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.

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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: Steven N. 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 01/01/17 to 12/31/17 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)
** Subject to the attached Accountants' Consulting Report*
(Date)
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 9 Parkway North, Suite 200 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: 01/01/17 Ending: 12/31/17

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	3,714	1,023	3,591	8,328	8
9	SNF/PED					9
10	ICF	33,421			33,421	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	37,135	1,023	3,591	41,749	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.99%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve 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 2,392

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: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	295,089	51,875	6,099	353,063		353,063	8,402	361,465			1
2	Food Purchase		258,878		258,878		258,878	387	259,265			2
3	Housekeeping	150,271	49,608		199,879		199,879	1,047	200,926			3
4	Laundry	86,767	17,254		104,021		104,021		104,021			4
5	Heat and Other Utilities			152,001	152,001		152,001	1,283	153,284			5
6	Maintenance	97,762		214,019	311,781		311,781	(4,303)	307,478			6
7	Other (specify):*							3,168	3,168			7
8	TOTAL General Services	629,889	377,615	372,119	1,379,623		1,379,623	9,984	1,389,607			8
	B. Health Care and Programs											
9	Medical Director			21,600	21,600		21,600		21,600			9
10	Nursing and Medical Records	1,894,098	133,947	278,004	2,306,049		2,306,049	35,087	2,341,136			10
10a	Therapy	159,206		921	160,127		160,127		160,127			10a
11	Activities	98,308	23,063		121,371		121,371		121,371			11
12	Social Services	256,467	4,107		260,574		260,574	29,697	290,271			12
13	CNA Training											13
14	Program Transportation			2,862	2,862		2,862		2,862			14
15	Other (specify):*	8,945			8,945		8,945	9,368	18,313			15
16	TOTAL Health Care and Programs	2,417,024	161,117	303,387	2,881,528		2,881,528	74,152	2,955,680			16
	C. General Administration											
17	Administrative	101,787			101,787		101,787	88,876	190,663			17
18	Directors Fees											18
19	Professional Services			383,977	383,977		383,977	(302,194)	81,783			19
20	Dues, Fees, Subscriptions & Promotions			72,366	72,366		72,366	(17,341)	55,025			20
21	Clerical & General Office Expenses	87,855	23,050	336,688	447,593		447,593	(163,302)	284,291			21
22	Employee Benefits & Payroll Taxes			638,343	638,343		638,343	(13,981)	624,362			22
23	Inservice Training & Education											23
24	Travel and Seminar			9,125	9,125		9,125	1,102	10,227			24
25	Other Admin. Staff Transportation			6,892	6,892		6,892	770	7,662			25
26	Insurance-Prop.Liab.Malpractice			131,176	131,176		131,176	1,941	133,117			26
27	Other (specify):*							35,996	35,996			27
28	TOTAL General Administration	189,642	23,050	1,578,567	1,791,259		1,791,259	(368,133)	1,423,126			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,236,555	561,782	2,254,073	6,052,410		6,052,410	(283,997)	5,768,413			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:** 01/01/17 **Ending:** 12/31/17

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			57,578	57,578		57,578	55,297	112,875			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			774	774		774	(774)				32
33	Real Estate Taxes			70,152	70,152		70,152	3,904	74,056			33
34	Rent-Facility & Grounds			480,000	480,000		480,000	(480,000)				34
35	Rent-Equipment & Vehicles			3,337	3,337		3,337	851	4,188			35
36	Other (specify):*			123,708	123,708		123,708	(123,708)	0			36
37	**TOTAL Ownership**			735,549	735,549		735,549	(544,429)	191,120			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		42,935	405,174	448,109		448,109	(5,577)	442,532			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			302,860	302,860		302,860		302,860			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		42,935	708,034	750,969		750,969	(5,577)	745,392			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,236,555	604,717	3,697,656	7,538,928		7,538,928	(834,004)	6,704,924			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: 01/01/17 Ending: 12/31/17

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 Reference	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	(4,932)	30		9
10	Interest and Other Investment Income	(13,290)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(63)	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	(270,633)	21		24
25	Fund Raising, Advertising and Promotional	(10,756)	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	(177,513)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (477,187)		$	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)	(356,817)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (356,817)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (834,004)		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: 01/01/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Political Donations	$ (166)	20	1
2	Annual Report	(250)	20	2
3	PAC Dues	(7,737)	20	3
4	Lobbying	(1,857)	21	4
5	Non-Allowable Legal Fees	(6,020)	19	5
6	Patient Clothing	(131)	10	6
7	Collection Expense	(2,716)	21	7
8	Amortization	(123,708)	36	8
9	Capitalized R&M	(14,515)	06	9
10	Building Company - Amortization	(8,297)	36	10
11	Building Company - Management Fees	(6,150)	17	11
12	Building Company - Filing Fee	(250)	20	12
13	Building Company - Bank Service Charge	(221)	21	13
14	Vacant Land Real Estate Tax	(5,496)	33	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**	(177,513)		49

