995	24.45	2
3	Registered Nurses	10,561	11,401	279,943	24.55	3
4	Licensed Practical Nurses	11,712	13,011	281,212	21.61	4
5	CNAs & Orderlies	67,517	70,827	825,407	11.65	5
6	CNA Trainees					6
7	Licensed Therapist	551	655	22,141	33.80	7
8	Rehab/Therapy Aides	6,305	7,531	99,774	13.25	8
9	Activity Director	1,340	1,481	19,956	13.47	9
10	Activity Assistants	3,224	3,624	43,999	12.14	10
11	Social Service Workers	9,057	9,953	163,321	16.41	11
12	Dietician					12
13	Food Service Supervisor	2,024	2,080	52,400	25.19	13
14	Head Cook	4,041	4,442	53,213	11.98	14
15	Cook Helpers/Assistants	14,255	15,223	141,917	9.32	15
16	Dishwashers					16
17	Maintenance Workers	6,523	8,187	91,347	11.16	17
18	Housekeepers	12,155	13,269	130,971	9.87	18
19	Laundry	5,956	6,324	58,318	9.22	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	2,725	2,969	68,497	23.07	22
23	Office Manager	1,860	2,115	25,312	11.97	23
24	Clerical	1,348	1,684	19,610	11.64	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	1,604	1,716	20,530	11.96	31
32	Other Health Care(specify)					32
33	Other(specify) <u>TRANSPORTATI</u>	4,146	4,456	61,418	13.78	33
34	TOTAL (lines 1 - 33)	171,504	186,150	\$ 2,610,058 *	\$ 14.02	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	174	\$ 6,960	1.3	35
36	Medical Director	192	24,000	9.3	36
37	Medical Records Consultant	16	1,025	19.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	27	2,361	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	29	1,425	11.3	44
45	Social Service Consultant	33	2,156	12.3	45
46	Other(specify) <u>MUSIC THERAPY</u>	22	1,100	11.3	46
47	<u>PHYSIATRIST CONSULTANT</u>	196	24,500	10.3	47
48	<u>MDS CONSULTANT</u>	30	750	19.3	48
49	TOTAL (lines 35 - 48)	719	\$ 64,277		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

WINNING WHEELS - 24745
Report Period Beginning – 7/1/2010
Report Period Ending – 6/30/2011
DETAIL SCHEDULE V-LINE 24

		Total Cost	Nursing	General & Admin	
1	Names & Titles Dates of Seminar Location Title of Seminar Sponsor Cost	Amber Temple, HR Director September 1, 2011 St. Charles, IL Work Comp Fall Seminar NHRMA			
		\$ 119		\$ 119	
2	Name & Title Dates of Seminar Location Title Sponsor Cost	Kay Richmond, Instructor Sally Masscho, Instructor September 14 - 17, 2011 Battlecreek, MI PATH certified instructor seminar PATH			
		\$ 2,387		\$ 2,387	Out of State
3	Name & Title Date of Seminar Location Title of Seminar Sponsor Total Cost	Geri Purvis, Director of Food Service September 20, 2011 Peoria, IL Food and Sanitation Seminar Martin Brothers			
		\$ 63		\$ 63	
4	Name & Title Date of Seminar Location Title of Seminar Sponsor Total Cost	Kelly Hopkins, RN September 28, 2011 Dixon, IL Train the Trainer INHNA			
		\$ 67	\$ 67		
5	Name & Title Date of Seminar Location	Gayla Bohms, Social Worker October 8, 2011 Davenport, IA			

WINNING WHEELS - 24745
Report Period Beginning – 7/1/2010
Report Period Ending – 6/30/2011
DETAIL SCHEDULE V-LINE 24

