		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.

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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: 09/01/93

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 01/01/11 to 12/31/11 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) Lisa M. Hanlon, C.P.A.
(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: 01/01/11 Ending: 12/31/11

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	3,918	87	2,004	6,009	8
9	SNF/PED					9
10	ICF	35,265	784		36,049	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	39,183	871	2,004	42,058	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.68%

D. How many bed-hold days during this year were paid by the Department?
None (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 1,981

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: 12/31/2011 Fiscal Year: 12/31/2011

* 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: 01/01/11 Ending: 12/31/11

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	269,996	35,644	1,131	306,771		306,771	5,068	311,839			1
2	Food Purchase		218,648		218,648		218,648	(2,430)	216,218			2
3	Housekeeping	144,046	37,688		181,734		181,734	(1,654)	180,080			3
4	Laundry	63,447	19,308		82,755		82,755	(747)	82,008			4
5	Heat and Other Utilities			157,728	157,728		157,728	919	158,647			5
6	Maintenance	82,228		165,790	248,018		248,018	7,065	255,083			6
7	Other (specify):*							2,504	2,504			7
8	**TOTAL General Services**	559,717	311,288	324,649	1,195,654		1,195,654	10,724	1,206,378			8
	B. Health Care and Programs											
9	Medical Director			15,600	15,600		15,600		15,600			9
10	Nursing and Medical Records	1,644,603	70,780	23,028	1,738,411		1,738,411	31,859	1,770,270			10
10a	Therapy	145,058			145,058		145,058		145,058			10a
11	Activities	112,570	9,882		122,452		122,452		122,452			11
12	Social Services	224,110	4,154	10,195	238,459		238,459	5,066	243,525			12
13	CNA Training											13
14	Program Transportation			30	30		30		30			14
15	Other (specify):*							9,843	9,843			15
16	**TOTAL Health Care and Programs**	2,126,341	84,816	48,853	2,260,010		2,260,010	46,768	2,306,778			16
	C. General Administration											
17	Administrative	92,318			92,318		92,318	40,073	132,391			17
18	Directors Fees											18
19	Professional Services			382,560	382,560		382,560	(254,037)	128,523			19
20	Dues, Fees, Subscriptions & Promotions			20,728	20,728		20,728	1,506	22,234			20
21	Clerical & General Office Expenses	66,395	17,718	108,082	192,195		192,195	64,818	257,013			21
22	Employee Benefits & Payroll Taxes			510,892	510,892		510,892	(17,304)	493,588			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,502	3,502		3,502	1,790	5,292			24
25	Other Admin. Staff Transportation			4,519	4,519		4,519	367	4,886			25
26	Insurance-Prop.Liab.Malpractice			157,157	157,157		157,157	817	157,974			26
27	Other (specify):*							24,549	24,549			27
28	**TOTAL General Administration**	158,713	17,718	1,187,440	1,363,871		1,363,871	(137,421)	1,226,450			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,844,771	413,822	1,560,942	4,819,535		4,819,535	(79,929)	4,739,606			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: 01/01/11 Ending: 12/31/11

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			52,074	52,074		52,074	106,854	158,928			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,186	1,186		1,186	162,650	163,836			32
33	Real Estate Taxes			58,329	58,329		58,329	1,360	59,689			33
34	Rent-Facility & Grounds			660,274	660,274		660,274	(660,000)	274			34
35	Rent-Equipment & Vehicles			4,795	4,795		4,795	(1,165)	3,630			35
36	Other (specify):*											36
37	**TOTAL Ownership**			776,658	776,658		776,658	(390,301)	386,357			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		161,075	122,105	283,180		283,180	(16,691)	266,489			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			251,276	251,276		251,276		251,276			42
43	Other (specify):*			20,000	20,000		20,000	(20,000)				43
44	**TOTAL Special Cost Centers**		161,075	393,381	554,456		554,456	(36,691)	517,765			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,844,771	574,897	2,730,981	6,150,649		6,150,649	(506,921)	5,643,728			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: 01/01/11 Ending: 12/31/11

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	56,366	30		9
10	Interest and Other Investment Income	(21,166)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(45)	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	(3,750)	21		18
19	Entertainment				19
20	Contributions	(750)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(214)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,984)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(62,606)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (36,149)		$	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)	(470,773)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (470,773)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (506,921)		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: 01/01/11

Ending: 12/31/11

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Patient Clothing	$ (201)	10	1
2	Theft Loss	(200)	21	2
3	Collection Expense	(2,724)	21	3
4	Building Co. - Admin Expense	(34)	21	4
5	Building Co. - Filing Fee	(250)	20	5
6	Building Co. - State Replacement Tax	(100)	21	6
7	Building Co. - Amortization	(3,723)	31	7
8	Vending Income	(2,596)	02	8
9	Non-Allowable Legal	(3,396)	19	9
10	Annual Report	(270)	20	10
11	Additional 2011 Seminar (PY Adj)	105	24	11
12	PPA - Office Expense (Achieve)	(20,989)	21	12
13	PPA - Professional Services	(6,433)	19	13
14	Other Income	(678)	21	14
15	Additional R&M	4,335	06	15
16	Non-Allowable Fees	(20,000)	43	16
17	Capitalized R&M	(5,452)	06	17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(62,606)		49

