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.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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: 9/1/1993

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 282-6300
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 01/01/15 to 12/31/15 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)
(Firm Name & Address) Marcum, LLP, 111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	3,906	690	2,422	7,018	8
9	SNF/PED					9
10	ICF	35,147			35,147	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	39,053	690	2,422	42,165	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.92%

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 1,551

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: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number Wheaton Care Center # 0039115 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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	297,278	39,691	5,148	342,117		342,117	7,870	349,987			1
2	Food Purchase		281,211		281,211		281,211	326	281,537			2
3	Housekeeping	160,905	54,130		215,035		215,035	1,085	216,120			3
4	Laundry	71,103	13,940		85,043		85,043		85,043			4
5	Heat and Other Utilities			150,270	150,270		150,270	1,631	151,901			5
6	Maintenance	83,025		194,245	277,270		277,270	11,029	288,299			6
7	Other (specify):*							3,554	3,554			7
8	**TOTAL General Services**	612,311	388,972	349,663	1,350,946		1,350,946	25,495	1,376,441			8
	B. Health Care and Programs											
9	Medical Director			19,200	19,200		19,200		19,200			9
10	Nursing and Medical Records	1,895,318	177,172	38,844	2,111,334		2,111,334	37,538	2,148,872			10
10a	Therapy	157,360			157,360		157,360		157,360			10a
11	Activities	116,965	16,981		133,946		133,946		133,946			11
12	Social Services	251,368	3,947		255,315		255,315	22,054	277,369			12
13	CNA Training											13
14	Program Transportation			562	562		562		562			14
15	Other (specify):*							7,563	7,563			15
16	**TOTAL Health Care and Programs**	2,421,011	198,100	58,606	2,677,717		2,677,717	67,155	2,744,872			16
	C. General Administration											
17	Administrative	97,766			97,766		97,766	77,482	175,248			17
18	Directors Fees											18
19	Professional Services			378,855	378,855		378,855	(305,801)	73,054			19
20	Dues, Fees, Subscriptions & Promotions			59,591	59,591		59,591	(17,968)	41,623			20
21	Clerical & General Office Expenses	76,656	28,796	160,633	266,085		266,085	34,163	300,248			21
22	Employee Benefits & Payroll Taxes			477,595	477,595		477,595	(9,958)	467,637			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,044	2,044		2,044	1,289	3,333			24
25	Other Admin. Staff Transportation			7,664	7,664		7,664	1,198	8,862			25
26	Insurance-Prop.Liab.Malpractice			125,033	125,033		125,033	1,700	126,733			26
27	Other (specify):*							29,497	29,497			27
28	**TOTAL General Administration**	174,422	28,796	1,211,415	1,414,633		1,414,633	(188,398)	1,226,235			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,207,744	615,868	1,619,684	5,443,296		5,443,296	(95,748)	5,347,548			29

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

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

Facility Name & ID Number Wheaton Care Center #0039115 Report Period Beginning: 01/01/15 Ending: 12/31/15

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			73,072	73,072		73,072	57,432	130,504			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			68,596	68,596		68,596	4,308	72,904			33
34	Rent-Facility & Grounds			480,000	480,000		480,000	(480,000)				34
35	Rent-Equipment & Vehicles			1,807	1,807		1,807	715	2,522			35
36	Other (specify):*											36
37	**TOTAL Ownership**			623,475	623,475		623,475	(417,545)	205,930			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		112,150	303,741	415,891		415,891	(903)	414,988			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			311,439	311,439		311,439		311,439			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		112,150	615,180	727,330		727,330	(903)	726,427			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,207,744	728,018	2,858,339	6,794,101		6,794,101	(514,196)	6,279,905			45

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

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	(3,009)	30		9
10	Interest and Other Investment Income	(9,707)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(46)	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				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(81,955)	21		24
25	Fund Raising, Advertising and Promotional	(11,960)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(40,278)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (146,956)		$	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)	(367,241)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (367,241)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (514,196)		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

Wheaton Care Center

ID# 0039115

Report Period Beginning: 01/01/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Theft Loss	$ (31)	21	1
2	Collections	(2,244)	21	2
3	Annual Report	(250)	20	3
4	Lobbying	(671)	21	4
5	PAC Dues	(6,791)	20	5
6	Non-Allowable Legal	(3,620)	19	6
7	Building Company - Amortization	(10,604)	36	7
8	Building Company - Management Fees	(6,150)	17	8
9	Building Company - Filing Fee	(318)	20	9
10	Building Company - Legal Fee	(7,635)	19	10
11	Building Company - Bank Service Charge	(88)	21	11
12	Capitalized R&M	(1,876)	06	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(40,278)		49