Title of Seminar	Brain Injury Behaviors					
Sponsor	BIA of Iowa					
Total Cost		\$	75	\$	75	
6 Name & Title	Carol Brown, Clinical Services Director					
	Neal Gapinski, Administrator					
Date of Seminar	October 15, 2011					
Location	Ankeny, IA					
Title of Seminar	Brain Injury Symposium					
Sponsor	On With Life					
Total Cost		\$	243	\$	121	\$ 122 Out of State
7 Name & Title	Geri Purvis, Director of Food Service					
Date of Seminar	October 15, 2011					
Location	Waterloo, IA					
Title of Seminar	Fall Food Show					
Sponsor	Martin Brothers					
Total Cost		\$	221	\$	221	Out of State
8 Name & Title	Erica Kershaw, Activity Director					
Date of Seminar	October 19, 2011					
Location	Rockford, IL					
Title of Seminar	Annual Activity Professionals Seminar					
Sponsor	IL Activity Professionals Association					
Total Cost		\$	245	\$	245	
9 Name & Title	Gayla Bohms, Social Worker					
	Jill Smith, Director of Admissions					
	Kathy Vanderslice, Director of Nursing					
Date of Seminar	October 28 - 29, 2011					
Location	Oakbrook, IL					
Title of Seminar	2011 BIA Conference					
Sponsor	BIA IL					
Total Cost		\$	1,722	\$	574	\$ 1,148

WINNING WHEELS - 24745
Report Period Beginning – 7/1/2010
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DETAIL SCHEDULE V-LINE 24

10 Name & Title	Amber Temple, HR Director					
Date of Seminar	November 11, 2011					
Location	Lyndon, IL					
Title of Seminar	Effective Personnel Performance					
Sponsor	IL Chamber of Commerce					
Total Cost		\$	99	\$	99	
11 Name & Title	MaryHelen Matthews - CNA					
	Geri Purvis, Director of Food Service					
	Jill Smith, Director of Admissions					
	Kathy Vanderslice, Director of Nursing					
	Chris Burks, Social Worker					
Date of Seminar	March 8 - 9, 2012					
Location	Des Moines, IA					
Title of Seminar	Best Practices in Brain Injury Services					
Sponsor	BIA of Iowa					
Total Cost		\$	2,086	\$	834	\$ 1,252 Out of State
12 Name & Title	Megan Swan					
Date of Seminar	March 8 - 9, 2012					
Location	Lisle, IL					
Title of Seminar	Continuing Care Infection Control					
Sponsor	IDPH					
Total Cost		\$	342	\$	342	
13 Name & Title	Chris Burks, Social Worker					
Date of Seminar	March 26 - 29, 2012					
Location	Springfield, IL					
Title of Seminar	MANDT Training					
Sponsor	MANDT					
Total Cost		\$	269	\$	269	
14 Name & Title	Jill Smith, Director of Admissions					

WINNING WHEELS - 24745
Report Period Beginning – 7/1/2010
Report Period Ending – 6/30/2011
DETAIL SCHEDULE V-LINE 24

Date of Seminar	Kathy Vanderslice, Director of Nursing					
Location	Lonnie Nichols, Administrator					
Title of Seminar	April 18 - 19, 2012					
Sponsor	Des Moines, IA					
Total Cost	Brain Injury Symposium					
	QLI	\$	546	\$	182	\$ 364 Out of State
15 Name & Title	Regi Fortune, RN					
Date of Seminar	April 20, 2012					
Location	Springfield, IL					
Title of Seminar	CNA Seminar					
Sponsor	LLCC					
Total Cost		\$	253	\$	253	
16 Name & Title	Lonnie Nichols, Administrator					
Date of Seminar	June 5 - 6, 2012					
Location	Peoria, IL					
Title of Seminar	Summer Seminar Series					
Sponsor	INHAA					
Total Cost		\$	95	\$	95	
	Total Seminars	\$	8,832	\$	2,468	\$ 6,365
	Employee mileage reimbursement	\$	2,354	\$	659	\$ 1,694
	Less: Out of State Travel and Seminars	\$	(5,483)	\$	(1,137)	\$ (4,346) Out of State
Total - Schedule V, Line 14				\$	1,990	
Total - Schedule V, Line 24					\$	3,713
		\$	5,703			

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	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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. \$4,195
- (3)

Did the nursing home make political contributions or payments to a political action organization?

