FOR BHF USE

LL1

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.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0039115

Facility Name: Wheaton Care Center

Address: 1325 Manchester Road (Number) Wheaton (City) 60187 (Zip Code)

County: Dupage

Telephone Number: (630) 668-2500 **Fax #** (630) 668-0232

HFS ID Number:

Date of Initial License for Current Owners: 09/01/1993

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236-1111
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 01/01/10 to 12/31/10 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed)
(Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed)
(Date)
(Print Name and Title) Andrew B. Cutler
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	264,321	29,453	10,162	303,936		303,936	2,835	306,771			1
2	Food Purchase		206,895		206,895		206,895	(1,318)	205,577			2
3	Housekeeping	148,948	33,019		181,967		181,967	(1,868)	180,099			3
4	Laundry	61,610	17,435		79,045		79,045	(645)	78,400			4
5	Heat and Other Utilities			127,168	127,168		127,168	967	128,135			5
6	Maintenance	66,817		163,020	229,837		229,837	1,375	231,212			6
7	Other (specify):*							1,379	1,379			7
8	**TOTAL General Services**	541,696	286,802	300,350	1,128,848		1,128,848	2,725	1,131,573			8
	B. Health Care and Programs											
9	Medical Director			13,800	13,800		13,800		13,800			9
10	Nursing and Medical Records	1,665,036	66,577	43,507	1,775,120		1,775,120	17,817	1,792,937			10
10a	Therapy	138,967			138,967		138,967	2,972	141,939			10a
11	Activities	108,745	10,179		118,924		118,924	(52)	118,872			11
12	Social Services	233,536	4,185	23,061	260,782		260,782	2,126	262,908			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							9,110	9,110			15
16	**TOTAL Health Care and Programs**	2,146,284	80,941	80,368	2,307,593		2,307,593	31,973	2,339,566			16
	C. General Administration											
17	Administrative	93,714		10,300	104,014		104,014	38,134	142,148			17
18	Directors Fees											18
19	Professional Services			320,393	320,393		320,393	(239,018)	81,375			19
20	Dues, Fees, Subscriptions & Promotions			20,901	20,901		20,901	244	21,145			20
21	Clerical & General Office Expenses	72,917	18,992	251,566	343,475		343,475	(83,431)	260,044			21
22	Employee Benefits & Payroll Taxes			479,684	479,684		479,684	(20,458)	459,226			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,801	5,801		5,801	1,473	7,274			24
25	Other Admin. Staff Transportation			5,259	5,259		5,259	549	5,808			25
26	Insurance-Prop.Liab.Malpractice			201,478	201,478		201,478	(12,116)	189,362			26
27	Other (specify):*							24,551	24,551			27
28	**TOTAL General Administration**	166,631	18,992	1,295,382	1,481,005		1,481,005	(290,072)	1,190,933			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,854,611	386,735	1,676,100	4,917,446		4,917,446	(255,374)	4,662,072			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 Wheaton Care Center # 0039115 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	82	Skilled (SNF)	82	29,930	1
2		Skilled Pediatric (SNF/PED)			2
3	41	Intermediate (ICF)	41	14,965	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	123	TOTALS	123	44,895	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,842	114	1,994	5,950	8
9	SNF/PED					9
10	ICF	34,582	1,022		35,604	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	38,424	1,136	1,994	41,554	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.56%

D. How many bed-hold days during this year were paid by the Department?
1,754 (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? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 09/01/1993

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 09/01/1993 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 81 and days of care provided 1,678

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center #0039115 Report Period Beginning: 01/01/10 Ending: 12/31/10

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			57,122	57,122		57,122	101,369	158,491			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			60,526	60,526		60,526	138,912	199,438			32
33	Real Estate Taxes			56,373	56,373		56,373	1,401	57,774			33
34	Rent-Facility & Grounds			660,000	660,000		660,000	(659,133)	867			34
35	Rent-Equipment & Vehicles			12,183	12,183		12,183	(4,544)	7,639			35
36	Other (specify):*											36
37	TOTAL Ownership			846,204	846,204		846,204	(421,995)	424,209			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		161,615	156,595	318,210		318,210	(25,073)	293,137			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			67,343	67,343		67,343		67,343			42
43	Other (specify):*			49,700	49,700		49,700	(49,700)				43
44	TOTAL Special Cost Centers		161,615	273,638	435,253		435,253	(74,773)	360,480			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,854,611	548,350	2,795,942	6,198,903		6,198,903	(752,142)	5,446,761			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/10 Ending: 12/31/10

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE 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	26,698	30		9
10	Interest and Other Investment Income	(93,994)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(56)	02		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	(3,850)	21		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	(170,036)	21		24
25	Fund Raising, Advertising and Promotional	(1,798)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(6,143)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(83,127)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (332,306)		$	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 Amount	2 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)	(419,836)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (419,836)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (752,142)		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 Yes	2 No	3 Amount	4 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