Wheaton Care Center

ID# 0039115

Report Period Beginning: 01/01/15

Ending: 12/31/15

	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	Total			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Wheaton Care Center # 0039115 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary			140		7,730							7,870	1
2	Food Purchase	(46)		372									326	2
3	Housekeeping			980		105							1,085	3
4	Laundry													4
5	Heat and Other Utilities			1,485		146							1,631	5
6	Maintenance	(1,876)		4,274	8,522	109							11,029	6
7	Other (specify):*				2,577	977							3,554	7
8	**TOTAL General Services**	(1,922)		7,251	11,099	9,067							25,495	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records					37,801				(165)	(99)		37,538	10
10a	Therapy													10a
11	Activities													11
12	Social Services					22,054							22,054	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					7,563							7,563	15
16	**TOTAL Health Care and Programs**					67,418				(165)	(99)		67,155	16
	C. General Administration													
17	Administrative	(6,150)	6,150	2,671	14,944	59,867							77,482	17
18	Directors Fees													18
19	Professional Services	(11,255)	158	(220,256)		(74,448)							(305,801)	19
20	Fees, Subscriptions & Promotions	(19,319)	318	876		157							(17,968)	20
21	Clerical & General Office Expenses	(84,989)	88	10,933	89,505	18,626							34,163	21
22	Employee Benefits & Payroll Taxes				(9,958)								(9,958)	22
23	Inservice Training & Education													23
24	Travel and Seminar			301		988							1,289	24
25	Other Admin. Staff Transportation			1,198									1,198	25
26	Insurance-Prop.Liab.Malpractice			1,222		478							1,700	26
27	Other (specify):*				19,748	9,749							29,497	27
28	**TOTAL General Administration**	(121,713)	6,714	(203,055)	114,239	15,417							(188,398)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(123,635)	6,714	(195,804)	125,338	91,902				(165)	(99)		(95,748)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Wheaton Care Center # 0039115 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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	(3,009)	57,862	1,937		642							57,432	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(9,707)	1,735	7,789		183								32
33	Real Estate Taxes			3,904		404							4,308	33
34	Rent-Facility & Grounds		(480,000)										(480,000)	34
35	Rent-Equipment & Vehicles			715									715	35
36	Other (specify):*	(10,604)	10,604											36
37	**TOTAL Ownership**	(23,320)	(409,799)	14,345		1,229							(417,545)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers									(903)			(903)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**									(903)			(903)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(146,956)	(403,085)	(181,459)	125,338	93,131				(1,067)	(99)		(514,196)	45

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	Rent	$ 480,000	Wheaton HC Properties, LLC	100.00%	$	$ (480,000)	1
2	V	33	Rent - Property Tax	68,596	Wheaton HC Properties, LLC	100.00%		(68,596)	2
3	V	17	Management Fee		Wheaton HC Properties, LLC	100.00%	6,150	6,150	3
4	V	21	Bank Charges		Wheaton HC Properties, LLC	100.00%	88	88	4
5	V	20	Filing Fee		Wheaton HC Properties, LLC	100.00%	318	318	5
6	V	30	Depreciation		Wheaton HC Properties, LLC	100.00%	57,862	57,862	6
7	V	36	Amortization		Wheaton HC Properties, LLC	100.00%	10,604	10,604	7
8	V	33	Real Estate Tax Expense		Wheaton HC Properties, LLC	100.00%	68,596	68,596	8
9	V	32	Interest	2,322	Wheaton HC Properties, LLC	100.00%	4,057	1,735	9
10	V	19	Legal Fee		Wheaton HC Properties, LLC	100.00%	158	158	10
11	V								11
12	V								12
13	V								13
14	Total			$ 550,918			$ 147,833	$ * (403,085)	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: 01/01/15 Ending: 12/31/15

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%	$ 140	$ 140	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	372	372	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	980	980	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	1,485	1,485	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	4,274	4,274	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	2,671	2,671	20
21	V	19	Professional Fees	224,976	Extended Care Consulting, LLC	100.00%	4,720	(220,256)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	876	876	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	10,933	10,933	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	301	301	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	1,198	1,198	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	1,222	1,222	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	1,937	1,937	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	7,789	7,789	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	3,904	3,904	29
30	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	715	715	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			$ 224,976			$ 43,517	$ * (181,459)	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: 01/01/15 Ending: 12/31/15

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%	8,522	$ 8,522	15
16	V	06	Maintenance (Direct)	14,678	Extended Care Consulting, LLC	100.00%	14,678		16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	733	733	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	1,844	1,844	18
19	V								19
20	V								20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	14,944	14,944	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	89,505	89,505	22
23	V	21	Office and Clerical (Direct)	18,516	Extended Care Consulting, LLC	100.00%	18,516		23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	17,930	17,930	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	1,818	1,818	25
26	V	22	Employee Benefits	9,958	Extended Care Consulting, LLC	100.00%		(9,958)	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			$ 43,152			$ 168,490	$ * 125,338	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: 01/01/15 Ending: 12/31/15