YES

If YES, have these costs been properly adjusted out of the cost report?

YES
- (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?

9.75
- (6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 37,821

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.

\$ 215,095

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.

\$ NON

Has any meal income been offset against related costs?

YES

Indicate the amount.

\$ 4,901
- (16)

Travel and Transportation

a. Are there costs included for out-of-state travel?

NO

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

YES

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$ 52,576

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?

YES

g. Does the facility transport residents to and from day training?

NO

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:

CLIFTON LARSON ALLEN
- (18)

Have all costs which do not relate to the provision of long term care been adjusted out 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?

N/A

Attach invoices and a summary of services for all architect and appraisal fees.

General Ledger Trial Balance for Period Ending 6/30/2012
Winning Wheels

Account #	Facility Code	Account Description	Cost Report Page	Cost Report Code	Debit	Credit	Total
5360-10	10	DIETARY	3	1.1	247,530.01		247,530.01
7360-10	10	DIETARY	3	1.2	25,421.73		25,421.73
7375-10	10	SUPPLEMENTALS	3	1.2	10,339.39		10,339.39
7410-10	10	LEASES NON CLINICAL	3	1.2	79.95		79.95
6360-10	10	DIETARY	3	1.3	6,960.00		6,960.00
7370-10	10	FOOD	3	2.2	165,265.00		165,265.00
5380-10	10	HOUSEKEEPING	3	3.1	130,970.69		130,970.69
7380-10	10	HOUSEKEEPING	3	3.2	27,972.00		27,972.00
5390-10	10	LAUNDRY	3	4.1	58,318.25		58,318.25
7390-10	10	LAUNDRY	3	4.2	25,382.11		25,382.11
6390-10	10	LAUNDRY	3	4.3	-		-
8010-10	10	ELECTRIC	3	5.3	69,060.05		69,060.05
8020-10	10	GAS	3	5.3	10,888.73		10,888.73
8040-10	10	WATER	3	5.3	4,571.53		4,571.53
8060-10	10	TRASH REMOVAL	3	5.3	10,876.50		10,876.50
8080-10	10	CABLEVISION	3	5.3	10,274.92		10,274.92
5420-10	10	MAINTENANCE	3	6.1	91,347.10		91,347.10
7420-10	10	MAINTENANCE	3	6.2	55,858.01		55,858.01
8100-10	10	REPAIRS & MAINTENANCE	3	6.3	33,924.97		33,924.97
6030-10	10	PHYSICIAN	3	9.3	24,000.00		24,000.00
5050-10	10	NURSING ADMINISTRATION	3	10.1	150,771.30		150,771.30
5060-10	10	NURSES	3	10.1	561,155.47		561,155.47
5070-00	10	AIDES	3	10.1	-		-
5070-10	10	AIDES	3	10.1	825,407.31		825,407.31
5340-10	10	MEDICAL RECORDS	3	10.1	20,529.63		20,529.63
6220-10	10	LAB	3	10.2	162.42		162.42
6225-10	10	LAB - MED A	3	10.2	689.12		689.12
6230-10	10	X-RAY	3	10.2	-		-
6235-10	10	X-RAY - MEDICARE A	3	10.2	262.00		262.00
7060-10	10	NURSING	3	10.2	139,821.50		139,821.50
7065-10	10	BRIEFS	3	10.2	24,730.49		24,730.49
7070-10	10	OXYGEN	3	10.2	630.00		630.00
7080-10	10	MATTRESSES / CUSHIONS	3	10.2	1,040.27		1,040.27
7150-10	10	NURSE AIDE TRAINING SUPPLIES	3	10.2	-		-