Wheaton Care Center

ID# 0039115

Report Period Beginning: 01/01/11

Ending: 12/31/11

	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:** 01/01/11 **Ending:** 12/31/11

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	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			219		6,126		(1,276)	(2)				5,068	1
2	Food Purchase	(2,641)		211									(2,430)	2
3	Housekeeping			444		80			(2,178)				(1,654)	3
4	Laundry								(747)				(747)	4
5	Heat and Other Utilities			779		140							919	5
6	Maintenance	(1,117)		2,236	5,917	29							7,065	6
7	Other (specify):*				1,473	1,031							2,504	7
8	**TOTAL General Services**	(3,758)		3,889	7,390	7,406		(1,276)	(2,927)				10,724	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(201)				34,182			(2,122)				31,859	10
10a	Therapy													10a
11	Activities													11
12	Social Services					5,066							5,066	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					6,607	3,236						9,843	15
16	**TOTAL Health Care and Programs**	(201)				45,855	3,236		(2,122)				46,768	16
	C. General Administration													
17	Administrative			2,336	7,953	29,784							40,073	17
18	Directors Fees													18
19	Professional Services	(9,829)		(193,586)		(50,622)							(254,037)	19
20	Fees, Subscriptions & Promotions	(1,484)	250	2,615		125							1,506	20
21	Clerical & General Office Expenses	(32,459)	134	9,686	81,295	6,162							64,818	21
22	Employee Benefits & Payroll Taxes				(14,046)		(3,236)		(22)				(17,304)	22
23	Inservice Training & Education													23
24	Travel and Seminar	105		145		1,540							1,790	24
25	Other Admin. Staff Transportation			367									367	25
26	Insurance-Prop.Liab.Malpractice			696		121							817	26
27	Other (specify):*				18,881	5,668							24,549	27
28	**TOTAL General Administration**	(43,667)	384	(177,741)	94,083	(7,222)	(3,236)		(22)				(137,421)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(47,626)	384	(173,852)	101,473	46,039		(1,276)	(5,071)				(79,929)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Wheaton Care Center # 0039115 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	56,366	41,818	7,518		1,152							106,854	30
31	Amortization of Pre-Op. & Org.	(3,723)	3,723											31
32	Interest	(21,166)	177,056	6,395		365							162,650	32
33	Real Estate Taxes			1,153		207							1,360	33
34	Rent-Facility & Grounds		(660,000)										(660,000)	34
35	Rent-Equipment & Vehicles			2,850						(4,015)			(1,165)	35
36	Other (specify):*													36
37	**TOTAL Ownership**	31,477	(437,403)	17,916		1,724				(4,015)			(390,301)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(791)	(2,508)	(7,664)	(5,644)	(84)	(16,691)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(20,000)											(20,000)	43
44	**TOTAL Special Cost Centers**	(20,000)						(791)	(2,508)	(7,664)	(5,644)	(84)	(36,691)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(36,149)	(437,019)	(155,936)	101,473	47,763		(2,067)	(7,579)	(11,679)	(5,644)	(84)	(506,921)	45

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

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, LLC	100.00%	$	$ (660,000)	1
2	V	21	Admin Expense		Wheaton HC Properties, LLC	100.00%	34	34	2
3	V	20	Filing Fee		Wheaton HC Properties, LLC	100.00%	250	250	3
4	V	21	State Replacement Tax		Wheaton HC Properties, LLC	100.00%	100	100	4
5	V	30	Depreciation		Wheaton HC Properties, LLC	100.00%	41,818	41,818	5
6	V	31	Amortization		Wheaton HC Properties, LLC	100.00%	3,723	3,723	6
7	V	32	Interest		Wheaton HC Properties, LLC	100.00%	177,056	177,056	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 660,000			$ 222,981	$ * (437,019)	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: 01/01/11 Ending: 12/31/11

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%	$ 219	$ 219	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	211	211	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	444	444	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	779	779	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	2,236	2,236	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	2,336	2,336	20
21	V	19	Professional Fees	201,043	Extended Care Consulting, LLC	100.00%	4,366	(193,586)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	2,615	2,615	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	9,686	9,686	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	145	145	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	367	367	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	696	696	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	7,518	7,518	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	6,395	6,395	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	1,153	1,153	29
30	V	34	Rent - Building		Extended Care Consulting, LLC	100.00%			30
31	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	2,850	2,850	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 201,043			$ 42,016	$ * (155,936)	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: 01/01/11 Ending: 12/31/11