SEE ACCOUNTANTS' COMPILATION REPORT

Wheaton Care Center

ID# 0039115

Report Period Beginning: 01/01/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Exercise Bike Revenue	$ (52)	11	1
2	Jury Duty Revenue	(22)	10	2
3	Vending Income	(1,563)	02	3
4	Patient Clothing	(165)	10	4
5	Account Collection Expense	(338)	21	5
6	Prior Period Insurance	(12,835)	26	6
7	Prior Period Computer Fees	(3,114)	21	7
8	Building Company Filing Fees	(250)	20	8
9	Building Company Replacement Tax	(32)	21	9
10	Building Company Penalty	(28)	21	10
11	Building Company Amortization	(3,723)	31	11
12	Non-Allowable Expense	(49,700)	43	12
13	Annual Report Fees	(350)	20	13
14	Website Fee	(12)	21	14
15	2011 Seminar	(105)	24	15
16	Additional 2010 Seminar	450	24	16
17	Non-Allowable Legal	(4,646)	19	17
18	Capitalized R&M	(6,642)	06	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**	(83,127)		49

Wheaton Care Center

ID# 0039115

Report Period Beginning: 01/01/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98				49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Wheaton Care Center # 0039115 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary			108		3,194		(467)					2,835	1
2	Food Purchase	(1,619)		301									(1,318)	2
3	Housekeeping			386		43					(2,297)		(1,868)	3
4	Laundry										(645)		(645)	4
5	Heat and Other Utilities			877		90							967	5
6	Maintenance	(6,642)		2,521	5,407	89							1,375	6
7	Other (specify):*				931	448							1,379	7
8	**TOTAL General Services**	(8,261)		4,193	6,338	3,864		(467)			(2,942)		2,725	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(187)				20,550					(2,546)		17,817	10
10a	Therapy					2,972							2,972	10a
11	Activities	(52)											(52)	11
12	Social Services					2,126							2,126	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					3,595	5,515						9,110	15
16	**TOTAL Health Care and Programs**	(239)				29,243	5,515				(2,546)		31,973	16
	C. General Administration													
17	Administrative			1,786	6,937	29,411							38,134	17
18	Directors Fees													18
19	Professional Services	(4,646)		(171,464)		(62,908)							(239,018)	19
20	Fees, Subscriptions & Promotions	(2,398)	250	2,265		127							244	20
21	Clerical & General Office Expenses	(183,553)	60	10,581	84,079	5,402							(83,431)	21
22	Employee Benefits & Payroll Taxes				(14,943)		(5,515)						(20,458)	22
23	Inservice Training & Education													23
24	Travel and Seminar	345		111		1,017							1,473	24
25	Other Admin. Staff Transportation			549									549	25
26	Insurance-Prop.Liab.Malpractice	(12,835)		603		116							(12,116)	26
27	Other (specify):*				19,839	4,712							24,551	27
28	**TOTAL General Administration**	(203,087)	310	(155,569)	95,912	(22,123)	(5,515)						(290,072)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(211,587)	310	(151,376)	102,250	10,984		(467)			(5,488)		(255,374)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Wheaton Care Center** **#** **0039115** **Report Period Beginning:** **01/01/10** **Ending:** **12/31/10**

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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	26,698	70,800	3,256		615							101,369	30
31	Amortization of Pre-Op. & Org.	(3,723)	3,723											31
32	Interest	(93,994)	214,954	6,214		11,738							138,912	32
33	Real Estate Taxes			1,262		139							1,401	33
34	Rent-Facility & Grounds		(660,000)	867									(659,133)	34
35	Rent-Equipment & Vehicles			1,554								(6,098)	(4,544)	35
36	Other (specify):*													36
37	TOTAL Ownership	(71,019)	(370,523)	13,153		12,492						(6,098)	(421,995)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(874)	(8,899)	(220)	(3,061)	(12,020)	(25,073)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(49,700)											(49,700)	43
44	TOTAL Special Cost Centers	(49,700)						(874)	(8,899)	(220)	(3,061)	(12,020)	(74,773)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(332,306)	(370,213)	(138,223)	102,250	23,476		(1,341)	(8,899)	(220)	(8,548)	(18,118)	(752,142)	45

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/10 Ending: 12/31/10

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
See Attached		See Attached		See Attached		
				Wheaton HC Properties		Building Co.

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	34	Rental Income	$ 660,000	Wheaton HC Properties	100.00%	$	$ (660,000)	1
2	V	20	Filing Fee		Wheaton HC Properties	100.00%	250	250	2
3	V	21	State Replacement Tax		Wheaton HC Properties	100.00%	32	32	3
4	V	21	Penalty		Wheaton HC Properties	100.00%	28	28	4
5	V	30	Depreciation		Wheaton HC Properties	100.00%	70,800	70,800	5
6	V	31	Amortization		Wheaton HC Properties	100.00%	3,723	3,723	6
7	V	32	Interest		Wheaton HC Properties	100.00%	214,954	214,954	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 660,000			$ 289,787	$ * (370,213)	14