7160-10	10	EQUIPMENT LEASES	3	10.2	1,640.00		1,640.00
7200-10	10	PHARMACY	3	10.2	24,025.81		24,025.81
7205-10	10	PHARMACY - MEDICARE A	3	10.2	15,090.23		15,090.23
7210-10	10	O.T.C MEDS	3	10.2	3,792.21		3,792.21
5720-10	10	UNIFORMS	3	10.3	6,993.96		6,993.96
6060-10	10	NURSES/AIDES	3	10.3	-		-
6150-10	10	PSYCHOLOGICAL	3	10.3	-		-
6200-10	10	PHARMACY	3	10.3	2,361.25		2,361.25
6240-10	10	RESPIRATORY THERAPY	3	10.3	-		-
5120-10	10	RECREATIONAL THERAPY	3	11.1	63,954.64		63,954.64
5180-10	10	COGNITIVE REHAB	3	11.1	-		-
7120-10	10	RECREATION	3	11.2	6,170.57		6,170.57
6120-10	10	RECREATION THERAPY	3	11.3	2,525.00		2,525.00
6125-10	10	THERAPEUTIC RIDING	3	11.3	12,000.00		12,000.00
6126-10	10	WHOA CORPORATE SPONSORSHIP	3	11.3	-		-
6127-10	10	WHOA IN-KIND CONTRIBUTION	3	11.3	579.26		579.26
5140-10	10	SOCIAL SERVICES	3	12.1	163,320.86		163,320.86
6140-10	10	SOCIAL SERVICES	3	12.3	2,156.18		2,156.18
5440-10	10	TRANSPORTATION	3	14.1	61,417.96		61,417.96
7440-10	10	TRANSPORTATION	3	14.2	37,956.73		37,956.73
7445-10	10	TRANSPORTATION - MEDICARE A	3	14.2	-		-
6040-10	10	DENTAL SERVICES	3	15.3	102.00		102.00
6460-10	10	ADMINISTRATIVE	3	17.3	210,072.50		210,072.50
6470-10	10	DATA PROCESSING	3	19.3	64,471.59		64,471.59
6480-10	10	CONSULTING	3	19.3	1,775.00		1,775.00
9100-10	10	LEGAL & ACCOUNTING	3	19.3	23,306.00		23,306.00
9020-10	10	DUES & SUBSCRIPTIONS	3	20.3	8,479.49		8,479.49
9110-10	10	MARKETING	3	20.3	6,715.58		6,715.58
9120-10	10	RECRUITMENT	3	20.3	8,915.95		8,915.95
9130-10	10	ADVERTISING	3	20.3	1,807.84		1,807.84
9170-10	10	BACKGROUND CHECK	3	20.3	1,810.00		1,810.00
9190-10	10	COMMUNITY RELATIONS	3	20.3	9,628.05		9,628.05
9200-10	10	DONATIONS	3	20.3	350.00		350.00
5460-10	10	ADMINISTRATION	3	21.1	113,419.31		113,419.31
7460-10	10	OFFICE	3	21.2	29,978.11		29,978.11
7470-10	10	COMPUTER SUPPLIES	3	21.2	9,476.57		9,476.57
7480-10	10	OTHER	3	21.2	-		-
8090-10	10	INTERNET	3	21.3	3,037.34		3,037.34
9010-10	10	PHONE	3	21.3	10,323.14		10,323.14