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%	5,917	$ 5,917	15
16	V	06	Maintenance (Direct)	2,492	Extended Care Consulting, LLC	100.00%	2,492		16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	1,061	1,061	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	412	412	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%	7,953	7,953	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	81,295	81,295	22
23	V	21	Office and Clerical (Direct)	27,036	Extended Care Consulting, LLC	100.00%	27,036		23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	15,356	15,356	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	3,525	3,525	25
26	V	22	Employee Benefits	14,046	Extended Care Consulting, LLC	100.00%		(14,046)	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			$ 43,574			$ 145,047	$ * 101,473	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: 01/01/11 Ending: 12/31/11

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%	$ 80	$ 80	15
16	V	05	Utilities		Extended Care Clinical, LLC	100.00%	140	140	16
17	V	06	Maintenance		Extended Care Clinical, LLC	100.00%	29	29	17
18	V	19	Professional Fees	65,988	Extended Care Clinical, LLC	100.00%	15,366	(50,622)	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	125	125	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC	100.00%	2,271	2,271	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC	100.00%	1,540	1,540	21
22	V	26	Insurance		Extended Care Clinical, LLC	100.00%	121	121	22
23	V	30	Depreciation		Extended Care Clinical, LLC	100.00%	1,152	1,152	23
24	V	32	Interest		Extended Care Clinical, LLC	100.00%	365	365	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC	100.00%	207	207	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC	100.00%	6,126	6,126	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	1,031	1,031	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC	100.00%	34,182	34,182	28
29	V	10a	Rehab Salary		Extended Care Clinical, LLC	100.00%			29
30	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%	5,066	5,066	30
31	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	6,607	6,607	31
32	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%	29,784	29,784	32
33	V	21	Office Salary		Extended Care Clinical, LLC	100.00%	3,891	3,891	33
34	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	5,668	5,668	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 65,988			$ 113,751	$ * 47,763	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: 01/01/11 Ending: 12/31/11

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 / Medical Record Salary	15,372	Extended Care Clinical, LLC	100.00%	15,372		17
18	V	12	Social Service / Admission Salary	10,195	Extended Care Clinical, LLC	100.00%	10,195		18
19	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	3,236	3,236	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	3,236	Extended Care Clinical, LLC	100.00%		(3,236)	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			$ 28,803			$ 28,803	$ *	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: 01/01/11 Ending: 12/31/11

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	$ 2,662	Care Centers Health Systems, Inc.	100.00%	$ 1,386	$ (1,276)	15
16	V	2	Food		Care Centers Health Systems, Inc.	100.00%			16
17	V	10	Nursing Supplies		Care Centers Health Systems, Inc.	100.00%			17
18	V	39	Ancillary Expense	1,651	Care Centers Health Systems, Inc.	100.00%	860	(791)	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			$ 4,313			$ 2,246	$ * (2,067)	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: 01/01/11 Ending: 12/31/11

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	$ 27	Xcel Supply, LLC	100.00%	$ 26	$ (2)	15
16	V	3	Housekeeping	35,929	Xcel Supply, LLC	100.00%	33,751	(2,178)	16
17	V	4	Laundry	12,330	Xcel Supply, LLC	100.00%	11,582	(747)	17
18	V	6	Repairs & Maintenance		Xcel Supply, LLC	100.00%			18
19	V	10	Nursing	34,999	Xcel Supply, LLC	100.00%	32,877	(2,122)	19
20	V	11	Activities		Xcel Supply, LLC	100.00%			20
21	V	21	Office And Clerical		Xcel Supply, LLC	100.00%			21
22	V	22	Employee Benefits	369	Xcel Supply, LLC	100.00%	347	(22)	22
23	V	30	Fixed Assets-Depreciation		Xcel Supply, LLC	100.00%			23
24	V	39	Ancillary	41,371	Xcel Supply, LLC	100.00%	38,863	(2,508)	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			$ 125,024			$ 117,445	$ * (7,579)	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: 01/01/11 Ending: 12/31/11

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	Ventilator Equipment	11,625	Vent Lease LLC	100.00%	3,961	(7,664)	15
16	V	39	Other Ancillary		Vent Lease LLC	100.00%			16
17	V	35	Matrix Leasing	4,015	Vent Lease LLC	100.00%		(4,015)	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	22	Employee Health Insurance	$	CCS Employee Benefits Group	100.00%	$ 98,175	$ 98,175	28
29	V								29
30	V								30
31	V								31
32	V	22	Employee Health Insurance	98,175	CCS Employee Benefits Group	100.00%		(98,175)	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 113,815			$ 102,136	$ * (11,679)	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: 01/01/11 Ending: 12/31/11

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	$ 110,480	TriCare Rehab	100.00%	$ 104,836	$ (5,644)	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			$ 110,480			$ 104,836	$ * (5,644)	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: 01/01/11 Ending: 12/31/11