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

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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)	
15	V	01	Dietary	$	Extended Care Consulting, LLC	100.00%	$ 108	$ 108	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	301	301	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	386	386	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	877	877	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	2,521	2,521	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	1,786	1,786	20
21	V	19	Professional Fees	177,591	Extended Care Consulting, LLC	100.00%	7,447	(171,464)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	2,265	2,265	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	10,581	10,581	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	111	111	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	549	549	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	603	603	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	3,256	3,256	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	6,214	6,214	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	1,262	1,262	29
30	V	34	Rent - Building		Extended Care Consulting, LLC	100.00%	867	867	30
31	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	1,554	1,554	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 177,591			$ 40,688	$ * (138,223)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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)	
15	V	06	Maintenance (Pooled)		Extended Care Consulting, LLC	100.00%	5,407	$ 5,407	15
16	V	06	Maintenance (Direct)	155	Extended Care Consulting, LLC	100.00%	155		16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	904	904	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	27	27	18
19	V	12	Admission (Direct)		Extended Care Consulting, LLC	100.00%			19
20	V	15	Emp. Ben. - Nursing (Direct)		Extended Care Consulting, LLC	100.00%			20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	6,937	6,937	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	84,079	84,079	22
23	V	21	Office and Clerical (Direct)	26,503	Extended Care Consulting, LLC	100.00%	26,503		23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	15,209	15,209	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	4,630	4,630	25
26	V	22	Employee Benefits	14,943	Extended Care Consulting, LLC	100.00%		(14,943)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 41,601			$ 143,851	$ * 102,250	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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)	
15	V	03	Housekeeping	$	Extended Care Clinical, LLC	100.00%	$ 43	$ 43	15
16	V	05	Utilities		Extended Care Clinical, LLC	100.00%	90	90	16
17	V	06	Maintenance		Extended Care Clinical, LLC	100.00%	89	89	17
18	V	19	Professional Fees	67,899	Extended Care Clinical, LLC	100.00%	4,991	(62,908)	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	127	127	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC	100.00%	1,192	1,192	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC	100.00%	1,017	1,017	21
22	V	26	Insurance		Extended Care Clinical, LLC	100.00%	116	116	22
23	V	30	Depreciation		Extended Care Clinical, LLC	100.00%	615	615	23
24	V	32	Interest		Extended Care Clinical, LLC	100.00%	11,738	11,738	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC	100.00%	139	139	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC	100.00%	3,194	3,194	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	448	448	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC	100.00%	20,550	20,550	28
29	V	10a	Rehab Salary		Extended Care Clinical, LLC	100.00%	2,972	2,972	29
30	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%	2,126	2,126	30
31	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	3,595	3,595	31
32	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%	29,411	29,411	32
33	V	21	Office Salary		Extended Care Clinical, LLC	100.00%	4,210	4,210	33
34	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	4,712	4,712	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 67,899			$ 91,375	$ * 23,476	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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)	
15	V	01	Dietary Salary	$	Extended Care Clinical, LLC	100.00%	$	$	15
16	V	07	Emp. Ben. - General		Extended Care Clinical, LLC	100.00%			16
17	V	10	Nursing Salary	22,342	Extended Care Clinical, LLC	100.00%	22,342		17
18	V	12	Social Service Salary	22,543	Extended Care Clinical, LLC	100.00%	22,543		18
19	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	5,515	5,515	19
20	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%			20
21	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%			21
22	V	22	Employee Benefits	5,515	Extended Care Clinical, LLC	100.00%		(5,515)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 50,400			$ 50,400	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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)	
15	V	1	Dietary Supplies, Supplements	$ 1,052	Care Centers Health Systems, Inc.	100.00%	$ 585	$ (467)	15
16	V	10	Nursing Supplies		Care Centers Health Systems, Inc.	100.00%			16
17	V	39	Ancillary Expense	1,967	Care Centers Health Systems, Inc.	100.00%	1,093	(874)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 3,018			$ 1,677	$ * (1,341)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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)	
15	V	39	Therapy	$ 128,304	TriCare Rehab	100.00%	$ 119,405	$ (8,899)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 128,304			$ 119,405	$ * (8,899)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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)	
15	V	6	R&M - Equipment	$	Reliable Medical of the Midwest, LLC	100.00%	$	$	15
16	V	10	Nursing Supplies		Reliable Medical of the Midwest, LLC	100.00%			16
17	V	39	Ancillary Expense	2,806	Reliable Medical of the Midwest, LLC	100.00%	2,586	(220)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 2,806			$ 2,586	$ * (220)	39