Wheaton Care Center

ID# 0039115

Report Period Beginning: 01/01/17

Ending: 12/31/17

	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: 01/01/17 Ending: 12/31/17

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary			154		8,248							8,402	1
2	Food Purchase	(63)		450									387	2
3	Housekeeping			931		116							1,047	3
4	Laundry													4
5	Heat and Other Utilities			1,153		130							1,283	5
6	Maintenance	(14,515)		3,175	6,812	225							(4,303)	6
7	Other (specify):*				2,013	1,155							3,168	7
8	TOTAL General Services	(14,578)		5,863	8,825	9,874							9,984	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(131)				37,199		(1,981)					35,087	10
10a	Therapy													10a
11	Activities													11
12	Social Services					29,697							29,697	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					9,368							9,368	15
16	TOTAL Health Care and Programs	(131)				76,264		(1,981)					74,152	16
	C. General Administration													
17	Administrative	(6,150)	6,150	2,376	13,660	72,840							88,876	17
18	Directors Fees													18
19	Professional Services	(6,020)		(221,922)		(74,296)		44					(302,194)	19
20	Fees, Subscriptions & Promotions	(19,159)	250	690		878							(17,341)	20
21	Clerical & General Office Expenses	(275,426)	221	6,827	85,439	19,637							(163,302)	21
22	Employee Benefits & Payroll Taxes				(13,981)								(13,981)	22
23	Inservice Training & Education													23
24	Travel and Seminar			30		1,072							1,102	24
25	Other Admin. Staff Transportation			770									770	25
26	Insurance-Prop.Liab.Malpractice			1,390		551							1,941	26
27	Other (specify):*				23,250	12,746							35,996	27
28	TOTAL General Administration	(306,755)	6,621	(209,839)	108,368	33,428		44					(368,133)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(321,464)	6,621	(203,976)	117,193	119,566		(1,937)					(283,997)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Wheaton Care Center # 0039115 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(4,932)	57,863	1,976		390							55,297	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(13,290)		12,374		142							(774)	32
33	Real Estate Taxes	(5,496)	5,495	3,472		433							3,904	33
34	Rent-Facility & Grounds		(480,000)										(480,000)	34
35	Rent-Equipment & Vehicles			851									851	35
36	Other (specify):*	(132,005)	8,297										(123,708)	36
37	**TOTAL Ownership**	(155,722)	(408,345)	18,673		965							(544,429)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(5,577)					(5,577)	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**							(5,577)					(5,577)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(477,187)	(401,724)	(185,303)	117,193	120,531		(7,514)					(834,004)	45

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	70,152	Wheaton HC Properties, LLC	100.00%		(70,152)	2
3	V	32	Interest	189,108	Wheaton HC Properties, LLC	100.00%	189,108		3
4	V	17	Management Fee		Wheaton HC Properties, LLC	100.00%	6,150	6,150	4
5	V	21	Bank Charges		Wheaton HC Properties, LLC	100.00%	221	221	5
6	V	20	Filing Fee		Wheaton HC Properties, LLC	100.00%	250	250	6
7	V	30	Depreciation		Wheaton HC Properties, LLC	100.00%	57,863	57,863	7
8	V	36	Amortization		Wheaton HC Properties, LLC	100.00%	8,297	8,297	8
9	V	33	Real Estate Tax Expense		Wheaton HC Properties, LLC	100.00%	75,647	75,647	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 739,260			$ 337,536	$ * (401,724)	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: 01/01/17 Ending: 12/31/17

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%	$ 154	$ 154	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	450	450	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	931	931	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	1,153	1,153	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	3,175	3,175	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	2,376	2,376	20
21	V	19	Professional Fees	224,976	Extended Care Consulting, LLC	100.00%	3,054	(221,922)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	690	690	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	6,827	6,827	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	30	30	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	770	770	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	1,390	1,390	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	1,976	1,976	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	12,374	12,374	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	3,472	3,472	29
30	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	851	851	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			$ 39,673	$ * (185,303)	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: 01/01/17 Ending: 12/31/17