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	9,436	Reliable Medical of the Midwest, LLC	100.00%	9,351	(84)	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			$ 9,436			$ 9,351	$ * (84)	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: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	ADAM VALES ACCUMULATION	4.065%	TRI-STATE NURSING & REHABILITATION CENTER, INC.	LANSING	WHEATON HC PROPERTIES, LI	EVANSTON	BUILDING CO.	1
2	DANIEL ROTHNER ACCUMULATION	4.065%	AVENUE CARE NURSING AND REHABILITATION CENTER,LLC	CHICAGO	EXTENDED CARE CONSULTING	EVANSTON	MANAGEMENT/BOOKKI	2
3	ERIC ROTHNER	38.211%	BEECHER MANOR NURSING AND REHABILITATION CENTER, LLC	BEECHER	EXTENDED CARE CLINICAL	EVANSTON	ADMINISTRATIVE	3
4	ILANA KLEIN REICH	0.813%	BOULEVARD CARE NURSING AND REHABILITATION CENTER,LLC	CHICAGO	CARE CENTER HEALTH SYSTE	DES PLAINES	DIETARY & FOOD SUPPI	4
5	JUDITH FREEMAN	1.626%	BRIAR PLACE, LTD.	INDIAN HEAD	CCS EMPLOYEE BENEFITS GR	EVANSTON	HEALTH INSURANCE	5
6	KATHRYN VALES ACCUMULATION	4.065%	CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	XCEL MEDICAL SUPPLY	EVANSTON	MEDICAL SUPPLIES	6
7	KIMBERLY RICHMOND ACCUMULATION	4.065%	COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	VENTLEASE, LLC	EVANSTON	VENTILATOR RENTAL	7
8	MELISSA ROTHNER ACCUMULATION	4.065%	DYER NURSING & REHAB	DYER, IN	TRICARE REHAB	HILLSIDE	THERAPY	8
9	MICHELLE KLEIN	0.813%	GRASMERE PLACE, LLC	CHICAGO	HARBOR LIGHT	GLEN ELLYN	HOSPICE	9
10	NATHAN & SHIRLEY ROTHNER FAMILY	26.829%	HILLCREST NURSING AND REHABILITATION CENTER,LLC	JOLIET	RELIABLE MEDICAL SUPPLY C	DES PLAINES	MEDICAL SUPPLY	10
11	NEAL ROTHNER	1.626%	HOMESTEAD NURSING & REHAB	LINCOLN, NE	2201 MAIN, LLC	EVANSTON	BLDG COMPANY	11
12	NWOS, INC.	1.626%	TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				12
13	RACHEL ROTHNER ACCUMULATION	4.065%	LAKE COUNTY NURSING & REHAB	EAST CHICAGO, IN				13
14	WILLIAM ROTHNER ACCUMULATION	4.065%	LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD				14
15			LANCASTER MANOR	LINCOLN, NE				15
16			LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT				16
17			MCKINLEY HEALTH CARE CENTER	CANTON, OH				17
18			OAK PARK HEALTHCARE CENTER, L.L.C.	OAK PARK				18
19			PARK HOUSE NURSING AND REHABILITATION CENTER,LLC	CHICAGO				19
20			PRAIRIE MANOR NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO HEIGHTS				20
21			PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				21
22			RAINBOW BEACH QOC, L.L.C.	CHICAGO				22
23			SEBOS NURSING & REHAB	HOLBART, IN				23
24			GOLDEN PLAINES	HUTCHINSON, KS				24
25			SHERIDAN SHORES CARE & REHABILITATION CENTER, INC.	CHICAGO				25
26			SNOW VALLEY NURSING AND REHABILITATION CENTER, L.L.C.	LISLE				26
27			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				27
28								28
29								29
30								30

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								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

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	G. Matt Silvers	Relative	Administrative	0.00%	See Attached	0.4	1.00%	Alloc Salary	$ 1,568	17-7	1
2	Mark Steinberg	Relative	Administrative	0.00%	See Attached	2.77	3.16%	Al Fee/Al Sal	9,066	17-7	2
3	Adam Vales	Shareholder	Clerical	4.07%	See Attached	0.72	1.80%	Alloc Salary	1,281	22-7	3
4											4
5											5
6											6
7											7
8											8
9	Where applicable, the amounts reported on this page have been adjusted from the actual costs										9
10	to reflect only amounts anticipated to be considered allowable by the IL Dept. of HFS.										10
11											11
12											12
13								TOTAL	$ 11,915		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: 01/01/11 Ending: 12/31/11