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

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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)	
15	V	1	Dietary	$	Xcel Supply, LLC	100.00%	$	$	15
16	V	3	Housekeeping	34,464	Xcel Supply, LLC	100.00%	32,167	(2,297)	16
17	V	4	Laundry	9,681	Xcel Supply, LLC	100.00%	9,036	(645)	17
18	V	6	Repairs & Maintenance		Xcel Supply, LLC	100.00%			18
19	V	10	Nursing	38,202	Xcel Supply, LLC	100.00%	35,656	(2,546)	19
20	V	11	Activities		Xcel Supply, LLC	100.00%			20
21	V	12	Social Service		Xcel Supply, LLC	100.00%			21
22	V	20	Dues, Fees And Subscriptions		Xcel Supply, LLC	100.00%			22
23	V	21	Office And Clerical		Xcel Supply, LLC	100.00%			23
24	V	22	Employee Benefits		Xcel Supply, LLC	100.00%			24
25	V	24	Seminars & Education		Xcel Supply, LLC	100.00%			25
26	V	39	Ancillary	45,929	Xcel Supply, LLC	100.00%	42,869	(3,061)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 128,276			$ 119,728	$ * (8,548)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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)	
15	V	22	Employee Health Insurance	$	CCS Employee Benefits Group	100.00%	$ 105,748	$ 105,748	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	105,748	CCS Employee Benefits Group	100.00%		(105,748)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V	35	Matrix Leasing	$ 11,346	Vent Lease LLC	100.00%	$ 5,248	(6,098)	27
28	V	39	Ventilator Equipment	22,365	Vent Lease LLC	100.00%	10,345	(12,020)	28
29	V	39	Other Ancillary		Vent Lease LLC	100.00%			29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 139,459			$ 121,341	$ * (18,118)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Shareholder	Administrative	38.21%	See Attached	1.03	2.21%	Mgmt Fees	$ 10,300	17-3	1
2	Mark Steinberg	Relative	Administrative	0.00%	See Attached	1.51	2.75%	Al Fee/Al Sal	4,393	17-7	2
3	Adam Vales	Shareholder	Clerical	4.07%	See Attached	0.56	1.40%	Alloc Salary	971	22-7	3
4	G. Matt Silvers	Relative	Administrative	0.00%	See Attached	0.22	0.99%	Alloc Salary	763	17-7	4
5											5
6											6
7	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only amounts anticipated to be considered allowable by the										7
8	IL Dept. of HFS.										8
9											9
10											10
11											11
12											12
13								TOTAL	$ 16,427		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 Wheaton Care Center # 0039115 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [X]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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 Wheaton Care Center # 0039115 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [X] NO [ ]

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

Name of Related Organization: Extended Care Consulting, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,512,273	34	$ 3,931	$	41,554	$ 108	1
2	02	Food	Patient Days	1,512,273	34	10,940		41,554	301	2
3	03	Housekeeping	Patient Days	1,512,273	34	14,059		41,554	386	3
4	05	Utilities	Patient Days	1,512,273	34	31,923		41,554	877	4
5	06	Maintenance	Patient Days	1,512,273	34	91,744		41,554	2,521	5
6	17	Administrative	Patient Days	1,512,273	34	65,000		41,554	1,786	6
7	19	Professional Fees	Patient Days	1,512,273	34	271,007		41,554	7,447	7
8	20	Dues and Subscriptions	Patient Days	1,512,273	34	82,419		41,554	2,265	8
9	21	Office and Clerical	Patient Days	1,512,273	34	385,083		41,554	10,581	9
10	24	Seminar and Travel	Patient Days	1,512,273	34	4,022		41,554	111	10
11	25	Other Staff Admin. Trans.	Patient Days	1,512,273	34	19,982		41,554	549	11
12	26	Insurance	Patient Days	1,512,273	34	21,934		41,554	603	12
13	30	Depreciation	Patient Days	1,512,273	34	118,510		41,554	3,256	13
14	32	Interest	Patient Days	1,512,273	34	226,162		41,554	6,214	14
15	33	Real Estate Taxes	Patient Days	1,512,273	34	45,910		41,554	1,262	15
16	34	Rent - Building	Patient Days	1,512,273	34	31,555		41,554	867	16
17	35	Rent - Equipment & Auto	Patient Days	1,512,273	34	56,569		41,554	1,554	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,480,749	$		$ 40,688	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [X] NO [ ]

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

Name of Related Organization: Extended Care Consulting, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	06	Maintenance (Pooled)	Patient Days	1,512,273	34	196,794	196,794	41,554	5,407	1
2	06	Maintenance (Direct)	Direct		34	32,478	32,478		155	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,512,273	34	32,885		41,554	904	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		34	3,607			27	4
5	12	Admission (Direct)	Direct		34	52,036	52,036			5
6	15	Emp. Ben. - Nursing (Direct)	Direct		34	5,270				6
7	17	Administrative (Pooled)	Patient Days	1,512,273	34	252,448	252,448	41,554	6,937	7
8	21	Office and Clerical (Pooled)	Patient Days	1,512,273	34	3,059,876	3,059,876	41,554	84,079	8
9	21	Office and Clerical (Direct)	Direct		34	771,063	771,063		26,503	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,512,273	34	553,505		41,554	15,209	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		34	94,865			4,630	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					$ 5,054,827	$ 4,364,695		$ 143,851	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [X] NO [ ]