9060-10	10	PRINTING	3	21.3	2,257.80		2,257.80
9080-10	10	POSTAGE	3	21.3	4,042.95		4,042.95
9160-10	10	LICENSE & TAXES	3	21.3	1,609.00		1,609.00
9180-10	10	OTHER	3	21.3	-		-
9185-10	10	PLANNING / MEETING EXPENSES	3	21.3	657.52		657.52
5620-10	10	FICA	3	22.3	198,616.54		198,616.54
5640-10	10	WORKER'S COMP	3	22.3	87,198.02		87,198.02
5650-10	10	UNEMPLOYMENT	3	22.3	45,501.24		45,501.24
5660-10	10	LIFE INSURANCE	3	22.3	6,693.88		6,693.88
5670-10	10	HEALTH INSURANCE	3	22.3	47,867.68		47,867.68
5680-10	10	403 B RETIREMENT	3	22.3	9,417.27		9,417.27
5685-10	10	DENTAL INSURANCE	3	22.3	3,530.00		3,530.00
5690-10	10	ST & LT DISABILITY INS.	3	22.3	24,258.65		24,258.65
5700-10	10	PHYSICALS	3	22.3	6,932.46		6,932.46
5730-10	10	CHILD CARE	3	22.3	9,506.92		9,506.92
5735-10	10	PROFESSIONAL LICENSE FEE	3	22.3	1,708.90		1,708.90
5736-10	10	PROFESSIONAL TRAINING	3	22.3	3,167.93		3,167.93
5740-10	10	TUITION ASSISTANCE	3	22.3	1,365.00		1,365.00
5745-10	10	TUITION REIMBURSEMENT	3	22.3	940.00		940.00
5746-10	10	RELOCATION ASSIST.	3	22.3	-		-
5750-10	10	OTHER	3	22.3	15,810.17		15,810.17
9151-10	10	NURSE AID TRAINING	3	22.3	619.00		619.00
9150-10	10	TRAINING	3	23.3	-		-
9140-10	10	TRAVEL & SEMINAR	3	24.3	8,832.32		8,832.32
9141-10	10	TRAVEL EXPENSES-NON SEMINAR	3	24.3	2,353.45		2,353.45
9040-10	10	INSURANCE	3	26.3	51,251.39		51,251.39
5100-10	10	PHYSICAL THERAPY	3	10a.1	56,460.07		56,460.07
5110-10	10	OCCUPATIONAL THERAPY	3	10a.1	43,314.01		43,314.01
5170-10	10	SPEECH THERAPY	3	10a.1	22,140.89		22,140.89
7140-10	10	PT & OT	3	10a.2	2,811.06		2,811.06
7145-10	10	SPEECH THERAPY SPLS	3	10a.2	8,587.55		8,587.55
6100-10	10	PHYSICAL THERAPY	3	10a.3	102,528.78		102,528.78
6105-10	10	PHYSICAL THERAPY - MED A	3	10a.3	4,824.17		4,824.17
6107-10	10	PHYSICAL THERAPY - MED B	3	10a.3	18,393.92		18,393.92
6110-10	10	OCCUPATIONAL THERAPY	3	10a.3	40,090.19		40,090.19
6115-10	10	OCCUPATIONAL THERAPY - MED A	3	10a.3	-		-
6117-10	10	OCCUPATIONAL THERAPY - MED B	3	10a.3	14,674.20		14,674.20
6130-10	10	MEDICARE A THERAPY	3	10a.3	-		-
6170-10	10	SPEECH	3	10a.3	8,335.12		8,335.12

6175-10	10	SPEECH THERAPY - MED B	3	10a.3	5,971.71		5,971.71
9450-10	10	DEPRECIATION	4	30.3	204,799.92		204,799.92
9340-10	10	INTEREST EXPENSE	4	32.3	29,488.86		29,488.86
8130-10	10	REAL ESTATE TAXES	4	33.3	-		-
4110-10	10	ASSESSMENT FEE TAX	4	42.3	215,094.67		215,094.67
					4,953,546.79	-	4,953,546.79
							4,953,550.00
							3.21