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	1,332,501	31	$ 6,942	$	42,058	$ 219	1
2	02	Food	Patient Days	1,332,501	31	6,677		42,058	211	2
3	03	Housekeeping	Patient Days	1,332,501	31	14,059		42,058	444	3
4	05	Utilities	Patient Days	1,332,501	31	24,674		42,058	779	4
5	06	Maintenance	Patient Days	1,332,501	31	70,833		42,058	2,236	5
6	17	Administrative	Patient Days	1,332,501	31	74,000		42,058	2,336	6
7	19	Professional Fees	Patient Days	1,332,501	31	138,332		42,058	4,366	7
8	20	Dues and Subscriptions	Patient Days	1,332,501	31	82,842		42,058	2,615	8
9	21	Office and Clerical	Patient Days	1,332,501	31	306,863		42,058	9,686	9
10	24	Seminar and Travel	Patient Days	1,332,501	31	4,580		42,058	145	10
11	25	Other Staff Admin. Trans.	Patient Days	1,332,501	31	11,637		42,058	367	11
12	26	Insurance	Patient Days	1,332,501	31	22,043		42,058	696	12
13	30	Depreciation	Patient Days	1,332,501	31	238,204		42,058	7,518	13
14	32	Interest	Patient Days	1,332,501	31	202,602		42,058	6,395	14
15	33	Real Estate Taxes	Patient Days	1,332,501	31	36,524		42,058	1,153	15
16	34	Rent - Building	Patient Days	1,332,501	31			42,058		16
17	35	Rent - Equipment & Auto	Patient Days	1,332,501	31	90,286		42,058	2,850	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,331,096	$		$ 42,016	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	1,332,501	31	187,474	187,474	42,058	5,917	1
2	06	Maintenance (Direct)	Direct		31	122,603	122,603		2,492	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,332,501	31	33,619		42,058	1,061	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		31	16,441			412	4
5	12	Admission (Direct)	Direct		31					5
6	15	Emp. Ben. - Nursing (Direct)	Direct		31					6
7	17	Administrative (Pooled)	Patient Days	1,332,501	31	251,959	251,959	42,058	7,953	7
8	21	Office and Clerical (Pooled)	Patient Days	1,332,501	31	2,575,611	2,575,611	42,058	81,295	8
9	21	Office and Clerical (Direct)	Direct		31	545,076	545,076		27,036	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,332,501	31	486,522		42,058	15,356	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		31	78,893			3,525	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					$ 4,298,198	$ 3,682,723		$ 145,047	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	817,528	19	$ 1,549	$	42,058	$ 80	1
2	05	Utilities	Patient Days	817,528	19	2,718		42,058	140	2
3	06	Maintenance	Patient Days	817,528	19	557		42,058	29	3
4	19	Professional Fees	Patient Days	817,528	19	298,695		42,058	15,366	4
5	20	Dues and Subscriptions	Patient Days	817,528	19	2,426		42,058	125	5
6	21	Office & Clerical	Patient Days	817,528	19	44,146		42,058	2,271	6
7	24	Travel and Seminar	Patient Days	817,528	19	29,934		42,058	1,540	7
8	26	Insurance	Patient Days	817,528	19	2,346		42,058	121	8
9	30	Depreciation	Patient Days	817,528	19	22,389		42,058	1,152	9
10	32	Interest	Patient Days	817,528	19	7,100		42,058	365	10
11	33	Real Estate Taxes	Patient Days	817,528	19	4,024		42,058	207	11
12	01	Dietary Salary	Patient Days	817,528	19	119,073	119,073	42,058	6,126	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	817,528	19	20,044		42,058	1,031	13
14	10	Nursing Salary	Patient Days	817,528	19	664,429	664,429	42,058	34,182	14
15	10a	Rehab Salary	Patient Days	817,528	19			42,058		15
16	12	Social Service Salary	Patient Days	817,528	19	98,474	98,474	42,058	5,066	16
17	15	Emp. Ben. - Healthcare	Patient Days	817,528	19	128,421		42,058	6,607	17
18	17	Administration Salary	Patient Days	817,528	19	578,938	578,938	42,058	29,784	18
19	21	Office Salary	Patient Days	817,528	19	75,625	75,625	42,058	3,891	19
20	27	Emp. Ben. - Gen. Admin.	Patient Days	817,528	19	110,184		42,058	5,668	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,211,073	$ 1,536,540		$ 113,751	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/11 Ending: 12/31/11

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			$	$		$	1
2	07	Emp. Ben. - General	Direct Allocation							2
3	10	Nursing / Medical Record Salary	Direct Allocation			344,209	344,209		15,372	3
4	12	Social Service / Admission Salary	Direct Allocation			174,668	174,668		10,195	4
5	15	Emp. Ben. - Healthcare	Direct Allocation			61,656			3,236	5
6	17	Administration Salary	Direct Allocation							6
7	27	Emp. Ben. - Gen. Admin.	Direct Allocation							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					$ 580,533	$ 518,877		$ 28,803	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/11 Ending: 12/31/11

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			$	$		$ 1,386	1
2	2	Food	Direct Allocation							2
3	10	Nursing Supplies	Direct Allocation							3
4	39	Ancillary Expense	Direct Allocation						860	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					$	$		$ 2,246	25

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/11 Ending: 12/31/11

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			$	$		$ 26	1
2	3	Housekeeping	Direct Allocation						33,751	2
3	4	Laundry	Direct Allocation						11,582	3
4	6	Repairs & Maintenance	Direct Allocation							4
5	10	Nursing	Direct Allocation						32,877	5
6	11	Activities	Direct Allocation							6
7	21	Office And Clerical	Direct Allocation							7
8	22	Employee Benefits	Direct Allocation						347	8
9	30	Fixed Assets-Depreciation	Direct Allocation							9
10	39	Ancillary	Direct Allocation						38,863	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					$	$		$ 117,445	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