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

Name of Related Organization: Extended Care Clinical, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	03	Housekeeping	Patient Days	1,512,273	34	$ 1,549	$	41,554	$ 43	1
2	05	Utilities	Patient Days	1,512,273	34	3,268		41,554	90	2
3	06	Maintenance	Patient Days	1,512,273	34	3,240		41,554	89	3
4	19	Professional Fees	Patient Days	1,512,273	34	181,624		41,554	4,991	4
5	20	Dues and Subscriptions	Patient Days	1,512,273	34	4,624		41,554	127	5
6	21	Office & Clerical	Patient Days	1,512,273	34	43,370		41,554	1,192	6
7	24	Travel and Seminar	Patient Days	1,512,273	34	37,025		41,554	1,017	7
8	26	Insurance	Patient Days	1,512,273	34	4,213		41,554	116	8
9	30	Depreciation	Patient Days	1,512,273	34	22,389		41,554	615	9
10	32	Interest	Patient Days	1,512,273	34	427,165		41,554	11,738	10
11	33	Real Estate Taxes	Patient Days	1,512,273	34	5,058		41,554	139	11
12	01	Dietary Salary	Patient Days	1,512,273	34	116,221	116,221	41,554	3,194	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	1,512,273	34	16,288		41,554	448	13
14	10	Nursing Salary	Patient Days	1,512,273	34	747,870	747,870	41,554	20,550	14
15	10a	Rehab Salary	Patient Days	1,512,273	34	108,151	108,151	41,554	2,972	15
16	12	Social Service Salary	Patient Days	1,512,273	34	77,377	77,377	41,554	2,126	16
17	15	Emp. Ben. - Healthcare	Patient Days	1,512,273	34	130,816		41,554	3,595	17
18	17	Administration Salary	Patient Days	1,512,273	34	1,070,339	1,070,339	41,554	29,411	18
19	21	Office Salary	Patient Days	1,512,273	34	153,206	153,206	41,554	4,210	19
20	27	Emp. Ben. - Gen. Admin.	Patient Days	1,512,273	34	171,480		41,554	4,712	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,325,274	$ 2,273,164		$ 91,375	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [X] NO [ ]

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

Name of Related Organization: Extended Care Clinical, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary Salary	Direct Allocation			$ 15,960	$ 15,960		$	1
2	07	Emp. Ben. - General	Direct Allocation			1,662				2
3	10	Nursing Salary	Direct Allocation			495,330	495,330		22,342	3
4	12	Social Service Salary	Direct Allocation			274,597	274,597		22,543	4
5	15	Emp. Ben. - Healthcare	Direct Allocation			94,697			5,515	5
6	17	Administration Salary	Direct Allocation			82,389	82,389			6
7	27	Emp. Ben. - Gen. Admin.	Direct Allocation			10,053				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					$ 974,688	$ 868,276		$ 50,400	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [X] NO [ ]

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

Name of Related Organization: Care Centers Health Systems, Inc.
Street Address: 200 Howard
City / State / Zip Code: Des Plaines, Illinois 60018
Phone Number: (224) 612-5662
Fax Number: (224) 612-5862

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary Supplies, Supplements	Direct Allocation			$	$		$ 585	1
2	10	Nursing Supplies	Direct Allocation							2
3	39	Ancillary Expense	Direct Allocation						1,093	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					$	$		$ 1,677	25

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [X] NO [ ]

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

Name of Related Organization: TriCare Rehab
Street Address: 150 Fencl Lane
City / State / Zip Code: Hillside, IL 60162
Phone Number: (773) 449-9400
Fax Number: (773) 449-9700

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Therapy	Direct Allocation			$	$		$ 119,405	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					$	$		$ 119,405	25

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [X] NO [ ]

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

Name of Related Organization: Reliable Medical of the Midwest, LLC
Street Address: 200 Howard Avenue
City / State / Zip Code: Des Plaines, Illinois 60018-5909
Phone Number: (847) 566-0800
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	R&M - Equipment	Direct Allocation			$	$		$	1
2	10	Nursing Supplies	Direct Allocation							2
3	39	Ancillary Expense	Direct Allocation						2,586	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					$	$		$ 2,586	25

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [X] NO [ ]

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

Name of Related Organization: Xcel Supply, LLC
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, IL 60202
Phone Number: (847)328-7600
Fax Number: (847)328-7615

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Direct Allocation			$	$		$	1
2	3	Housekeeping	Direct Allocation						32,167	2
3	4	Laundry	Direct Allocation						9,036	3
4	6	Repairs & Maintenance	Direct Allocation							4
5	10	Nursing	Direct Allocation						35,656	5
6	11	Activities	Direct Allocation							6
7	12	Social Service	Direct Allocation							7
8	20	Dues, Fees And Subscriptions	Direct Allocation							8
9	21	Office And Clerical	Direct Allocation							9
10	22	Employee Benefits	Direct Allocation							10
11	24	Seminars & Education	Direct Allocation							11
12	39	Ancillary	Direct Allocation						42,869	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					$	$		$ 119,728	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [X] NO [ ]

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

Name of Related Organization: CCS Emp. Ben. Group / Vent Lease LLC
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847)905-4000 / (847) 674-1180
Fax Number: (847)905-4040 / (847-673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Employee Health Insurance	Direct Allocation			$	$		$ 105,748	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11	35	Matrix Leasing	Direct Allocation			$	$		$ 5,248	11
12	39	Ventilator Equipment	Direct Allocation						10,345	12
13	39	Other Ancillary	Direct Allocation							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					$	$		$ 121,341	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/10 Ending: 12/31/10

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	CIB		X	Mortgage			$	$ 1,277,608			$ 85,001	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	DAIWA		X	Line of Credit							60,018	6
7	Xerox		X	Copiers				3,906			508	7
8	See Supplemental Schedule							941,899			129,953	8
9	TOTAL Facility Related						$	$ 2,223,413			$ 275,480	9
	B. Non-Facility Related*											
10	Interest Income		X								(93,994)	10
11	Allocated From EC Consulting		X								6,214	11
12												12
13	See Supplemental Schedule										11,738	13
14	TOTAL Non-Facility Related						$	$			$ (76,042)	14
15	TOTALS (line 9+line14)						$	$ 2,223,413			$ 199,438	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/10 Ending: 12/31/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Manchester Manor		X	Loan			$	$ 941,899			$ 129,953	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital							941,899			129,953	14
	B. Non-Facility Related*											
15	Allocated From EC Clinical		X				$	$			$ 11,738	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related										11,738	20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Wheaton Care Center # 0039115 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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 must accompany the cost report.

