

Facility Name & ID Number Wheaton Care Center

0039115 Report Period Beginning: 01/01/03 Ending: 12/31/03

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	Other		
8	SNF	<u>4,076</u>	<u>176</u>	<u>510</u>	<u>4,762</u>	8
9	SNF/PED					9
10	ICF	<u>36,678</u>	<u>1,586</u>		<u>38,264</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>40,754</u>	<u>1,762</u>	<u>510</u>	<u>43,026</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.84%

D. How many bed-hold days during this year were paid by Public Aid? 953 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
N/A

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

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

I. On what date did you start providing long term care at this location?
Date started 09/01/93

J. Was the facility purchased or leased after January 1, 1978?
YES Date 09/01/93 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 13 and days of care provided 510

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/03 Fiscal Year: 12/31/03

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

Facility Name & ID Number

Wheaton Care Center

0039115

Report Period Beginning:

01/01/03

Ending:

12/31/03

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	214,928	20,574	11,170	246,672		246,672	(8,712)	237,960		1
2	Food Purchase		168,166		168,166		168,166	3,224	171,390		2
3	Housekeeping	121,730	20,095		141,825		141,825	(1,860)	139,965		3
4	Laundry	69,927	17,079	503	87,509		87,509		87,509		4
5	Heat and Other Utilities			107,131	107,131		107,131	1,127	108,258		5
6	Maintenance	43,226		79,754	122,980		122,980	3,761	126,741		6
7	Other (specify):*							1,083	1,083		7
8	TOTAL General Services	449,811	225,914	198,558	874,283		874,283	(1,378)	872,905		8
	B. Health Care and Programs										
9	Medical Director			1,460	1,460		1,460		1,460		9
10	Nursing and Medical Records	1,323,338	29,017	70,341	1,422,696		1,422,696	3,985	1,426,681		10
10a	Therapy	39,788	441		40,229		40,229	381	40,610		10a
11	Activities	80,838	8,434	2,626	91,898		91,898	20	91,918		11
12	Social Services	200,584		5,801	206,385		206,385	2,557	208,942		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*							9,382	9,382		15
16	TOTAL Health Care and Programs	1,644,548	37,892	80,228	1,762,668		1,762,668	16,325	1,778,993		16
	C. General Administration										
17	Administrative			123,430	123,430		123,430	8,337	131,767		17
18	Directors Fees										18
19	Professional Services			238,614	238,614		238,614	(166,308)	72,306		19
20	Dues, Fees, Subscriptions & Promotions			27,786	27,786		27,786	(14,487)	13,299		20
21	Clerical & General Office Expenses	75,437	10,489	59,824	145,750		145,750	56,005	201,755		21
22	Employee Benefits & Payroll Taxes			318,573	318,573		318,573	(22,582)	295,991		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,488	3,488		3,488	873	4,361		24
25	Other Admin. Staff Transportation			5,443	5,443		5,443		5,443		25
26	Insurance-Prop.Liab.Malpractice			119,726	119,726		119,726	932	120,658		26
27	Other (specify):*							21,153	21,153		27
28	TOTAL General Administration	75,437	10,489	896,884	982,810		982,810	(116,077)	866,733		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,169,796	274,295	1,175,670	3,619,761		3,619,761	(101,131)	3,518,630		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Wheaton Care Center

#0039115

Report Period Beginning:

01/01/03

Ending:

12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			85,576	85,576		85,576	(13,882)	71,694			30
31	Amortization of Pre-Op. & Org.			798	798		798		798			31
32	Interest			13,301	13,301		13,301	(13,301)				32
33	Real Estate Taxes			51,782	51,782		51,782	1,674	53,456			33
34	Rent-Facility & Grounds			662,160	662,160		662,160	2,771	664,931			34
35	Rent-Equipment & Vehicles			3,310	3,310		3,310	1,375	4,685			35
36	Other (specify):*											36
37	TOTAL Ownership			816,927	816,927		816,927	(21,363)	795,564			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	2,519	37,962	21,670	62,151		62,151	(3,452)	58,699			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			67,343	67,343		67,343		67,343			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	2,519	37,962	89,013	129,494		129,494	(3,452)	126,042			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,172,315	312,257	2,081,610	4,566,182		4,566,182	(125,945)	4,440,237			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center