	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	Ventilator Equipment	Direct Allocation						3,961	1
2	39	Other Ancillary	Direct Allocation							2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14	22	Employee Health Insurance	Direct Allocation			$	$		$ 98,175	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 102,136	25

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/11 Ending: 12/31/11

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			$	$		$ 104,836	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					$	$		$ 104,836	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/11 Ending: 12/31/11

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						9,351	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					$	$		$ 9,351	25

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/11 Ending: 12/31/11

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			$	$ 1,018,531			$ 69,588	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Xerox		X	Copiers				2,695			459	6
7	DAIWA		X	Line of Credit				517,648			727	7
8	See Supplemental Schedule							758,507			107,468	8
9	TOTAL Facility Related						$	$ 2,297,381			$ 178,242	9
	B. Non-Facility Related*											
10	Interest Income (Facility)		X								(21,166)	10
11	Allocated from EC Consulting		X								6,395	11
12	Allocated from EC Clinical		X								365	12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (14,406)	14
15	TOTALS (line 9+line14)						$	$ 2,297,381			$ 163,836	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: 01/01/11 Ending: 12/31/11

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			$	$ 758,507			$ 107,468	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital							758,507			107,468	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											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:** 01/01/11 **Ending:** 12/31/11

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 57,679	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.)		$ 57,949	2
3. Under or (over) accrual (line 2 minus line 1).		$ 270	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 59,419	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.		$ 59,689	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	58,513	8
	2007	63,240	9
	2008	53,561	10
	2009	54,933	11
	2010	56,589	12

2011 Accrual =$56,589 x 1.05 = $59,419

Allocated from Extended Care Consulting = $1,153

Allocated from Extended Care Clinical = $207

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 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 2010 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 2010.

	(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	$ 56,589.16	$ 56,589.16
2.	See Attached	Allocated from 2201 Main	$ 126,481.18	$ 1,898.43
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 183,070.34	$ 58,487.59

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

C. **Tax Bills**

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Wheaton Care Center COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0039115

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2000 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 2000.

	(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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/11 Ending: 12/31/11