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%	$ 105	$ 105	15
16	V	05	Utilities		Extended Care Clinical, LLC	100.00%	146	146	16
17	V	06	Maintenance		Extended Care Clinical, LLC	100.00%	109	109	17
18	V	19	Professional Fees	74,988	Extended Care Clinical, LLC	100.00%	540	(74,448)	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	157	157	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC	100.00%	1,338	1,338	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC	100.00%	988	988	21
22	V	26	Insurance		Extended Care Clinical, LLC	100.00%	478	478	22
23	V	30	Depreciation		Extended Care Clinical, LLC	100.00%	642	642	23
24	V	32	Interest		Extended Care Clinical, LLC	100.00%	183	183	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC	100.00%	404	404	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC	100.00%	7,730	7,730	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	977	977	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC	100.00%	37,801	37,801	28
29	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%	22,054	22,054	29
30	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	7,563	7,563	30
31	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%	59,867	59,867	31
32	V	21	Office Salary		Extended Care Clinical, LLC	100.00%	17,288	17,288	32
33	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	9,749	9,749	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 74,988			$ 168,119	$ * 93,131	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: 01/01/15 Ending: 12/31/15

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	Various Equipment	3,280	Vent Lease LLC	100.00%	3,280	$	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			$ 3,280			$ 3,280	$ *	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: 01/01/15 Ending: 12/31/15

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	$ 137,039	Tri Care Rehab	100.00%	$ 137,039	$	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			$ 137,039			$ 137,039	$ *	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: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Health Insurance	$	CCS Employee Benefits Group	100.00%	$ 171,968	$ 171,968	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	171,968	CCS Employee Benefits Group	100.00%		(171,968)	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			$ 171,968			$ 171,968	$ *	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: 01/01/15 Ending: 12/31/15

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	10	Nursing and Medical Records	$ 12,472	MAC Rx, LLC	100.00%	$ 12,307	$ (165)	15
16	V	39	Ancillary	68,353	MAC Rx, LLC	100.00%	67,451	(903)	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			$ 80,825			$ 79,758	$ * (1,067)	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: 01/01/15 Ending: 12/31/15

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	10	Nursing Supplies / Nursing Equip. Rental	350	Reliable Medical of the Midwest, LLC	100.00%	251	$ (99)	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			$ 350			$ 251	$ * (99)	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: 01/01/15 Ending: 12/31/15

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. ☐ 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			$			$	$	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			$			$	$ *	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: 01/01/15 Ending: 12/31/15

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 TRUST	4.07%	BEECHER MANOR NURSING AND REHABILITATION CENTER, LLC	BEECHER	WHEATON HEALTHCARE PROPERTIES, LLC		Building Company	1
2	DANIEL ROTHNER ACCUMULATION TRUST	4.07%	BRIAR PLACE LTD.	INDIAN HEAD PARK	Extended Care Consulting	Evanston	Mgmt / Bookkeeping	2
3	ERIC ROTHNER	38.21%	CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	Extended Care Clinical	Evanston	Clinical	3
4	ILANA KLEIN REICH	0.81%	COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	Care Centers Building	Evanston	Building Company	4
5	JUDITH FREEMAN	1.63%	GRASMERE PLACE, LLC	CHICAGO	Vent Lease LLC	Evanston	Ventilator Equipment	5
6	KATHRYN VALES ACCUMULATION TRUST	4.07%	LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD	Tri Care Rehab	Hillside	Therapy	6
7	KIMBERLY RICHMOND ACCUMULATION TRUST	4.07%	LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT	C.C.S. Veba	Evanston	Health Insurance	7
8	MELISSA ROTHNER ACCUMULATION TRUST	4.07%	MAJOR HOSPITAL DYER	DYER, IN	MAC RX	Des Plaines	Pharmacy	8
9	COOPER KLEIN	0.81%	MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN	Reliable Medical Supply	Des Plaines	Medical Supplies	9
10	NATHAN & SHIRLEY ROTHNER FAMILY TRUST	26.83%	MAJOR HOSPITAL LINCOLNSHIRE	MERRIVILLE, IN				10
11	NEAL ROTHNER	1.63%	MAJOR HOSPITAL MUNSTER	MUNSTER, IN				11
12	NWOS, INC.	1.63%	MAJOR HOSPITAL SEBOS	HOBART, IN				12
13	RACHEL ROTHNER ACCUMULATION TRUST	4.07%	MCKINLEY HEALTH CARE CENTER	CANTON, OH				13
14	WILLIAM ROTHNER ACCUMULATION TRUST	4.07%	PARK HOUSE NURSING AND REHABILITATION CENTER,LLC	CHICAGO				14
15			PRAIRIE MANOR NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO HEIGHTS				15
16			PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				16
17			RAINBOW BEACH QOC, L.L.C.	CHICAGO				17
18			SHEFFIELD MANOR	DYER, IN				18
19			SHERIDAN SHORES CARE & REHABILITATION CENTER, INC.	CHICAGO				19
20			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				20
21			ST. JAMES WELLNESS REHAB VILLAS	CRETE				21
22			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				22
23			TRI-STATE NURSING & REHABILITATION CENTER, INC.	LANSING				23
24			PARC AT JOLIET	JOLIET				24
25			SPRING CREEK	JOLIET				25
26			ESTATES OF HYDE PARK	CHICAGO				26
27								27
28								28
29								29
30								30