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%	6,812	$ 6,812	15
16	V	06	Maintenance (Direct)	15,912	Extended Care Consulting, LLC	100.00%	15,912		16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	632	632	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	1,381	1,381	18
19	V								19
20	V								20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	13,660	13,660	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	85,439	85,439	22
23	V	21	Office and Clerical (Direct)	30,692	Extended Care Consulting, LLC	100.00%	30,692		23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	19,148	19,148	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	4,102	4,102	25
26	V	22	Employee Benefits	13,981	Extended Care Consulting, LLC	100.00%		(13,981)	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			$ 60,585			$ 177,778	$ * 117,193	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: 01/01/17 Ending: 12/31/17

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%	$ 116	$ 116	15
16	V	05	Utilities		Extended Care Clinical, LLC	100.00%	130	130	16
17	V	06	Maintenance		Extended Care Clinical, LLC	100.00%	225	225	17
18	V	19	Professional Fees	74,988	Extended Care Clinical, LLC	100.00%	692	(74,296)	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	878	878	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC	100.00%	1,459	1,459	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC	100.00%	1,072	1,072	21
22	V	26	Insurance		Extended Care Clinical, LLC	100.00%	551	551	22
23	V	30	Depreciation		Extended Care Clinical, LLC	100.00%	390	390	23
24	V	32	Interest		Extended Care Clinical, LLC	100.00%	142	142	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC	100.00%	433	433	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC	100.00%	8,248	8,248	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	1,155	1,155	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC	100.00%	37,199	37,199	28
29	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%	29,697	29,697	29
30	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	9,368	9,368	30
31	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%	72,840	72,840	31
32	V	21	Office Salary		Extended Care Clinical, LLC	100.00%	18,178	18,178	32
33	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	12,746	12,746	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 74,988			$ 195,519	$ * 120,531	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: 01/01/17 Ending: 12/31/17

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	Various Equipment	1,840	Vent Lease LLC	100.00%	1,840	$	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			$ 1,840			$ 1,840	$ *	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: 01/01/17 Ending: 12/31/17

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	23,983	MAC Rx, LLC	100.00%	22,002	(1,981)	15
16	V	10A	Therapy		MAC Rx, LLC	100.00%			16
17	V	19	Professional Services	(535)	MAC Rx, LLC	100.00%	(491)	44	17
18	V	21	Clerical & General Office Expenses		MAC Rx, LLC	100.00%			18
19	V	22	Employee Benefits		MAC Rx, LLC	100.00%			19
20	V	39	Ancillary	67,520	MAC Rx, LLC	100.00%	61,943	(5,577)	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			$ 90,968			$ 83,454	$ * (7,514)	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: 01/01/17 Ending: 12/31/17

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%	$ 285,690	$ 285,690	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	285,690	CCS Employee Benefits Group	100.00%		(285,690)	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			$ 285,690			$ 285,690	$ *	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: 01/01/17 Ending: 12/31/17

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: 01/01/17 Ending: 12/31/17

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: 01/01/17 Ending: 12/31/17

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: 01/01/17 Ending: 12/31/17

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 HC PROPERTIES, LI	WHEATON	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	NURSING EQUIPMENT	5
6	KATHRYN VALES ACCUMULATION TRUST	4.07%	LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	6
7	KIMBERLY RICHMOND ACCUMULATION TRUST	4.07%	LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT	MAC RX	DES PLAINES	PHARMACY	7
8	MELISSA ROTHNER ACCUMULATION TRUST	4.07%	MAJOR HOSPITAL DYER	DYER, IN	RELIABLE MEDICAL SUPPLY	DES PLAINES	MEDICAL SUPPLIES	8
9	COOPER KLEIN	0.81%	MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN				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%	LITTLE VILLAGE NURSING & REHABILITATION CENTER, L.L.C.	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			SPRING CREEK NURSING & REHAB CENTER	JOLIET				21
22			SPRING MILL HEALTH CAMPUS	MERRIVILLE, IN				22
23			ST. JAMES WELLNESS REHAB VILLAS	CRETE				23
24			THE ESTATES OF HYDE PARK	CHICAGO				24
25			THE PARC AT JOLIET	JOLIET				25
26			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				26
27			TRI-STATE NURSING & REHABILITATION CENTER, INC.	LANSING				27
28								28
29								29
30								30

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/17 Ending: 12/31/17

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: 01/01/17 Ending: 12/31/17

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	1.27	3.18%	Alloc. Sal.	$ 2,195	22-07	1
2	Mark Steinberg	Relative	Administrative	N/A	See Attached	2.35	4.27%	Alloc Fee/Sal	8,536	17-07	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 10,731		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: 01/01/17 Ending: 12/31/17