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 30,000 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			12,308	2
3	TOTALS			$ 840,489	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	123			1972	$ 1,548,078	$ 41,818	39	$ 39,694	$ (2,124)	$ 259,643	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	41,331		20	2,067	2,067	37,928	9
10	Various			1994	104,965		20	5,248	5,248	92,784	10
11	Various			1995	16,968		20	848	848	14,227	11
12	Various			1996	158,287		20	7,914	7,914	122,841	12
13	Various			1997	103,690		20	5,185	5,185	75,631	13
14	Various			1998	56,873		20	2,844	2,844	38,034	14
15	Various			1999	21,286		20	1,064	1,064	13,344	15
16	Various			2000	57,068		20	2,292	2,292	33,700	16
17	Various			2001	48,282		20	2,430	2,430	27,359	17
18	Various			2002	15,745		20	1,311	1,311	14,459	18
19	Various			2003	18,300		20	1,087	1,087	14,856	19
20	Various			2004	134,063		20	10,368	10,368	102,879	20
21	Various			2005	38,153		20	3,282	3,282	22,349	21
22	Various			2006	95,583		20	8,639	8,639	47,969	22
23	Various			2007	76,180		20	7,025	7,025	44,672	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: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	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)								67
68	Related Party Allocations (Pages 12H & 12I)		49,841	3,388		3,388		27,025	68
69	Financial Statement Depreciation			52,074			(52,074)		69
70	TOTAL (lines 4 thru 69)		$ 2,584,693	$ 97,280		$ 104,686	$ 7,406	$ 989,699	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: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,584,693	$ 97,280		$ 104,686	$ 7,406	$ 989,699	1
2	Remodel 2 Bathrooms	2008	11,500		20	1,150	1,150	4,313	2
3	Install Power Line	2008	6,625		20	663	663	2,484	3
4	Improve Heating System	2008	2,700		20	270	270	878	4
5	Sprinkler System Repair	2008	2,535		20	254	254	803	5
6	Repair Broken Water Pipe	2008	5,870		20	587	587	1,859	6
7	Sealcoating	2008	2,550		20	128	128	468	7
8	Painting	2009	6,303		20			6,303	8
9	Lobby & Dining Room Remodeling- Floor, Tiles, Labor	2009	5,577		20	558	558	1,348	9
10	Arm Fireguard Cortega	2009	2,721		20	272	272	567	10
11	Plater- Paint & Fix Various Walls	2010	4,050		20	405	405	439	11
12	Replace 16 Burners At Make Up Air Unit	2010	2,592		20	259	259	281	12
13	3 Ductless Mini Splits Cooling	2011	25,500		20	1,913	1,913	1,913	13
14	New Soffit-Dry Wall, Cover Holes	2011	4,550		20	341	341	341	14
15	Roof Repairs	2011	3,000		20	175	175	175	15
16	Fire Alarm Repair	2011	6,624		20	331	331	331	16
17	Attach Ac Units To Em Panel	2011	4,600		20	230	230	230	17
18	New 5 Ton Ac Unit	2011	6,175		20	206	206	206	18
19	Dry Wall, Cover Pipes	2011	3,400		20	25	25	25	19
20	Install Of New Double Doors	2011	2,570		20	14	14	14	20
21	Roof Work	2011	3,585		20	19	19	19	21
22	Generator Work	2011	2,896		20	15	15	15	22
23	Painting	2011	2,512		20	52	52	52	23
24	Painting	2011	2,940		20	12	12	12	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)		$ 2,706,069	$ 97,280		$ 112,564	$ 15,284	$ 1,012,773	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: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,706,069	$ 97,280		$ 112,564	$ 15,284	$ 1,012,773	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
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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)		$ 2,706,069	$ 97,280		$ 112,564	$ 15,284	$ 1,012,773	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: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 2,706,069	$ 97,280		$ 112,564	$ 15,284	$ 1,012,773	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,706,069	$ 97,280		$ 112,564	$ 15,284	$ 1,012,773	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: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 2,706,069	$ 97,280		$ 112,564	$ 15,284	$ 1,012,773	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,706,069	$ 97,280		$ 112,564	$ 15,284	$ 1,012,773	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: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3									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
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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: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
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
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		$	$		$	$	$	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: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		$	$		$	$	$	1
2	Buildings:								2
3	Allocated From Extended Care Consulting 2201 Main	2002	14,379	369	39	369		3,426	3
4	Allocated From Extended Care Clinical 2201 Main	2002	2,582	66	39	66		615	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated From Extended Care Consulting	2007	145	7	20	7		36	9
10	Allocated From Extended Care Consulting	2009	87	4	20	4		13	10
11	Allocated From Extended Care Consulting	2010	852	43	20	43		85	11
12	Allocated From Extended Care Consulting	2011	306	15	20	15		15	12
13									13
14	Allocated From Extended Care Consulting 2201 Main	2002	11,878	1,086	20	1,086		8,695	14
15	Allocated From Extended Care Consulting 2201 Main	2003	13,998	1,279	20	1,279		10,246	15
16	Allocated From Extended Care Consulting 2201 Main	2005	695	74	20	74		399	16
17	Allocated From Extended Care Consulting 2201 Main	2009	125	6	20	6		19	17
18									18
19	Allocated From Extended Care Clinical 2201 Main	2002	2,133	195	20	195		1,561	19
20	Allocated From Extended Care Clinical 2201 Main	2003	2,513	230	20	230		1,840	20
21	Allocated From Extended Care Clinical 2201 Main	2005	125	13	20	13		72	21
22	Allocated From Extended Care Clinical 2201 Main	2009	23	1	20	1		3	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: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
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
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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)		$ 49,841	$ 3,388		$ 3,388	$	$ 27,025	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: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 536,818	$ 4,538	$ 45,620	$ 41,082	10	$ 498,101	71
72	Current Year Purchases	103	10	10		10	10	72
73	Fully Depreciated Assets	318,754				10	318,754	73
74								74
75	TOTALS	$ 855,676	$ 4,548	$ 45,630	$ 41,082		$ 816,866	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		VAN	2003	$ 19,994	$	$	$	5	$ 19,994	76
77		Allocated From EC Consulting	2011	793	159	159		5	634	77
78		Allocated From EC Consulting	2011	9,357				5	9,357	78
79		Allocated From EC Clinical	2011	2,876	575	575		5	1,917	79
80	TOTALS			$ 33,020	$ 734	$ 734	$		$ 31,902	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)	$ 4,435,254	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 102,562	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 158,928	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 56,366	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,861,541	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: 01/01/11 Ending: 12/31/11

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	Storage Rental				274			5
6								6
7	TOTAL				$ 274 **			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.	/2012	$
13.	/2013	$
14.	/2014	$

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: $ 3,630 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: 01/01/11 Ending: 12/31/11

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: 01/01/11 Ending: 12/31/11

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 15,153	$		$ 15,153	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			32,904			32,904	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			62,423			62,423	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				105,400		105,400	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					11,625	55,675		67,300	13
14	TOTAL			$		$ 122,105	$ 161,075		$ 283,180	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: 01/01/11 Ending: 12/31/11

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/11 (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	$ 39,894	$ 55,594	1
2	Cash-Patient Deposits	46,636	46,636	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,955,715	1,955,715	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	234,994	234,994	6
7	Other Prepaid Expenses	3,366	3,366	7
8	Accounts Receivable (owners or related parties)	678	1,320,792	8
9	Other(specify): See Attached Schedule	176,510	327,510	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,457,793	$ 3,944,607	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	1,017,112	1,068,873	15
16	Equipment, at Historical Cost	482,220	813,492	16
17	Accumulated Depreciation (book methods)	(1,261,904)	(1,859,189)	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	1,228,577	1,251,787	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,466,005	$ 3,599,461	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,923,798	$ 7,544,068	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 915,354	$ 915,353	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	29,599	29,599	28
29	Short-Term Notes Payable	520,343	520,343	29
30	Accrued Salaries Payable	186,005	186,005	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,768	9,768	31
32	Accrued Real Estate Taxes(Sch.IX-B)	59,419	59,419	32
33	Accrued Interest Payable		13,319	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	1,313,925	1,320,325	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,034,413	$ 3,054,131	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		758,507	39
40	Mortgage Payable		1,018,531	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)**	$	$ 1,777,038	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,034,413	$ 4,831,169	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 889,385	$ 2,712,899	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,923,798	$ 7,544,068	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/11 Ending: 12/31/11