1. Real Estate Tax accrual used on 2009 report.	$	56,239	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.)	$	56,334	2
3. Under or (over) accrual (line 2 minus line 1).	$	95	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)	$	57,679	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.	$	57,774	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	56,181	8
	2006	58,513	9
	2007	63,240	10
	2008	53,561	11
	2009	54,933	12

2010 Accrual: $54,933 X 1.05 =$57,679

Allocated From Extended Care Consulting $1,262

Allocated From Extended Care Clinical $139

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Wheaton Care Center COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0039115

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	05-17-114-010	Long Term Care Property	$ 54,932.80	$ 54,932.80
2.	See Attached	Allocated From 2201 Main	$ 116,500.56	$ 1,432.73
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 171,433.36	$ 56,365.53

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? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 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 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 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 Office of Health Finance at (217) 782-1630.

2008 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Wheaton Care Center COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0039115

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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 Wheaton Care Center # 0039115 Report Period Beginning: 01/01/10 Ending: 12/31/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 3,000 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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 [X] (b) Rent equipment from a Related Organization. [X] (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).

None

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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		2005	$ 828,181	1
2	Allocation From EC Consulting 2201 Main/EC Clinical 2201 Main			10,085	2
3	TOTALS			$ 838,266	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	41,331		20	2,067	2,067	35,861	9
10	Various			1994	104,965		20	5,248	5,248	87,535	10
11	Various			1995	16,968		20	848	848	13,379	11
12	Various			1996	158,287		20	7,914	7,914	114,926	12
13	Various			1997	103,690		20	5,185	5,185	70,447	13
14	Various			1998	56,873		20	2,844	2,844	35,190	14
15	Various			1999	21,286		20	1,064	1,064	12,280	15
16	Various			2000	57,068		20	2,292	2,292	31,408	16
17	Various			2001	48,282		20	2,531	2,531	24,929	17
18	Various			2002	15,745		20	1,311	1,311	13,148	18
19	Various			2003	18,300		20	1,403	1,403	13,770	19
20	Various			2004	134,063		20	10,368	10,368	92,511	20
21	Various			2005	38,153		20	3,282	3,282	19,067	21
22	Various			2006	95,583		20	8,639	8,639	39,330	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