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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	Adam Vales	Relative	Clerical	N/A	See Attached	1.09	2.73%	Alloc. Sal.	$ 1,845	22-07	1
2	Mark Steinberg	Relative	Administrative	N/A	See Attached	2.43	4.42%	Alloc Fee/Sal	8,989	17-07	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 10,834		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: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	1,326,152	31	$ 4,390	$	42,165	$ 140	1
2	02	Food	Patient Days	1,326,152	31	11,689		42,165	372	2
3	03	Housekeeping	Patient Days	1,326,152	31	30,827		42,165	980	3
4	05	Utilities	Patient Days	1,326,152	31	46,718		42,165	1,485	4
5	06	Maintenance	Patient Days	1,326,152	31	134,435		42,165	4,274	5
6	17	Administrative	Patient Days	1,326,152	31	84,000		42,165	2,671	6
7	19	Professional Fees	Patient Days	1,326,152	31	148,456		42,165	4,720	7
8	20	Dues and Subscriptions	Patient Days	1,326,152	31	27,539		42,165	876	8
9	21	Office and Clerical	Patient Days	1,326,152	31	343,869		42,165	10,933	9
10	24	Seminar and Travel	Patient Days	1,326,152	31	9,455		42,165	301	10
11	25	Other Staff Admin. Trans.	Patient Days	1,326,152	31	37,668		42,165	1,198	11
12	26	Insurance	Patient Days	1,326,152	31	38,431		42,165	1,222	12
13	30	Depreciation	Patient Days	1,326,152	31	60,912		42,165	1,937	13
14	32	Interest	Patient Days	1,326,152	31	244,990		42,165	7,789	14
15	33	Real Estate Taxes	Patient Days	1,326,152	31	122,786		42,165	3,904	15
16	35	Rent - Equipment & Auto	Patient Days	1,326,152	31	22,475		42,165	715	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,368,640	$		$ 43,517	25

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	1,326,152	31	268,019	268,019	42,165	8,522	1
2	06	Maintenance (Direct)	Direct		31	325,218	325,218		14,678	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,326,152	31	23,065		42,165	733	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		31	38,919			1,844	4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,326,152	31	470,018	470,018	42,165	14,944	7
8	21	Office and Clerical (Pooled)	Patient Days	1,326,152	31	2,815,061	2,815,061	42,165	89,505	8
9	21	Office and Clerical (Direct)	Direct		31	402,441	402,441		18,516	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,326,152	31	563,937		42,165	17,930	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		31	58,253			1,818	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					$ 4,964,932	$ 4,280,758		$ 168,490	25

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/15 Ending: 12/31/15

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 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	794,254	19	$ 1,974	$	42,165	$ 105	1
2	05	Utilities	Patient Days	794,254	19	2,745		42,165	146	2
3	06	Maintenance	Patient Days	794,254	19	2,053		42,165	109	3
4	19	Professional Fees	Patient Days	794,254	19	10,180		42,165	540	4
5	20	Dues and Subscriptions	Patient Days	794,254	19	2,961		42,165	157	5
6	21	Office & Clerical	Patient Days	794,254	19	25,207		42,165	1,338	6
7	24	Travel and Seminar	Patient Days	794,254	19	18,605		42,165	988	7
8	26	Insurance	Patient Days	794,254	19	9,008		42,165	478	8
9	30	Depreciation	Patient Days	794,254	19	12,096		42,165	642	9
10	32	Interest	Patient Days	794,254	19	3,455		42,165	183	10
11	33	Real Estate Taxes	Patient Days	794,254	19	7,615		42,165	404	11
12	01	Dietary Salary	Patient Days	794,254	19	145,601	145,601	42,165	7,730	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	794,254	19	18,397		42,165	977	13
14	10	Nursing Salary	Patient Days	794,254	19	712,051	712,051	42,165	37,801	14
15	12	Social Service Salary	Patient Days	794,254	19	415,434	415,434	42,165	22,054	15
16	15	Emp. Ben. - Healthcare	Patient Days	794,254	19	142,463		42,165	7,563	16
17	17	Administration Salary	Patient Days	794,254	19	1,127,702	1,127,702	42,165	59,867	17
18	21	Office Salary	Patient Days	794,254	19	325,657	325,657	42,165	17,288	18
19	27	Emp. Ben. - Gen. Admin.	Patient Days	794,254	19	183,638		42,165	9,749	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,166,842	$ 2,726,445		$ 168,119	25