0039115

Report Period Beginning: 01/01/03

Ending: 12/31/03

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF 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	(19,884)	30		9
10	Interest and Other Investment Income	(25,116)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(69)	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	(36,000)	21		24
25	Fund Raising, Advertising and Promotional	(2,630)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(3,814)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (87,513)		\$	30

OHF USE ONLY					
48		49	50	51	52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(38,432)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (38,432)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (125,945)		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		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	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Wheaton Care Center

Year: 003915
 Report Period Beginning: 01/01/03
 Ending: 12/31/03

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1	Ill. Council on LTC - COPE Dues	(1,500)	20
2	Collection Expenses	(114)	21
3	Bank Charges	(2,144)	23
4	Theft Loss	(50)	23
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
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87			87
88			88
89			89
90			90
91			91
92			92
93			93
94			94
95			95
96			96
97			97
98			98
99			99
100			100
101	Total	(3,814)	101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Wheaton Care Center# 0039115 Report Period Beginning:01/01/03Ending: 12/31/03

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			37		(2,030)	(5,282)		(1,437)				(8,712)	1
2	Food Purchase	(69)		(66)			3,379		(20)				3,224	2
3	Housekeeping					706			(2,566)				(1,860)	3
4	Laundry													4
5	Heat and Other Utilities			1,127									1,127	5
6	Maintenance			1,176	35	2,586	6		(42)				3,761	6
7	Other (specify):*				202	713	168						1,083	7
8	TOTAL General Services	(69)		2,274	237	1,975	(1,729)		(4,066)				(1,378)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			149	(1,725)	8,168			(2,607)				3,985	10
10a	Therapy					381							381	10a
11	Activities			20									20	11
12	Social Services				2,443	114							2,557	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*				8,328	1,054							9,382	15
16	TOTAL Health Care and Programs			169	9,046	9,717			(2,607)				16,325	16
	C. General Administration													
17	Administrative					8,217	120						8,337	17
18	Directors Fees													18
19	Professional Services			(166,347)			39						(166,308)	19
20	Fees, Subscriptions & Promotions	(4,138)		(10,360)			11						(14,487)	20
21	Clerical & General Office Expenses	(38,306)		12,535		81,519	257						56,005	21
22	Employee Benefits & Payroll Taxes				(22,178)			(335)	(70)				(22,582)	22
23	Inservice Training & Education													23
24	Travel and Seminar			542			331						873	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			932									932	26
27	Other (specify):*				10,065	11,088							21,153	27
28	TOTAL General Administration	(42,444)		(162,698)	(12,113)	100,824	758	(335)	(70)				(116,077)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(42,513)		(160,255)	(2,830)	112,516	(971)	(335)	(6,743)				(101,131)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Wheaton Care Center# 0039115 Report Period Beginning:01/01/03 Ending:12/31/03

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(19,884)		6,002									(13,882)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(25,116)		11,812			3						(13,301)	32
33	Real Estate Taxes			1,674									1,674	33
34	Rent-Facility & Grounds			2,771									2,771	34
35	Rent-Equipment & Vehicles			1,311			64						1,375	35
36	Other (specify):*													36
37	TOTAL Ownership	(45,000)		23,570			67						(21,363)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(1,463)		(1,989)				(3,452)	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						(1,463)		(1,989)				(3,452)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(87,513)		(136,685)	(2,830)	112,516	(2,367)	(335)	(8,732)				(125,945)	45

Facility Name & ID Number Wheaton Care Center

0039115

Report Period Beginning:

01/01/03

Ending:

12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	01 Dietary	\$	Care Centers, Inc.	100.00%	\$ 37	\$ 37
16	V	05 Utilities		Care Centers, Inc.	100.00%	1,127	1,127
17	V	06 Maintenance		Care Centers, Inc.	100.00%	1,176	1,176
18	V	10 Nursing	22	Care Centers, Inc.	100.00%	171	149
19	V	11 Activities		Care Centers, Inc.	100.00%	20	20
20	V	19 Professional Fees	173,882	Care Centers, Inc.	100.00%	7,535	(166,347)
21	V	20 Dues and Subscriptions	11,224	Care Centers, Inc.	100.00%	864	(10,360)
22	V	21 Office & Clerical		Care Centers, Inc.	100.00%	12,535	12,535
23	V	24 Travel and Seminar		Care Centers, Inc.	100.00%	542	542
24	V	26 Insurance		Care Centers, Inc.	100.00%	932	932
25	V	30 Depreciation		Care Centers, Inc.	100.00%	6,002	6,002
26	V	32 Interest		Care Centers, Inc.	100.00%	11,812	11,812
27	V	33 Real Estate Taxes		Care Centers, Inc.	100.00%	1,674	1,674
28	V	34 Rent - Building		Care Centers, Inc.	100.00%	2,771	2,771
29	V	35 Rent - Equipment and Auto		Care Centers, Inc.	100.00%	1,311	1,311
30	V	25 Bus Reimbursement		Care Centers, Inc.	100.00%		
31	V	02 Food	66	Care Centers, Inc.	100.00%		(66)
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 185,194			\$ 48,509	\$ * (136,685)