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: 01/01/17 Ending: 12/31/17

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	1,476,506	37	$ 5,451	$	41,759	$ 154	1
2	02	Food	Patient Days	1,476,506	37	15,903		41,759	450	2
3	03	Housekeeping	Patient Days	1,476,506	37	32,901		41,759	931	3
4	05	Utilities	Patient Days	1,476,506	37	40,755		41,759	1,153	4
5	06	Maintenance	Patient Days	1,476,506	37	112,249		41,759	3,175	5
6	17	Administrative	Patient Days	1,476,506	37	84,000		41,759	2,376	6
7	19	Professional Fees	Patient Days	1,476,506	37	107,994		41,759	3,054	7
8	20	Dues and Subscriptions	Patient Days	1,476,506	37	24,409		41,759	690	8
9	21	Office and Clerical	Patient Days	1,476,506	37	241,371		41,759	6,827	9
10	24	Seminar and Travel	Patient Days	1,476,506	37	1,048		41,759	30	10
11	25	Other Staff Admin. Trans.	Patient Days	1,476,506	37	27,239		41,759	770	11
12	26	Insurance	Patient Days	1,476,506	37	49,139		41,759	1,390	12
13	30	Depreciation	Patient Days	1,476,506	37	69,861		41,759	1,976	13
14	32	Interest	Patient Days	1,476,506	37	437,528		41,759	12,374	14
15	33	Real Estate Taxes	Patient Days	1,476,506	37	122,769		41,759	3,472	15
16	35	Rent - Equipment & Auto	Patient Days	1,476,506	37	30,092		41,759	851	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,402,709	$		$ 39,673	25

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	1,476,506	37	240,841	240,841	41,759	6,812	1
2	06	Maintenance (Direct)	Direct		21	358,056	358,056		15,912	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,476,506	37	22,330		41,759	632	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		21	51,193			1,381	4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,476,506	37	483,002	483,002	41,759	13,660	7
8	21	Office and Clerical (Pooled)	Patient Days	1,476,506	37	3,020,951	3,020,951	41,759	85,439	8
9	21	Office and Clerical (Direct)	Direct		28	498,631	498,631		30,692	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,476,506	37	677,040		41,759	19,148	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		28	74,203			4,102	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,426,248	$ 4,601,481		$ 177,778	25

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	781,509	20	$ 2,174	$	41,759	$ 116	1
2	05	Utilities	Patient Days	781,509	20	2,440		41,759	130	2
3	06	Maintenance	Patient Days	781,509	20	4,212		41,759	225	3
4	19	Professional Fees	Patient Days	781,509	20	12,959		41,759	692	4
5	20	Dues and Subscriptions	Patient Days	781,509	20	16,422		41,759	878	5
6	21	Office & Clerical	Patient Days	781,509	20	27,302		41,759	1,459	6
7	24	Travel and Seminar	Patient Days	781,509	20	20,068		41,759	1,072	7
8	26	Insurance	Patient Days	781,509	20	10,303		41,759	551	8
9	30	Depreciation	Patient Days	781,509	20	7,302		41,759	390	9
10	32	Interest	Patient Days	781,509	20	2,656		41,759	142	10
11	33	Real Estate Taxes	Patient Days	781,509	20	8,112		41,759	433	11
12	01	Dietary Salary	Patient Days	781,509	20	154,359	154,359	41,759	8,248	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	781,509	20	21,616		41,759	1,155	13
14	10	Nursing Salary	Patient Days	781,509	20	696,174	696,174	41,759	37,199	14
15	12	Social Service Salary	Patient Days	781,509	20	555,767	555,767	41,759	29,697	15
16	15	Emp. Ben. - Healthcare	Patient Days	781,509	20	175,320		41,759	9,368	16
17	17	Administration Salary	Patient Days	781,509	20	1,363,182	1,363,182	41,759	72,840	17
18	21	Office Salary	Patient Days	781,509	20	340,193	340,193	41,759	18,178	18
19	27	Emp. Ben. - Gen. Admin.	Patient Days	781,509	20	238,538		41,759	12,746	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,659,098	$ 3,109,674		$ 195,519	25

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	10	Various Equipment	Direct Allocation						1,840	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					$	$		$ 1,840	25