1100-00	10	PETTY CASH	17	1.1	1,500.00		1,500.00
1110-00	10	FARMERS NATIONAL BANK	17	1.1	173,627.29		173,627.29
1120-00	10	FNB-INSURANCE ACCOUNT	17	1.1	-		-
1130-00	10	MIDLAND CHECKING	17	1.1	-		-
1150-00	10	SPECIFIC PURPOSE	17	1.1	21,010.03		21,010.03
1190-10	10	RESIDENT TRUST ACCOUNTS - WHEELS	17	2.1	20,185.84		20,185.84
1210-00	10	PUBLIC AID	17	3.1	-		-
1210-01	10	PUBLIC AID - WHEELS	17	3.1	1,110,109.69		1,110,109.69
1210-03	10	PA CLEARING ACCOUNT	17	3.1	-		-
1220-00	10	ACTIVE TREATMENT	17	3.1	2,440.00		2,440.00
1230-00	10	PRIVATE PAY	17	3.1	110,361.58		110,361.58
1240-00	10	MEDICARE PART B - SUPPLIES	17	3.1	26,534.66		26,534.66
1240-01	10	MEDICARE PART B - THERAPY	17	3.1	32,927.12		32,927.12
1250-00	10	MEDICARE A	17	3.1	90,001.63		90,001.63
1255-00	10	PUBLIC AID CO-INSURANCE	17	3.1	13,111.43		13,111.43
1260-00	10	BOND OFFSET	17	3.1	-		-
1265-00	10	COLLECTIONS	17	3.1	25,410.57		25,410.57
1270-00	10	TRANSPORTATION	17	3.1	5,316.79		5,316.79
1271-00	10	PUBLIC TRANSPORTATION	17	3.1	392.30		392.30
1275-00	10	AHE-OTHER	17	3.1	-		-
1280-00	10	ALLOWANCES	17	3.1		67,614.19	(67,614.19)
1280-01	10	ALLOWANCES	17	3.1	-		-
1280-10	10	MEDICARE PART B - ALLOWANCE	17	3.1	-		-
1350-00	10	INVENTORY	17	4.1	31,133.17		31,133.17
1150-10	10	SPECIFIC PURPOSE INVESTMENT	17	5.1	-		-
1170-01	10	INVESTMENTS	17	5.1	-		-
1170-10	10	INVESTMENTS	17	5.1	30.32		30.32
1430-00	10	INSURANCE	17	6.1	17,664.25		17,664.25
1410-00	10	PREPAID EXPENSES	17	7.1	5,186.34		5,186.34
1460-00	10	DATA PROCESSING	17	7.1	-		-