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/15 Ending: 12/31/15

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
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Various Equipment	Direct Allocation						3,280	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					$	$		$ 3,280	25

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/15 Ending: 12/31/15

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: 240 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			$	$		$ 137,039	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					$	$		$ 137,039	25

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

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

Name of Related Organization: CCS Employee Benefits Group, Inc.
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847)905-4000
Fax Number: (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	22	Employee Health Insurance	Direct Allocation			$	$		$ 171,968	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					$	$		$ 171,968	25

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/15 Ending: 12/31/15

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: MAC Rx, LLC
Street Address: 2307 S. Mount Prospect Road
City / State / Zip Code: Des Plaines, IL 60018
Phone Number: (224)220-2700
Fax Number: (224)220-2730

	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	10	Nursing And Medical Records	Direct Allocation			$	$		$ 12,307	1
2	39	Ancillary	Direct Allocation						67,451	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					$	$		$ 79,758	25

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	10	Nursing Supplies / Nursing Equip.	Direct Allocation						251	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					$	$		$ 251	25

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/15 Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	Private Bank		X	Mortgage			$	$ 5,000,000			$ 3,797	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Other		X								260	6
7												7
8	See Supplemental Schedule										7,972	8
9	TOTAL Facility Related						$	$ 5,000,000			$ 12,029	9
	B. Non-Facility Related*											
10	Interest Income		X								(9,707)	10
11	Interest Income - Bldg Co		X								(2,322)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (12,029)	14
15	TOTALS (line 9+line14)						$	$ 5,000,000			$	15

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

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

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

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	Alloc from Extended Care Consulting		X				$	$			$ 7,789	8
9	Alloc from Extended Care Clinical		X								183	9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										7,972	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:** 01/01/15 **Ending:** 12/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 68,307	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.)		$ 71,090	2
3. Under or (over) accrual (line 2 minus line 1).		$ 2,783	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 70,121	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.		$ 72,904	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	56,589	8
	2011	57,597	9
	2012	63,385	10
	2013	65,054	11
	2014	66,782	12

2015 Accrual = $66,782 x 1.05 = $70,121

Allocated from Extended Care Consulting LLC $3,904

Allocated from Extended Care Clinical LLC $404

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 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 2014 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 2014.

	(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	$ 66,782.38	$ 66,782.38
2.	See Attached	Alloc from Extended Care Consult	$ 165,913.23	$ 4,086.40
3.	See Attached	Alloc from Dyer Admin Office	$ 3,814.66	$ 121.29
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 236,510.27	$ 70,990.07

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

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

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

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 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 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: 01/01/15 Ending: 12/31/15

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 33,417 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	Allocated from 2201 Main			20,197	2
3	TOTALS			$ 848,378	3

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 57,862	39	$ 39,694	$ (18,168)	$ 418,419	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	41,331		20			41,331	9
10	Various			1994	104,965		20			104,935	10
11	Various			1995	16,968		20	189	189	16,961	11
12	Various			1996	158,287		20	7,914	7,914	154,498	12
13	Various			1997	103,690		20	5,185	5,185	96,369	13
14	Various			1998	56,873		20	2,844	2,844	49,408	14
15	Various			1999	21,286		20	1,064	1,064	17,601	15
16	Various			2000	57,068		20	2,292	2,292	42,867	16
17	Various			2001	48,282		20	2,297	2,297	36,547	17
18	Various			2002	15,745		20	198	198	15,513	18
19	Various			2003	18,300		20	202	202	17,231	19
20	Various			2004	134,063		20	1,161	1,161	129,723	20
21	Various			2005	38,153		20	865	865	33,062	21
22	Various			2006	95,583		20	8,639	8,639	82,526	22
23	Various			2007	76,180		20	4,801	4,801	69,251	23
24	Various			2008	31,780		20	3,051	3,051	23,005	24
25	Various			2009	9,024		20	272	272	7,958	25
26	Various			2010	6,642		20	664	664	3,376	26
27	Various			2011	68,352		20	5,637	5,637	25,881	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: 01/01/15 Ending: 12/31/15