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/17 Ending: 12/31/17

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						22,002	1
2	10A	Therapy	Direct Allocation							2
3	19	Professional Services	Direct Allocation						(491)	3
4	21	Clerical & General Office Expense	Direct Allocation							4
5	22	Employee Benefits	Direct Allocation							5
6	39	Ancillary	Direct Allocation						61,943	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					$	$		$ 83,454	25

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/17 Ending: 12/31/17

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			$	$		$ 285,690	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					$	$		$ 285,690	25

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/17 Ending: 12/31/17

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: 01/01/17 Ending: 12/31/17

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: 01/01/17 Ending: 12/31/17

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: 01/01/17 Ending: 12/31/17

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	The Private Bank		X	Mortgage			$	$ 4,650,000			$ 189,108	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Allocated from EC Consulting		X								12,374	6
7	Allocated from EC Clinical		X								142	7
8												8
9	TOTAL Facility Related						$	$ 4,650,000			$ 201,624	9
	B. Non-Facility Related*											
10	Interest Income		X								(13,290)	10
11	Interest		X								774	11
12	Interest Income - Bldg Co.		X								(189,108)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (201,624)	14
15	TOTALS (line 9+line14)						$	$ 4,650,000			$	15

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

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

** 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:** 01/01/17 **Ending:** 12/31/17

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 72,880	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.)		$ 73,677	2
3. Under or (over) accrual (line 2 minus line 1).		$ 797	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 73,260	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.		$ 74,057	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	63,385	8
	2013	65,054	9
	2014	66,782	10
	2015	69,409	11
	2016	69,772	12

2017 Accrual = $69,772 x 1.05 = 73,260

Allocated from Extended Care Consulting = $3,472

Allocated from Extended Care Clinical = $433

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 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) 282-6300 FAX #: (847) 282-6301

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(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	$ 69,771.88	$ 69,771.88
2.	See Attached	Alloc from Extended Care Consulting	$ 181,041.32	$ 3,472.19
3.	See Attached	Alloc from Extended Care Clinical	$ 181,041.32	$ 433.46
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 431,854.52	$ 73,677.53

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation 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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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: 2016 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 2016 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2016.

Please complete the Real Estate Tax Statement below and include it in the 2017 cost report along with a copy of your 2016 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2016 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) 282-6300 FAX #: (847) 282-6301

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(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 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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Care Center Building			17,690	2
3	TOTALS			$ 845,871	3

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 57,863	39	$ 39,694	$ (18,169)	$ 497,807	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			16,961	11
12	Various			1996	158,287		20			158,274	12
13	Various			1997	103,690		20	2,129	2,129	103,682	13
14	Various			1998	56,873		20	2,844	2,844	55,095	14
15	Various			1999	21,286		20	1,064	1,064	19,730	15
16	Various			2000	57,068		20	2,292	2,292	47,451	16
17	Various			2001	48,282		20	2,297	2,297	41,142	17
18	Various			2002	15,745		20	33	33	15,745	18
19	Various			2003	18,300		20	169	169	17,570	19
20	Various			2004	134,063		20	1,161	1,161	132,046	20
21	Various			2005	38,153		20	533	533	34,127	21
22	Various			2006	95,583		20	919	919	87,389	22
23	Various			2007	76,180		20	2,127	2,127	76,180	23
24	Various			2008	31,780		20	3,051	3,051	29,106	24
25	Various			2009	9,024		20	272	272	8,502	25
26	Various			2010	6,642		20	664	664	4,705	26
27	Various			2011	68,352		20	5,637	5,637	37,155	27
28	Various			2012	133,305		20	13,331	13,331	76,694	28
29	Various			2013	81,719		20	6,644	6,644	29,356	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: 01/01/17 Ending: 12/31/17

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)		86,516	1,291		1,291		57,982	68
69	Financial Statement Depreciation			57,578			(57,578)		69
70	TOTAL (lines 4 thru 69)		$ 2,952,191	$ 116,732		$ 86,152	$ (30,580)	$ 1,692,965	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: 01/01/17 Ending: 12/31/17