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 738,662	1
2	Restatements (describe):		2
3	Rounding	(3)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 738,659	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	151,326	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	(600)	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)**	$ 150,726	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)**	$ 889,385	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	$ 6,229,780	1
2	Discounts and Allowances for all Levels	(490,138)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,739,642	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	368,246	6
7	Oxygen	220	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 368,466	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	112,380	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	21,939	19
20	Radiology and X-Ray	4,860	20
21	Other Medical Services	30,248	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 169,427	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	21,166	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 21,166	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	3,274	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,274	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,301,975	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,195,654	31
32	Health Care	2,260,010	32
33	General Administration	1,363,871	33
	B. Capital Expense		
34	Ownership	776,658	34
	C. Ancillary Expense		
35	Special Cost Centers	303,180	35
36	Provider Participation Fee	251,276	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,150,649	40
41	**Income before Income Taxes (line 30 minus line 40)****	151,326	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 151,326	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: 01/01/11 Ending: 12/31/11

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	1,880	2,054	$ 81,693	$ 39.77	1
2	Assistant Director of Nursing	1,872	2,062	66,089	32.05	2
3	Registered Nurses	12,150	13,051	385,798	29.56	3
4	Licensed Practical Nurses	16,072	17,232	439,394	25.50	4
5	CNAs & Orderlies	47,883	51,892	639,671	12.33	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,182	7,841	145,058	18.50	8
9	Activity Director	1,919	2,186	35,525	16.25	9
10	Activity Assistants	7,494	8,001	77,045	9.63	10
11	Social Service Workers	11,417	12,772	224,110	17.55	11
12	Dietician	907	941	18,402	19.56	12
13	Food Service Supervisor	1,913	2,217	56,396	25.44	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,484	6,073	82,586	13.60	15
16	Dishwashers	11,755	12,747	112,612	8.83	16
17	Maintenance Workers	4,546	5,078	82,228	16.19	17
18	Housekeepers	12,399	13,967	144,046	10.31	18
19	Laundry	5,761	6,469	63,447	9.81	19
20	Administrator	1,867	1,880	92,318	49.11	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,562	5,820	66,395	11.41	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	1,958	2,171	31,958	14.72	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	160,021	174,454	$ 2,844,771 *	$ 16.31	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	24	$ 1,131	01-03	35
36	Medical Director	Monthly	15,600	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,656	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				45
46	Other(specify)				46
47					47
48	See Attached		25,567		48
49	TOTAL (lines 35 - 48)	24	$ 49,954		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

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: 01/01/11 Ending: 12/31/11

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Delnaz Vazifdar (01/01/2011-11/30/2011)	Administrator	0.00%	$ 84,300
Christopher Beymer (12/01/2011-Present)	Administrator	0.00%	8,018
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 92,318

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
See Attached	Legal	$ 11,061
Frost, Ruttenberg & Rothblatt	Accounting	50,650
Extended Care Consulting	Home Office Expense	197,952
Extended Care Clinical	Home Office Expense	65,988
Personnel Planners, Inc.	Unemployement Consulting	1,410
DAIWA	Line of Credit Audit	10,950
Prospect Resources	Natural Gas Procurement	1,300
Pinnacle Consulting	Customer Satisfaction	4,552
Blymass	Tax Credit Consulting	1,557
Extended Care Consulting	Other Professional Services	3,091
Legat Architects	Architectural Services	1,200
See Supplemetal Schedule		32,849
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 382,560

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 180,983
Unemployment Compensation Insurance	30,685
FICA Taxes	213,400
Employee Health Insurance	54,927
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	3,858
Other Employee Welfare	7,085
Holiday Expense	2,650
TOTAL (agree to Schedule V, line 22, col.8)	$ 493,587

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	$ 35
Advertising: Employee Recruitment	448
Health Care Worker Background Check	
(Indicate # of checks performed 110)	1,100
Patient Background Checks 157	2,134
Dues & Subscriptions	12,632
Licenses & Fees	3,145
Advertising & Promotions	214
Allocated from EC Consulting	2,615
See Supplemental Schedule	125
Less: Public Relations Expense	( )
Non-allowable advertising	(214)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 22,234

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,607
Allocated from EC Consulting	145
Allocated from EC Clinical	1,540
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,292

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/11 Ending: 12/31/11

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													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(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 = $11,113**

(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. $ **17,596** 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. $ **251,276**
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.

SEE ACCOUNTANTS' COMPILATION REPORT

(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? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.