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)		85,059	1,146		1,146		61,836	68
69	Financial Statement Depreciation			73,072			(73,072)		69
70	TOTAL (lines 4 thru 69)		$ 2,735,710	$ 132,080		$ 88,115	$ (43,965)	$ 1,448,301	70

**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: 01/01/15 Ending: 12/31/15

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		$ 2,735,710	$ 132,080		$ 88,115	$ (43,965)	$ 1,448,301	1
2	Duct Installation	2012	5,600		20	560	560	2,240	2
3	Supply Duct Distribution System	2012	33,000		20	3,300	3,300	13,200	3
4	Exhaust Fan & Duct Work	2012	7,300		20	730	730	2,677	4
5	Elevator Renovation - Install 6 Inch Cylinder For 2 Stop Hydrauli	2012	35,183		20	3,518	3,518	12,900	5
6	Elevator Renovation - Replace Passenger Elevator Hydraulic Cyli	2012	28,575		20	2,858	2,858	11,192	6
7	Installation Of A 24 Channel Cable System	2012	14,328		20	1,433	1,433	4,776	7
8	Running Conduit	2012	5,848		20	585	585	1,949	8
9	Complete Remodel Of Basement Bathroom-New Walls, Tile, Toile	2012	3,471		20	347	347	1,099	9
10	New Grease Trap	2013	7,800		20	780	780	2,340	10
11	Flooring Installation	2013	3,890		20	389	389	1,167	11
12	Water Heater Code Violation Fix	2013	2,557		20	511	511	1,279	12
13	New Compressor	2013	13,954		20	1,395	1,395	3,256	13
14	Re-Do Parking Lot	2013	53,518		20	3,568	3,568	8,028	14
15	Door Repairs	2014	14,500		20	725	725	1,329	15
16	Sewer Work	2014	14,800		20	740	740	1,172	16
17	Compressor	2014	7,140		20	357	357	536	17
18	Sprinkler System	2014	9,293		20	465	465	620	18
19	Rooftop A/C Unit	2014	5,950		20	298	298	397	19
20	Elevator Work	2014	7,608		20	380	380	412	20
21	Passenger Elevator Repair	2014	5,711		20	286	286	428	21
22	Asphalt Repairs To Parking Lot	2014	13,336		20	889	889	889	22
23	Tear Off & Install 25 Sq Flat Roof	2015	9,050		20	377	377	377	23
24	Roofing And Flashing	2015	54,450		20	2,269	2,269	2,269	24
25	Reinsulate 2 Attic Areas	2015	13,500		20	394	394	394	25
26	Remote Air Cooled Chiller (30 Ton)	2015	36,000		20	1,050	1,050	1,050	26
27	Chimney Repair	2015	4,200		20	123	123	123	27
28	Replace 1200 Sf Vinyl Siding, All Soffit & All Fascia	2015	19,404		20	485	485	485	28
29	Gutters	2015	8,740		20	219	219	219	29
30	Emergency Generator System	2015	11,000		20	229	229	229	30
31	New Storm Sewer Line	2015	32,000		20	667	667	667	31
32	Plumbing And Sewers	2015	6,500		20	81	81	81	32
33	Radiator And Boiler	2015	7,053		20	22	22	22	33
34	TOTAL (lines 1 thru 33)		$ 3,230,969	$ 132,080		$ 118,143	$ (13,937)	$ 1,526,100	34

**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: 01/01/15 Ending: 12/31/15

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		$ 3,230,969	$ 132,080		$ 118,143	$ (13,937)	$ 1,526,100	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,230,969	$ 132,080		$ 118,143	$ (13,937)	$ 1,526,100	34

**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: 01/01/15 Ending: 12/31/15

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		$ 3,230,969	$ 132,080		$ 118,143	$ (13,937)	$ 1,526,100	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,230,969	$ 132,080		$ 118,143	$ (13,937)	$ 1,526,100	34

**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: 01/01/15 Ending: 12/31/15

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		$ 3,230,969	$ 132,080		$ 118,143	$ (13,937)	$ 1,526,100	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,230,969	$ 132,080		$ 118,143	$ (13,937)	$ 1,526,100	34

**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: 01/01/15 Ending: 12/31/15

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		$	$		$	$	$	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
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

**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: 01/01/15 Ending: 12/31/15

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 12F, Carried Forward		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