*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 Wheaton Care Center # 0039115 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									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	Related Building Company (Pages 12F & 12G)		1,548,078	41,818		39,694	(2,124)	219,949	67
68	Related Party Allocations (Pages 12H & 12I)		40,641	2,766		2,766		19,371	68
69	Financial Statement Depreciation			48,728			(48,728)		69
70	TOTAL (lines 4 thru 69)		$ 2,499,313	$ 93,312		$ 97,456	$ 4,144	$ 843,100	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	
1	Totals from Page 12A, Carried Forward		$ 2,499,313	$ 93,312		$ 97,456	$ 4,144	$ 843,100	1
2	Major Plumbing Renovation	2007	8,924		20	892	892	3,570	2
3	Plumbing Renovation	2007	2,590		20	259	259	971	3
4	Mini Split Heating Units	2007	23,500		20	2,350	2,350	8,421	4
5	New Camera System W Bracket	2007	15,566		20	2,224	2,224	7,968	5
6	Painting Front Of Building	2007	12,600		20			12,600	6
7	Install New Doors	2007	6,500		20	650	650	2,058	7
8	Supply & Install New Flood Lighting	2007	6,500		20	650	650	2,058	8
9	Remodel 2 Bathrooms	2008	11,500		20	1,150	1,150	3,163	9
10	Install Power Line	2008	6,625		20	663	663	1,822	10
11	Improve Heating System	2008	2,700		20	270	270	608	11
12	Sprinkler System Repair	2008	2,535		20	254	254	549	12
13	Repair Broken Water Pipe	2008	5,870		20	587	587	1,272	13
14	Sealcoating	2008	2,550		20	128	128	340	14
15	Painting	2009	6,303		20	3,677	3,677	6,303	15
16	Lobby & Dining Room Remodeling- Floor, Tiles, Labor	2009	5,577		20	558	558	790	16
17	Arm Fireguard Cortega	2009	2,721		20	272	272	295	17
18	Plaster--Paint & Fix Various Walls	2010	4,050		20	203	203	203	18
19	Replace 16 Burners At Make Up Air Unit	2010	2,592		20	130	130	130	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	TOTAL (lines 1 thru 33)		$ 2,628,516	$ 93,312		$ 112,371	$ 19,059	$ 896,220	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	
1	Totals from Page 12B, Carried Forward		$ 2,628,516	$ 93,312		$ 112,371	$ 19,059	$ 896,220	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,628,516	$ 93,312		$ 112,371	$ 19,059	$ 896,220	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	
1	Totals from Page 12C, Carried Forward		$ 2,628,516	$ 93,312		$ 112,371	$ 19,059	$ 896,220	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,628,516	$ 93,312		$ 112,371	$ 19,059	$ 896,220	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	
1	Totals from Page 12D, Carried Forward		$ 2,628,516	$ 93,312		$ 112,371	$ 19,059	$ 896,220	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,628,516	$ 93,312		$ 112,371	$ 19,059	$ 896,220	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	
1	Building Company Information								1
2	Buildings:								2
3	123 Beds	1972	1,548,078	41,818	39	39,694	(2,124)	219,949	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	
1	Building Company Information Continued		$	$		$	$	$	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
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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 (12F & 12G lines 1 thru 33)		$ 1,548,078	$ 41,818		$ 39,694	$ (2,124)	$ 219,949	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	
1	Related Party Information		$	$		$	$	$	1
2	Buildings:								2
3	Allocated From Extended Care Consulting 2201 Main	2002	12,518	321	39	321		2,661	3
4	Allocated From Extended Care Clinical 2201 Main	2002	1,379	35	39	35		293	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated From Extended Care Consulting	2007	126	6	20	6		25	9
10	Allocated From Extended Care Consulting	2009	76	4	20	4		8	10
11	Allocated From Extended Care Consulting	2010	741	37	20	37		37	11
12									12
13	Allocated From Extended Care Consulting 2201 Main	2002	10,341	945	20	945		6,624	13
14	Allocated From Extended Care Consulting 2201 Main	2003	12,186	1,114	20	1,114		7,807	14
15	Allocated From Extended Care Consulting 2201 Main	2005	605	64	20	64		283	15
16	Allocated From Extended Care Consulting 2201 Main	2009	109	5	20	5		11	16
17									17
18	Allocated From Extended Care Clinical 2201 Main	2002	1,139	104	20	104		730	18
19	Allocated From Extended Care Clinical 2201 Main	2003	1,342	123	20	123		860	19
20	Allocated From Extended Care Clinical 2201 Main	2005	67	7	20	7		31	20
21	Allocated From Extended Care Clinical 2201 Main	2009	12	1	20	1		1	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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	
1	Related Party Information Continued								1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		$ 40,641	$ 2,766		$ 2,766	$	$ 19,371	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	$ 521,539	$ 37,234	$ 44,874	$ 7,640	10	$ 448,276	71
72	Current Year Purchases	4,211	802	802		10	802	72
73	Fully Depreciated Assets	283,174				10	283,174	73
74								74
75	TOTALS	$ 808,924	$ 38,036	$ 45,676	$ 7,640		$ 732,252	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	Facility	VAN	2003	$ 19,994	$	$	$	5	$ 19,994	76
77		Allocated From EC Consulting	2010	8,836	138	138		5	8,560	77
78		Allocated From EC Clinical	2010	1,536	307	307		5	717	78
79										79
80	TOTALS			$ 30,366	$ 445	$ 445	$		$ 29,271	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,306,072	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 131,793	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 158,491	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 26,698	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,657,743	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/10 Ending: 12/31/10

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
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	Allocated From EC Consulting				867			5
6								6
7	TOTAL				$ 867 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

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.	/2011	$
13.	/2012	$
14.	/2013	$

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: $ 7,639 Description: See Attached Schedule
(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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/10 Ending: 12/31/10

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] 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

ALLOCATION OF COSTS (d)

		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)	$			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 40,430	$		$ 40,430	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			25,576			25,576	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			62,298			62,298	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				104,958		104,958	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					28,291	56,657		84,948	13
14	TOTAL			$		$ 156,595	$ 161,615		$ 318,210	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.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Wheaton Care Center **#** 0039115 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/10 **(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	$ 1,100	$ 65,277	1
2	Cash-Patient Deposits	66,400	66,400	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	342,588	342,588	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	229,123	229,123	6
7	Other Prepaid Expenses	544	544	7
8	Accounts Receivable (owners or related parties)	10,700	1,239,169	8
9	Other(specify): See Attached Schedule	1,347,276	1,498,276	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,997,731	$ 3,441,377	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		828,181	13
14	Buildings, at Historical Cost		1,496,317	14
15	Leasehold Improvements, at Historical Cost	954,212	1,005,973	15
16	Equipment, at Historical Cost	477,885	809,157	16
17	Accumulated Depreciation (book methods)	(1,209,830)	(1,765,297)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	1,234,469	1,261,402	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,456,736	$ 3,635,733	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,454,467	$ 7,077,110	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,166,324	$ 1,166,324	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	33,455	33,455	28
29	Short-Term Notes Payable	1,211	1,211	29
30	Accrued Salaries Payable	166,935	166,935	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,607	7,607	31
32	Accrued Real Estate Taxes(Sch.IX-B)	57,679	57,679	32
33	Accrued Interest Payable		16,641	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	1,279,899	1,279,899	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,713,110	$ 2,729,751	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,695	944,594	39
40	Mortgage Payable		1,277,608	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,695	$ 2,222,202	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,715,805	$ 4,951,953	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 738,662	$ 2,125,157	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,454,467	$ 7,077,110	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/10 Ending: 12/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,270,127	1
2	Restatements (describe):		2
3	**Dividends**	(410,106)	3
4	**Medicare Settlement**	(7,857)	4
5	**Rounding Adjustment**	6	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 852,170	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(113,508)	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)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (113,508)	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)**	$ 738,662	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,976,913	1
2	Discounts and Allowances for all Levels	(477,401)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,499,512	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	363,278	6
7	Oxygen	132	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 363,410	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	107,144	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,883	19
20	Radiology and X-Ray	5,300	20
21	Other Medical Services	3,515	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 126,842	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	93,994	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 93,994	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	1,637	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,637	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,085,395	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,128,848	31
32	Health Care	2,307,593	32
33	General Administration	1,481,005	33
	B. Capital Expense		
34	Ownership	846,204	34
	C. Ancillary Expense		
35	Special Cost Centers	367,910	35
36	Provider Participation Fee	67,343	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,198,903	40
41	**Income before Income Taxes (line 30 minus line 40)****	(113,508)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (113,508)	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Not Complete **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.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/10 Ending: 12/31/10