1470-00	10	PREPAID DUES	17	7.1	10,894.90		10,894.90
1570-00	10	DUE FROM WHOA	17	8.1	57,000.00		57,000.00
1575-00	10	DUE FROM P/P SLF	17	8.1	833.60		833.60
1600-00	10	NOTE RECEIVABLE - BIG MEADOWS	17	8.1	-		-
1610-10	10	RENT RECEIVABLE - BIG MEADOWS	17	8.1	560,556.30		560,556.30
1620-00	10	LINE OF CREDIT - BIG MEADOWS	17	8.1	480,000.00		480,000.00
1580-00	10	DEPOSIT IN FRONTIER HOLLOW	17	9.1	392,661.79		392,661.79
1585-00	10	DEPOSIT IN PINNACLE PLACE	17	9.1	97,600.91		97,600.91
1590-00	10	INVESTMENT-AL'S PLACE LP	17	9.1		56,044.00	(56,044.00)
1720-00	10	LAND	17	13.1	23,500.00		23,500.00
1730-00	10	BUILDING & IMPROVEMENTS	17	14.1	3,508,734.83		3,508,734.83
1750-00	10	FURNITURE AND FIXTURES	17	16.1	1,336,896.19		1,336,896.19
1755-00	10	FF&E UNDER \$2500	17	16.1	11,560.65		11,560.65
1770-00	10	VEHICLES - WHEELS	17	16.1	305,347.55		305,347.55
1810-00	10	OFFICE EQUIPMENT	17	16.1	410,414.25		410,414.25
1740-00	10	ACCUM. DEPR. - BLDG & IMPR.	17	17.1		2,410,215.91	(2,410,215.91)
1760-00	10	ACCUM. DEPR. - FURN. & FIX.	17	17.1		1,079,194.52	(1,079,194.52)
1765-00	10	ACCUM. DEPR. - FF&E UNDER \$2500	17	17.1		1,643.17	(1,643.17)
1780-00	10	ACCUM. DEPR. - VEHICLES	17	17.1		205,736.60	(205,736.60)
1820-00	10	ACCUM. DEPR. - OFFICE	17	17.1		379,292.92	(379,292.92)
1940-00	10	ACCUM. DEPR. - DEF. MNT. COSTS	17	17.1		13,597.46	(13,597.46)
1950-00	10	DEFERRED MAINT LESS ACC/DEPR.	17	17.1	-		-
1930-00	10	DEFERRED COSTS	17	18.1	22,166.43		22,166.43
1920-00	10	WHEELS CONSTR. IN PROGRESS	17	23.1	258,999.26		258,999.26
2100-00	10	ACCOUNTS PAYABLE	17	26.1		361,216.70	(361,216.70)
2120-00	10	UNVOUCHERED	17	26.1		-	-
2130-00	10	AHE-MANAGEMENT FEES	17	26.1		-	-
2135-00	10	AHE-OTHER	17	26.1	12,643.12		12,643.12
2270-00	10	THIRD PARTY SICK PAY	17	26.1		-	-
2280-00	10	GROUP DISABILITY INS	17	26.1		-	-
2340-00	10	UNITED WAY	17	26.1		6.00	(6.00)
2350-00	10	CREDIT UNION	17	26.1		-	-
2360-00	10	ADVANCES & GARNISHMENTS	17	26.1		-	-
2370-00	10	INSURANCE - POP	17	26.1		-	-
2371-00	10	VOLUNTARY LIFE	17	26.1		-	-
2372-00	10	MEDICAL	17	26.1		-	-
2373-00	10	DENTAL	17	26.1		63.04	(63.04)
2374-00	10	VISION	17	26.1		-	-
2375-00	10	INDIVIDUAL INSURANCE	17	26.1		-	-

2376-00	10	SUPPLEMENTAL INS	17	26.1		-	-
2377-00	10	COBRA	17	26.1		-	-
2378-00	10	BLUE CROSS	17	26.1	2,553.63		2,553.63
2379-00	10	CHIP	17	26.1	828.32		828.32
2380-00	10	ANNUITY	17	26.1		-	-
2125-10	10	RESIDENT TRUST ACCOUNTS PAYABLE - WHEELS	17	28.1		20,185.84	(20,185.84)
2060-00	10	LINE OF CREDIT - FNB	17	29.1		1,339,203.52	(1,339,203.52)
2560-00	10	LINE OF CREDIT - FARMERS NATIONAL BANK	17	29.1		-	-
2250-00	10	ACCRUED PAYROLL	17	30.1		127,859.25	(127,859.25)
2260-00	10	ACCRUED VACATION	17	30.1		80,198.07	(80,198.07)
2140-00	10	ASSESSMENT PAYABLE	17	31.1		82,468.68	(82,468.68)
2160-00	10	UNEMPLOYMENT	17	31.1		11,617.96	(11,617.96)
2290-00	10	ACCRUED IOWA WITHHOLDING	17	31.1		-	-
2310-00	10	ACCRUED FICA	17	31.1		10,113.08	(10,113.08)
2320-00	10	ACCRUED FEDERAL W/H	17	31.1		-	-
2330-00	10	ACCRUED ILLINOIS W/H	17	31.1		-	-
2335-00	10	ACCRUED IOWA W/H	17	31.1		436.00	(436.00)
2145-00	10	ACCRUED REAL ESTATE TAXES	17	32.1		-	-
2450-00	10	ACCRUED INTEREST	17	33.1		104.36	(104.36)
2150-00	10	WORKER'S COMP	17	36.1		12,536.11	(12,536.11)
2050-00	10	MORTGAGE - WINNING WHEELS	17	40.1		-	-
2550-00	10	MORTGAGE - WINNING WHEELS	17	40.1		-	-
2610-00	10	PUBLIC AID ADVANCE	17	43.1		7,690.72	(7,690.72)
2650-00	10	RESIDENT S.S.	17	44.1		4,742.49	(4,742.49)
2960-00	10	FUND BALANCE	17	47.1		2,878,346.66	(2,878,346.66)
					9,180,134.74	9,150,127.25	4,950,770.90
							4,950,770.00
							(0.90)
3920-00	10	PUBLIC AID	19	1.1		-	-
3920-10	10	PUBLIC AID	19	1.1		27,085.00	(27,085.00)
3925-00	10	EXCEPTIONAL CARE	19	1.1		-	-
3925-10	10	EXCEPTIONAL CARE	19	1.1		-	-
3930-00	10	PRIVATE PAY	19	1.1		-	-
3940-00	10	PRIVATE PAY	19	1.1		-	-
3940-10	10	PRIVATE PAY	19	1.1		1,039.00	(1,039.00)
3945-00	10	VETERANS	19	1.1		-	-
3945-10	10	VETERANS	19	1.1		366.00	(366.00)
3950-00	10	MEDICARE A	19	1.1		-	-