**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: 01/01/15 Ending: 12/31/15

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		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from 2201 Main/Care Center Building LLC	2002	25,144	645	20	645		8,569	3
4	Allocated from Extended Care Clinical LLC	2002	2,688	69	20	69		916	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Extended Care Consulting LLC	2007	146	7	20	7		66	9
10	Allocated from Extended Care Consulting LLC	2009	87	4	20	4		31	10
11	Allocated from Extended Care Consulting LLC	2010	858	43	20	43		257	11
12	Allocated from Extended Care Consulting LLC	2011	309	15	20	15		77	12
13	Allocated from Extended Care Consulting LLC	2012	102	5	20	5		20	13
14	Allocated from Extended Care Consulting LLC	2014	1,410	71	20	71		141	14
15									15
16	Allocated from 2201 Main/Care Center Building LLC	2002	20,771		20			20,771	16
17	Allocated from 2201 Main/Care Center Building LLC	2003	24,477		20			24,477	17
18	Allocated from 2201 Main/Care Center Building LLC	2005	1,216	129	20	129		1,214	18
19	Allocated from 2201 Main/Care Center Building LLC	2009	219	11	20	11		77	19
20	Allocated from 2201 Main/Care Center Building LLC	2014	2,041	102	20	102		204	20
21	Allocated from 2201 Main/Care Center Building LLC	2015	346	17	20	17		17	21
22									22
23	Allocated from Extended Care Clinical LLC	2002	2,220					2,220	23
24	Allocated from Extended Care Clinical LLC	2003	2,617					2,617	24
25	Allocated from Extended Care Clinical LLC	2005	130	14	20	14		130	25
26	Allocated from Extended Care Clinical LLC	2009	23	1	20	1		8	26
27	Allocated from Extended Care Clinical LLC	2014	218	11	20	11		22	27
28	Allocated from Extended Care Clinical LLC	2015	37	2	20	2		2	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 85,059	$ 1,146		$ 1,146	$	$ 61,836	34

**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: 01/01/15 Ending: 12/31/15

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 12H, Carried Forward		$ 85,059	$ 1,146		$ 1,146	$	$ 61,836	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
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20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 85,059	$ 1,146		$ 1,146	$	$ 61,836	34

**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: 01/01/15 Ending: 12/31/15

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	$ 170,749	$ 627	$ 11,204	$ 10,577	10	$ 132,817	71
72	Current Year Purchases	3,984	98	449	351	10	449	72
73	Fully Depreciated Assets	699,833				10	699,833	73
74								74
75	TOTALS	$ 874,567	$ 725	$ 11,653	$ 10,928		$ 833,099	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 Extended Care Cc	2015	5,738	162	162		5	5,252	77
78		Allocated from Extended Care Cl	2012	2,727	545	545		5	1,897	78
79										79
80	TOTALS			$ 28,459	$ 707	$ 707	$		$ 27,143	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)	$ 4,982,372	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 133,512	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 130,503	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (3,009)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,386,341	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: 01/01/15 Ending: 12/31/15

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								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be 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.	/2016	$
13.	/2017	$
14.	/2018	$

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: $ 2,522 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.

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/15 Ending: 12/31/15

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.

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$		$ 85,034	$		$ 85,034	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			32,899			32,899	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			179,136			179,136	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				99,314		99,314	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					6,672	12,836		19,508	13
14	TOTAL			$		$ 303,741	$ 112,150		$ 415,891	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.

STATE OF ILLINOIS

Facility Name & ID Number Wheaton Care Center **#** 0039115 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/15 **(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	$ 84,775	$ 134,447	1
2	Cash-Patient Deposits	30,986	30,986	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	203,791	203,791	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	153,546	153,546	6
7	Other Prepaid Expenses	7,066	7,066	7
8	Accounts Receivable (owners or related parties)		5,000,000	8
9	Other(specify):	962,135	943,328	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,442,299	$ 6,473,164	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,464,179	13
14	Buildings, at Historical Cost		1,496,317	14
15	Leasehold Improvements, at Historical Cost	1,502,040	1,553,801	15
16	Equipment, at Historical Cost	509,874	841,146	16
17	Accumulated Depreciation (book methods)	(1,529,136)	(2,460,154)	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):	1,228,469	1,285,328	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,711,247	$ 4,180,617	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,153,546	$ 10,653,781	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 930,157	$ 935,668	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	25,184	25,184	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	130,954	130,954	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,715	3,715	31
32	Accrued Real Estate Taxes(Sch.IX-B)	70,121	70,121	32
33	Accrued Interest Payable		2,322	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	1,234,828	351,934	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,394,959	$ 1,519,898	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,000,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 5,000,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,394,959	$ 6,519,898	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 758,587	$ 4,133,883	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,153,546	$ 10,653,781	48

***(See instructions.)**

Facility Name & ID Number Wheaton Care Center **#** 0039115 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 823,583	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 823,583	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	437,784	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	(502,780)	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)**	$ (64,996)	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)**	$ 758,587	24 *