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,926	2,147	$ 83,505	$ 38.89	1
2	Assistant Director of Nursing	1,778	2,032	58,263	28.67	2
3	Registered Nurses	11,087	12,341	362,186	29.35	3
4	Licensed Practical Nurses	16,673	18,262	461,150	25.25	4
5	CNAs & Orderlies	49,669	53,818	639,582	11.88	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,104	7,807	138,967	17.80	8
9	Activity Director	2,348	2,608	38,957	14.94	9
10	Activity Assistants	6,605	7,192	69,788	9.70	10
11	Social Service Workers	11,400	12,732	233,536	18.34	11
12	Dietician	906	962	18,402	19.13	12
13	Food Service Supervisor	1,894	2,134	54,229	25.41	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,371	7,035	87,957	12.50	15
16	Dishwashers	11,000	12,134	103,733	8.55	16
17	Maintenance Workers	3,812	4,179	66,817	15.99	17
18	Housekeepers	13,215	14,790	148,948	10.07	18
19	Laundry	5,261	6,247	61,610	9.86	19
20	Administrator	1,980	1,979	93,714	47.35	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,365	5,775	72,917	12.63	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	1,816	2,094	29,471	14.07	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	1,923	2,167	30,879	14.25	33
34	TOTAL (lines 1 - 33)	162,133	178,435	$ 2,854,611 *	$ 16.00	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	212	$ 10,162	01-03	35
36	Medical Director	Monthly	13,800	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,318	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	12	518	12-03	45
46	Other(specify)				46
47					47
48	See Attached		44,885		48
49	TOTAL (lines 35 - 48)	224	$ 76,683		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	139	$ 8,165	10-03	50
51	Licensed Practical Nurses	127	5,182	10-03	51
52	Certified Nurse Assistants/Aides	16	500	10-03	52
53	TOTAL (lines 50 - 52)	282	$ 13,847		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/10 Ending: 12/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Delnaz Vazifdar	Administrator	0.00%	$ 93,714
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 93,714

B. Administrative - Other

Description	Amount
Eric Rothner Management Fees	$ 10,300
TOTAL (agree to Schedule V, line 17, col. 3)	$ 10,300
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Extended Care Consulting	Home Office Expenses	$ 177,591
Extended Care Clinical	Home Office Expenses	67,899
Frost, Ruttenberg & Rothblatt	Accounting	28,474
Personnel Planners	Unemployment Consulting	1,675
See Attached	Legal	5,764
Prospect Resources	Natural Gas Procurement	1,296
Chad Cournaya	Medicare Consultant	138
Michelle Frauendorff	Therapy Consultant	614
Blymass	Tax Credit Consulting	894
DIAWA	Audit Fees For LOC	13,800
National Hotline Services	Employee Compliance	218
See Supplemetal Schedule		22,030
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 320,393

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 143,889
Unemployment Compensation Insurance	19,879
FICA Taxes	214,836
Employee Health Insurance	64,849
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	4,980
Other Employee Welfare	8,693
Holiday Expense	2,100
TOTAL (agree to Schedule V, line 22, col.8)	$ 459,226

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 995
Advertising: Employee Recruitment	1,690
Health Care Worker Background Check	
(Indicate # of checks performed 60)	1,460
Patient Background Checks 123	1,364
Advertising & Promotions	1,798
Dues & Subscriptions	11,250
Licenses, Inspections, Permits	1,994
See Supplemental Schedule	2,392
Less: Public Relations Expense	( )
Non-allowable advertising	(1,798)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 21,145

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	6,146
Allocated From EC Consulting	111
Allocated From EC Clinical	1,017
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,274

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
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14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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 Council on LTC $10,146**

(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? **N/A**

(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? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **17,619** Line **10-2**

(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. **N/A**

(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.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **67,343**
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. $ Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(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? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% ln 14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
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? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **N/A**

(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.