(2,042,416.75)
2,042,417
0.25

3950-10	10	MEDICARE A	19	1.1		583.00	(583.00)
3990-00	10	RESIDENT DAYS OFFSET	19	1.1		-	-
3990-10	10	RESIDENT DAYS OFFSET TOTAL	19	1.1	29,073.00		29,073.00
3999-00	10	RESIDENT DAYS OFFSET	19	1.1		-	-
4020-00	10	PUBLIC AID	19	1.1		-	-
4020-10	10	PUBLIC AID	19	1.1		4,265,458.90	(4,265,458.90)
4030-10	10	ACTIVE TREATMENT	19	1.1		7,290.00	(7,290.00)
4040-00	10	PRIVATE PAY	19	1.1		-	-
4040-10	10	PRIVATE PAY	19	1.1		203,821.25	(203,821.25)
4045-10	10	VETERANS	19	1.1		81,471.65	(81,471.65)
4050-10	10	EXCEPTIONAL CARE	19	1.1		-	-
4060-01	10	MEDICARE PART B	19	1.1		-	-
4060-10	10	MEDICARE PART B - THERAPY	19	1.1		133,430.00	(133,430.00)
4080-10	10	ANCILLARIES	19	1.1		1,066.66	(1,066.66)
4090-10	10	MEDICARE PART B - SUPPLIES	19	1.1		21,175.08	(21,175.08)
4100-10	10	MEDICARE A	19	1.1		211,596.86	(211,596.86)
4150-10	10	BAD DEBTS	19	2.1	12,000.00		12,000.00
4370-10	10	CNA REIMBURSEMENT	19	11.1		6,766.53	(6,766.53)
4300-10	10	MEALS	19	14.1		4,901.00	(4,901.00)
4630-00	10	DONATIONS	19	24.1		-	-
4360-10	10	INTEREST	19	25.1		14,552.08	(14,552.08)
4385-10	10	GAIN (LOSS) ON SALE:	19	25.1		-	-
4240-10	10	TRANSPORTATION	19	28.1		42,834.81	(42,834.81)
4130-10	10	GAIN/LOSS ON PARTNERSHIP	19	28a.1	16,451.00	4,000.00	12,451.00
4375-10	10	EMPLOYEES AT OTHER FACILITIES	19	28a.1		309.09	(309.09)
4377-10	10	ADMIN. FEE - OTHER FACILITIES	19	28a.1		12,000.00	(12,000.00)
4380-10	10	MISCELLANEOUS	19	28a.1		1,331.37	(1,331.37)
						57,524.00	5,041,078.28
							(4,983,554.28)
							4,983,554.00
							(0.28)
					14,191,205.53	14,191,205.53	0.00

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14,191,205.53 14,191,205.53

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