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	06 Maintenance Salary	\$ 1,636	Care Centers, Inc.	100.00%	\$ 1,671	\$ 35
16	V	07 Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	202	202
17	V	10 Nursing Salary	62,077	Care Centers, Inc.	100.00%	60,352	(1,725)
18	V	10a Rehab Salary		Care Centers, Inc.	100.00%		
19	V	11 Activity Salary	322	Care Centers, Inc.	100.00%	322	
20	V	12 Social Service Salary	3,617	Care Centers, Inc.	100.00%	6,060	2,443
21	V	15 Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	8,328	8,328
22	V	17 Administration Salary	63,130	Care Centers, Inc.	100.00%	63,130	
23	V	21 Office Salary	16,660	Care Centers, Inc.	100.00%	16,660	
24	V	27 Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	10,065	10,065
25	V	22 Employee Benefits	22,178	Care Centers, Inc.	100.00%		(22,178)
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 169,620			\$ 166,790	\$ * (2,830)

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	01 Dietary Salary	\$ 4,490	Care Centers, Inc.	100.00%	\$ 2,460	\$ (2,030)
16	V	03 Housekeeping Salary		Care Centers, Inc.	100.00%	706	706
17	V	06 Maintenance Salary		Care Centers, Inc.	100.00%	2,586	2,586
18	V	07 Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	713	713
19	V	10 Nursing Salary		Care Centers, Inc.	100.00%	8,168	8,168
20	V	10a Rehab Salary		Care Centers, Inc.	100.00%	381	381
21	V	12 Social Services Salary		Care Centers, Inc.	100.00%	114	114
22	V	15 Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	1,054	1,054
23	V	17 Administration Salary		Care Centers, Inc.	100.00%	8,217	8,217
24	V	21 Office Salary		Care Centers, Inc.	100.00%	81,519	81,519
25	V	27 Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	11,088	11,088
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 4,490			\$ 117,006	\$ * 112,516

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	01 Dietary	\$ 7,242	Care Centers, Inc. - Health Systems Division	100.00%	\$ 667	\$ (6,575)
16	V	02 Food		Care Centers, Inc. - Health Systems Division	100.00%	3,379	3,379
17	V	06 Maintenance		Care Centers, Inc. - Health Systems Division	100.00%	6	6
18	V	17 Administration		Care Centers, Inc. - Health Systems Division	100.00%	120	120
19	V	19 Professional Fees		Care Centers, Inc. - Health Systems Division	100.00%	39	39
20	V	20 Dues & Subscriptions		Care Centers, Inc. - Health Systems Division	100.00%	11	11
21	V	21 Office & Clerical		Care Centers, Inc. - Health Systems Division	100.00%	257	257
22	V	24 Travel & Seminar		Care Centers, Inc. - Health Systems Division	100.00%	331	331
23	V	32 Interest Expense		Care Centers, Inc. - Health Systems Division	100.00%	3	3
24	V	35 Rent - Equipment & Auto		Care Centers, Inc. - Health Systems Division	100.00%	64	64
25	V	39 Ancillary Enteral Supplies	2,743	Care Centers, Inc. - Health Systems Division	100.00%	1,280	(1,463)
26	V	01 Dietary - Salary		Care Centers, Inc. - Health Systems Division	100.00%	1,293	1,293
27	V	07 Emp. Ben. - Gen. Serv.		Care Centers, Inc. - Health Systems Division	100.00%	168	168
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 9,985			\$ 7,618	\$ * (2,367)

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	22 EMPLOYEE HEALTH INSURANCE	\$	CCS EMPLOYEE BENEFIT GROUP	100.00%	\$ 79,342	\$ 79,342	15
16	V							16
17	V							17
18	V							18
19	V	22 EMPLOYEE HEALTH INSURANCE	79,677	CCS EMPLOYEE BENEFIT GROUP	100.00%		(79,677)	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		\$ 79,677			\$ 79,342	\$ * (335)	39