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

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,152,368	1
2	Discounts and Allowances for all Levels	(1,185,688)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,966,680	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,124,040	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,124,040	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	94,429	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	15,071	19
20	Radiology and X-Ray	4,680	20
21	Other Medical Services	7,861	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 122,041	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	19,124	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 19,124	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,231,885	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,350,946	31
32	Health Care	2,677,717	32
33	General Administration	1,414,633	33
	B. Capital Expense		
34	Ownership	623,475	34
	C. Ancillary Expense		
35	Special Cost Centers	415,891	35
36	Provider Participation Fee	311,439	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,794,101	40
41	**Income before Income Taxes (line 30 minus line 40)****	437,784	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 437,784	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,725,267	44
45	Private Pay - Net Inpatient Revenue	126,620	45
46	Medicare - Net Inpatient Revenue	81,900	46
47	Other-(specify) Hospice	36,011	47
48	Other-(specify) Insurance	(3,118)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,966,680	49

* **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.**

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

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	1,888	2,451	$ 105,592	$ 43.08	1
2	Assistant Director of Nursing	1,900	2,211	74,503	33.70	2
3	Registered Nurses	8,820	9,764	327,042	33.49	3
4	Licensed Practical Nurses	21,617	23,284	588,997	25.30	4
5	CNAs & Orderlies	49,082	54,054	732,849	13.56	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,310	7,809	157,360	20.15	8
9	Activity Director	1,989	2,195	36,882	16.80	9
10	Activity Assistants	6,678	7,310	80,083	10.96	10
11	Social Service Workers	11,291	12,338	251,368	20.37	11
12	Dietician	922	955	21,036	22.03	12
13	Food Service Supervisor	1,946	2,189	52,745	24.10	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,975	6,764	95,759	14.16	15
16	Dishwashers	12,040	13,476	127,738	9.48	16
17	Maintenance Workers	4,291	4,613	83,025	18.00	17
18	Housekeepers	12,933	14,706	160,905	10.94	18
19	Laundry	6,487	7,133	71,103	9.97	19
20	Administrator	2,000	2,145	97,766	45.58	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,894	6,433	76,656	11.92	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	1,912	2,211	37,412	16.92	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	1,631	1,655	28,923	17.48	33
34	TOTAL (lines 1 - 33)	166,606	183,696	$ 3,207,744 *	$ 17.46	34

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

** See instructions.

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	103	$ 5,148	01-03	35
36	Medical Director	Monthly	19,200	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,944	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					48
49	TOTAL (lines 35 - 48)	103	$ 31,292		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	47	$ 1,517	10-03	50
51	Licensed Practical Nurses	39	1,905	10-03	51
52	Certified Nurse Assistants/Aides	1,182	28,478	10-03	52
53	TOTAL (lines 50 - 52)	1,267	$ 31,900		53

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/15 Ending: 12/31/15

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
David Taylor	Administrator		$ 97,261
Stephanie Rucker	Administrator		505
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 97,766

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
FRR/Marcum LLP	Accounting	$ 29,599
See Attached	Legal	16,243
Personnel Planners	Unemployment Consultant	785
Extended Care Consulting LLC	Home Office Allocation	224,976
Extended Care Clinical LLC	Home Office Allocation	74,988
Pro Payroll Solutions	Data Processing	16,910
E-Health Data Solutions	Data Processing	2,385
AIS Assessment & Intelligence	Data Processing	1,319
Ability Network	Medicare Billing	1,580
National Datacare Corporation	Resident Fund Processing	3,971
Online MSDS	MSDS Management	642
See Supplemental Schedule		5,457
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 378,854

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 78,554
Unemployment Compensation Insurance	36,912
FICA Taxes	238,041
Employee Health Insurance	102,275
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	2,375
Other Employee Welfare	7,680
Holiday Expense	1,800
TOTAL (agree to Schedule V, line 22, col.8)	$ 467,637

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,483
Advertising: Employee Recruitment	12,159
Health Care Worker Background Check	2,646
(Indicate # of checks performed)	
Patient Background Checks	
Dues and Subscriptions	20,807
License and Permits	1,496
Alloc from Extended Care Consulting	876
Alloc from Extended Care Clinical	157
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 41,624

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,045
Alloc from Extended Care Consulting	301
Alloc from Extended Care Clinical	988
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,334

**See instructions.

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/15 Ending: 12/31/15

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													
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10													
11													
12													
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14													
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16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number **Wheaton Care Center** **#** **0039115** **Report Period Beginning:** **01/01/15** **Ending:** **12/31/15**

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 Long Term Care $20,580**

(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 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **46,130** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **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. $ **311,439**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% ln 14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? **No**
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.