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		$ 2,952,191	$ 116,732		$ 86,152	$ (30,580)	$ 1,692,965	1
2	Door Repairs	2014	14,500		20	725	725	2,779	2
3	Sewer Work	2014	14,800		20	740	740	2,652	3
4	Compressor	2014	7,140		20	357	357	1,250	4
5	Sprinkler System	2014	9,293		20	465	465	1,549	5
6	Rooftop A/C Unit	2014	5,950		20	298	298	992	6
7	Elevator Work	2014	7,608		20	380	380	1,173	7
8	Passenger Elevator Repair	2014	5,711		20	286	286	999	8
9	Asphalt Repairs To Parking Lot	2014	13,336		20	667	667	2,278	9
10	Tear Off & Install 25 Sq Flat Roof	2015	9,050		20	453	453	1,282	10
11	Roofing And Flashing	2015	54,450		20	2,723	2,723	7,714	11
12	Reinsulate 2 Attic Areas	2015	13,500		20	675	675	1,744	12
13	Remote Air Cooled Chiller (30 Ton)	2015	36,000		20	1,800	1,800	4,650	13
14	Chimney Repair	2015	4,200		20	210	210	543	14
15	Replace 1200 Sf Vinyl Siding, All Soffit & All Fascia	2015	19,404		20	970	970	2,426	15
16	Gutters	2015	8,740		20	437	437	1,093	16
17	Emergency Generator System	2015	11,000		20	550	550	1,329	17
18	New Storm Sewer Line	2015	32,000		20	1,600	1,600	3,867	18
19	Plumbing And Sewers	2015	6,500		20	325	325	731	19
20	Radiator And Boiler	2015	7,053		20	353	353	735	20
21	Fiberglass Insulation	2016	4,218		20	211	211	422	21
22	Draft Vent System For Hot Water Tank	2016	2,600		20	130	130	163	22
23	Repairs To 78 Hvac Units	2016	2,920		20	146	146	158	23
24	Rewiring Of Signal Cable For 1St Floor Call Lights	2017	4,559		20	133	133	133	24
25	Piping - Reinsulate Game Room, B5, B6, Cafeteria	2017	10,433		20	217	217	217	25
26	Gas Repair - Main Boiler, Water Heaters, 2Nd Floor Furnace, 2 R	2017	7,770		20	162	162	162	26
27	78 Unit Maintenance-Change Filters,Blow Out/Repipe Drains,Rep	2017	3,768		20	47	47	47	27
28	Kitchen/Laundry Room Hot Water Tank	2017	2,538		20	127	127	127	28
29	Elevator Repair - Replace Coil	2017	5,309		20	265	265	265	29
30	Elevator Repair - Install New Contact Kits	2017	3,988		20	199	199	199	30
31	Sprinkler System - Replace Defective Flange	2017	2,681		20	134	134	134	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,283,207	$ 116,732		$ 101,935	$ (14,797)	$ 1,734,776	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: 01/01/17 Ending: 12/31/17

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		$ 3,283,207	$ 116,732		$ 101,935	$ (14,797)	$ 1,734,776	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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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)		$ 3,283,207	$ 116,732		$ 101,935	$ (14,797)	$ 1,734,776	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: 01/01/17 Ending: 12/31/17

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		$ 3,283,207	$ 116,732		$ 101,935	$ (14,797)	$ 1,734,776	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
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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)		$ 3,283,207	$ 116,732		$ 101,935	$ (14,797)	$ 1,734,776	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: 01/01/17 Ending: 12/31/17

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		$ 3,283,207	$ 116,732		$ 101,935	$ (14,797)	$ 1,734,776	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)		$ 3,283,207	$ 116,732		$ 101,935	$ (14,797)	$ 1,734,776	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: 01/01/17 Ending: 12/31/17

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									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: 01/01/17 Ending: 12/31/17