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	01 DIETARY	\$ 10,918	XCEL MEDICAL SUPPLY, LLC	100.00%	\$ 9,481	\$ (1,437)
16	V	02 FOOD	156	XCEL MEDICAL SUPPLY, LLC	100.00%	135	(20)
17	V	03 HOUSEKEEPING	19,497	XCEL MEDICAL SUPPLY, LLC	100.00%	16,930	(2,566)
18	V	04 LAUNDRY		XCEL MEDICAL SUPPLY, LLC	100.00%		
19	V	06 REPAIRS & MAINTENANCE	321	XCEL MEDICAL SUPPLY, LLC	100.00%	279	(42)
20	V	10 NURSING	19,807	XCEL MEDICAL SUPPLY, LLC	100.00%	17,200	(2,607)
21	V	10A THERAPY		XCEL MEDICAL SUPPLY, LLC	100.00%		
22	V	12 SOCIAL SERVICE		XCEL MEDICAL SUPPLY, LLC	100.00%		
23	V	21 CLERICAL & GENERAL OFFICE		XCEL MEDICAL SUPPLY, LLC	100.00%		
24	V	22 EMPLOYEE BENEFITS	530	XCEL MEDICAL SUPPLY, LLC	100.00%	460	(70)
25	V	39 ANCILLARY	15,107	XCEL MEDICAL SUPPLY, LLC	100.00%	13,119	(1,989)
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 66,336			\$ 57,604	\$ * (8,732)

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

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	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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.

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	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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.

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	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Owner	Administrative	21.95%	See Attached	0.91	1.65%	Mgmt Fees	\$ 60,300	17-3	1
2	Adam Vales	Relative	Clerical	0%	See Attached	0.41	1.03%	Alloc Salary	318	22-7	2
3	Norman Goldberg	Owner	Administrative	4.07%	See Attached	1.50	2.83%	Alloc Salary	2,940	17-7	3
4	Mark Steinberg	Relative	Administrative	0%	See Attached	1.50	2.97%	Alloc Salary	1,140	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 64,698		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center

0039115 Report Period Beginning: 01/01/03

Ending: 12/31/03

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/03 Ending: 12/31/03

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

Name of Related Organization Care Centers, Inc.
 Street Address 2202 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	42	\$ 1,527	\$	43,026	\$ 37	1
2	05	Utilities	Patient Days	42	46,229		43,026	1,127	2
3	06	Maintenance	Patient Days	42	48,251		43,026	1,176	3
4	10	Nursing	Patient Days	42	7,018		43,026	171	4
5	11	Activities	Patient Days	42	838		43,026	20	5
6	19	Professional Fees	Patient Days	42	309,074		43,026	7,535	6
7	20	Dues and Subscriptions	Patient Days	42	35,428		43,026	864	7
8	21	Office & Clerical	Patient Days	42	523,091		43,026	12,535	8
9	24	Travel and Seminar	Patient Days	42	22,233		43,026	542	9
10	26	Insurance	Patient Days	42	38,230		43,026	932	10
11	30	Depreciation	Patient Days	42	246,194		43,026	6,002	11
12	32	Interest	Patient Days	42	484,531		43,026	11,812	12
13	33	Real Estate Taxes	Patient Days	42	68,681		43,026	1,674	13
14	34	Rent - Building	Patient Days	42	113,677		43,026	2,771	14
15	35	Rent - Equipment & Auto	Patient Days	42	53,777		43,026	1,311	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,998,780	\$		\$ 48,509	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/03 Ending: 12/31/03

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

Name of Related Organization Care Centers, Inc.
 Street Address 2202 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

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

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 Salary	Direct Cost		213,393	213,393		1,671	1
2	07	Emp. Ben. - Gen. Serv.	Direct Cost		26,918			202	2
3	10	Nursing Salary	Direct Cost		976,718	976,718		60,352	3
4	10a	Rehab Salary	Direct Cost		103,898	103,898			4
5	11	Activity Salary	Direct Cost		10,902	10,902		322	5
6	12	Social Service Salary	Direct Cost		306,863	306,863		6,060	6
7	15	Emp. Ben. - Healthcare	Direct Cost		174,348			8,328	7
8	17	Administration Salary	Direct Cost		1,191,200	1,191,200		63,130	8
9	21	Office Salary	Direct Cost		698,886	698,886		16,660	9
10	27	Emp. Ben. - Gen. Admin.	Direct Cost		238,998			10,065	10
11	22	Employee Benefits							11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 3,942,124	\$ 3,501,860		\$ 166,790	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/03 Ending: 12/31/03