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: 01/01/17 Ending: 12/31/17

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 Extended Care Consulting-Care Center Bldg	2002	21,672	556	35	556		8,498	3
4	Allocated from Extended Care Consulting-Dyer Building	2007	6,788	150	35	150		1,579	4
5	Allocated from Extended Care Clinical - Care Center Bldg	2002	2,706	69	35	69		1,061	5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Extended Care Consulting, LLC	2007	130	7	20	7		72	9
10	Allocated from Extended Care Consulting, LLC	2009	78	4	20	4		35	10
11	Allocated from Extended Care Consulting, LLC	2010	763	38	20	38		305	11
12	Allocated from Extended Care Consulting, LLC	2011	275	14	20	14		96	12
13	Allocated from Extended Care Consulting, LLC	2012	91	5	20	5		27	13
14	Allocated from Extended Care Consulting, LLC	2014	1,254	63	20	63		251	14
15	Allocated from Extended Care Consulting, LLC	2016	1,504	75	20	75		150	15
16									16
17	Allocated from Extended Care Consulting-Care Center Bldg	2002	17,903		20			17,903	17
18	Allocated from Extended Care Consulting-Care Center Bldg	2003	21,098		20			21,098	18
19	Allocated from Extended Care Consulting-Care Center Bldg	2005	1,048		20			1,048	19
20	Allocated from Extended Care Consulting-Care Center Bldg	2009	189	9	20	9		85	20
21	Allocated from Extended Care Consulting-Care Center Bldg	2014	1,815	91	20	91		363	21
22	Allocated from Extended Care Consulting-Care Center Bldg	2015	298	15	20	15		96	22
23	Allocated from Extended Care Consulting-Care Center Bldg	2016	1,178	59	20	59		118	23
24	Allocated from Extended Care Consulting-Care Center Bldg	2017	2,043	102	20	102		102	24
25									25
26	Allocated from Extended Care Clinical - Care Center Bldg	2002	2,235		20			2,235	26
27	Allocated from Extended Care Clinical - Care Center Bldg	2003	2,634		20			2,634	27
28	Allocated from Extended Care Clinical - Care Center Bldg	2005	131		20			131	28
29	Allocated from Extended Care Clinical - Care Center Bldg	2009	24	1	20	1		11	29
30	Allocated from Extended Care Clinical - Care Center Bldg	2014	220	11	20	11		44	30
31	Allocated from Extended Care Clinical - Care Center Bldg	2015	37	2	20	2		12	31
32	Allocated from Extended Care Clinical - Care Center Bldg	2016	147	7	20	7		15	32
33	Allocated from Extended Care Clinical - Care Center Bldg	2017	255	13	20	13		13	33
34	TOTAL (lines 1 thru 33)		$ 86,516	$ 1,291		$ 1,291	$	$ 57,982	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: 01/01/17 Ending: 12/31/17

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		$ 86,516	$ 1,291		$ 1,291	$	$ 57,982	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
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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)		$ 86,516	$ 1,291		$ 1,291	$	$ 57,982	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: 01/01/17 Ending: 12/31/17

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	$ 173,934	$ 645	$ 10,510	$ 9,865	10	$ 155,266	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	688,919				10	688,919	73
74								74
75	TOTALS	$ 862,853	$ 645	$ 10,510	$ 9,865		$ 844,186	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 Consulting, LLC		5,104	144	144		5	4,960	77
78		Allocated from Extended Care Clinical, LLC		2,745	287	287		5	2,745	78
79										79
80	TOTALS			$ 27,843	$ 431	$ 431	$		$ 27,699	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,019,774	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 117,808	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 112,876	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (4,932)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,606,661	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: 01/01/17 Ending: 12/31/17

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

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.	/2018	$
13.	/2019	$
14.	/2020	$

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

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

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

16. Rental Amount for movable equipment: $ 4,188 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: 01/01/17 Ending: 12/31/17

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: 01/01/17 Ending: 12/31/17

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	$		$ 126,831	$		$ 126,831	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			70,351			70,351	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			206,239			206,239	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				23,407		23,407	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					1,753	19,528		21,281	13
14	TOTAL			$		$ 405,174	$ 42,935		$ 448,109	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:** 01/01/17 **Ending:** 12/31/17

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/17 **(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	$ 5,175	$ 234,296	1
2	Cash-Patient Deposits	29,218	29,218	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	680,974	680,974	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	107,158	107,158	6
7	Other Prepaid Expenses	9,087	9,087	7
8	Accounts Receivable (owners or related parties)		4,650,000	8
9	Other(specify): See Attached Schedule	859,598	903,281	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,691,210	$ 6,614,014	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,464,135	13
14	Buildings, at Historical Cost		1,496,317	14
15	Leasehold Improvements, at Historical Cost	1,538,307	1,590,068	15
16	Equipment, at Historical Cost	509,874	841,146	16
17	Accumulated Depreciation (book methods)	(1,661,989)	(2,708,732)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	861,148	932,939	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,247,340	$ 3,615,873	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,938,550	$ 10,229,887	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 336,970	$ 336,969	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	26,196	26,196	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	160,915	160,915	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,640	5,640	31
32	Accrued Real Estate Taxes(Sch.IX-B)	73,260	73,260	32
33	Accrued Interest Payable		23,191	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	1,535,374	2,480	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,138,355	$ 628,651	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,650,000	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)**	$	$ 4,650,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,138,355	$ 5,278,651	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 800,195	$ 4,951,236	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,938,550	$ 10,229,887	48

***(See instructions.)**

Facility Name & ID Number Wheaton Care Center **#** 0039115 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,052,081	1
2	Restatements (describe):		2
3	Rounding	(1)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,052,080	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	48,115	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	(300,000)	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)**	$ (251,885)	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)**	$ 800,195	24 *

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

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 7,336,431	1
2	Discounts and Allowances for all Levels	(1,257,940)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,078,491	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,296,939	6
7	Oxygen	2,160	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,299,099	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	147,926	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	16,802	19
20	Radiology and X-Ray	6,450	20
21	Other Medical Services	9,921	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 181,099	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	28,354	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 28,354	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)**	$ 7,587,043	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,379,623	31
32	Health Care	2,881,528	32
33	General Administration	1,791,259	33
	B. Capital Expense		
34	Ownership	735,549	34
	C. Ancillary Expense		
35	Special Cost Centers	448,109	35
36	Provider Participation Fee	302,860	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,538,928	40
41	**Income before Income Taxes (line 30 minus line 40)****	48,115	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 48,115	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,537,748	44
45	Private Pay - Net Inpatient Revenue	200,204	45
46	Medicare - Net Inpatient Revenue	210,584	46
47	Other-(specify) Hospice	95,915	47
48	Other-(specify) Insurance	34,040	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,078,491	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: 01/01/17 Ending: 12/31/17

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	1,918	2,373	$ 109,575	$ 46.18	1
2	Assistant Director of Nursing	1,889	2,417	84,704	35.05	2
3	Registered Nurses	8,446	9,488	329,901	34.77	3
4	Licensed Practical Nurses	23,027	25,234	695,177	27.55	4
5	CNAs & Orderlies	42,102	44,677	634,369	14.20	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,744	7,500	159,206	21.23	8
9	Activity Director	1,770	1,928	35,148	18.23	9
10	Activity Assistants	5,634	6,221	63,160	10.15	10
11	Social Service Workers	10,945	11,797	256,467	21.74	11
12	Dietician					12
13	Food Service Supervisor	2,849	3,127	75,258	24.07	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,997	19,917	219,831	11.04	15
16	Dishwashers					16
17	Maintenance Workers	4,886	5,212	97,762	18.76	17
18	Housekeepers	11,635	12,452	150,271	12.07	18
19	Laundry	6,750	7,475	86,767	11.61	19
20	Administrator	1,952	2,142	101,787	47.52	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,464	6,897	87,855	12.74	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	1,991	2,233	40,372	18.08	31
32	Other Health Care(specify)					32
33	Other(specify)	733	816	8,945	10.96	33
34	TOTAL (lines 1 - 33)	158,732	171,906	$ 3,236,555 *	$ 18.83	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	125	$ 6,099	01-03	35
36	Medical Director	Monthly	21,600	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	10,562	10-03	39
40	Physical Therapy Consultant	Monthly	921	10a-03	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)	125	$ 39,182		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	76	$ 3,803	10-03	50
51	Licensed Practical Nurses	746	26,101	10-03	51
52	Certified Nurse Assistants/Aides	9,502	237,538	10-03	52
53	TOTAL (lines 50 - 52)	10,323	$ 267,442		53

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/17 Ending: 12/31/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
David Taylor	Administrator	0	$ 101,787
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 101,787

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
Marcum LLP	Accounting	$ 27,314
Personnel Planners	Unemployment Consulting	795
Extended Care Consulting	Home Office Expenses	224,976
Extended Care Clinical	Home Office Expenses	74,988
Paycor Payroll Services	Data Processing	17,456
Matrixcare	Data Processing	14,063
Ability Network	Medicare Billing	4,796
National Datacare Corporation	Resident Fund Processing	2,231
Pinnacle Quality Insight	Customer Satisfaction	2,897
Blymas	Tax Services	1,431
Benefit Service Group	Benefits Consulting	515
See Supplemental Schedule		12,514
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 383,976

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 121,926
Unemployment Compensation Insurance	24,487
FICA Taxes	239,967
Employee Health Insurance	226,413
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	774
Other Employee Welfare	9,655
Holiday Expense	1,140
TOTAL (agree to Schedule V, line 22, col.8)	$ 624,362

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	28,707
Health Care Worker Background Check	
(Indicate # of checks performed 88)	1,456
Patient Background Checks	
License and Permits	2,459
Dues and Subscriptions	18,845
Allocated from Extended Care Consulting	690
Allocated from Extended Care Clinical	878
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 55,025

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	9,125
Allocated from Extended Care Consulting	30
Allocated from Extended Care Clinical	1,072
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,227

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/17 Ending: 12/31/17

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. **ICLTC - $15,473**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **31,250** 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. $ **302,860**
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? **Yes**

(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