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

Name of Related Organization Care Centers, Inc.
 Street Address 2202 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01 Dietary Salary	Patient Days	1,764,895	42	100,923	100,923	43,026	2,460	1
2	03 Housekeeping Salary	Patient Days	1,764,895	42	28,979	28,979	43,026	706	2
3	06 Maintenance Salary	Patient Days	1,764,895	42	106,088	106,088	43,026	2,586	3
4	07 Emp. Ben. - Gen. Serv.	Patient Days	1,764,895	42	29,264		43,026	713	4
5	10 Nursing Salary	Patient Days	1,764,895	42	335,028	335,028	43,026	8,168	5
6	10a Rehab Salary	Patient Days	1,764,895	42	15,649	15,649	43,026	381	6
7	12 Social Services Salary	Patient Days	1,764,895	42	4,661	4,661	43,026	114	7
8	15 Emp. Ben. - Healthcare	Patient Days	1,764,895	42	43,235		43,026	1,054	8
9	17 Administration Salary	Patient Days	1,764,895	42	337,043	337,043	43,026	8,217	9
10	21 Office Salary	Patient Days	1,764,895	42	3,343,864	3,343,864	43,026	81,519	10
11	27 Emp. Ben. - Gen. Admin.	Patient Days	1,764,895	42	454,813		43,026	11,088	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 4,799,547	\$ 4,272,235		\$ 117,006	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/03 Ending: 12/31/03

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

Name of Related Organization Care Centers, Inc.
 Street Address 2202 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

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

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	Billable Income	2,073,579	138,556		9,985	667	1
2	02	Food	Billable Income	2,073,579	852,614		9,985	3,379	2
3	06	Maintenance	Billable Income	2,073,579	1,311		9,985	6	3
4	17	Administration	Billable Income	2,073,579	25,000		9,985	120	4
5	19	Professional Fees	Billable Income	2,073,579	8,170		9,985	39	5
6	20	Dues & Subscriptions	Billable Income	2,073,579	2,312		9,985	11	6
7	21	Office & Clerical	Billable Income	2,073,579	53,285		9,985	257	7
8	24	Travel & Seminar	Billable Income	2,073,579	68,680		9,985	331	8
9	32	Interest Expense	Billable Income	2,073,579	571		9,985	3	9
10	35	Rent - Equipment & Auto	Billable Income	2,073,579	13,336		9,985	64	10
11	39	Ancillary Enteral Supplies	Billable Income	2,073,579	114,955		9,985	1,280	11
12	01	Dietary - Salary	Billable Income	2,073,579	268,554	268,554	9,985	1,293	12
13	07	Emp. Ben. - Gen. Serv.	Billable Income	2,073,579	34,942		9,985	168	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				\$ 1,582,287	\$ 268,554	\$	\$ 7,618	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/03 Ending: 12/31/03

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

Name of Related Organization CCS EMPLOYEE BENEFITS GROUP, INC.
 Street Address 4101 W. MAIN ST.
 City / State / Zip Code SKOKIE, IL 60076
 Phone Number (847)905-4000
 Fax Number (847)905-4040

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

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		\$	\$		\$ 79,342	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				\$	\$		\$ 79,342	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center

0039115 Report Period Beginning: 01/01/03

Ending: 12/31/03

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

Name of Related Organization XCEL MEDICAL SUPPLY, LLC
 Street Address 2201 MAIN STREET
 City / State / Zip Code EVANSTON, IL 60202
 Phone Number (847)328-7600
 Fax Number (847)328-7615

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	01	DIETARY	Direct Allocation		\$	\$		\$ 9,481	1
2	02	FOOD	Direct Allocation					135	2
3	03	HOUSEKEEPING	Direct Allocation					16,930	3
4	04	LAUNDRY	Direct Allocation						4
5	06	REPAIRS & MAINTENANCE	Direct Allocation					279	5
6	10	NURSING	Direct Allocation					17,200	6
7	10A	THERAPY	Direct Allocation						7
8	12	SOCIAL SERVICE	Direct Allocation						8
9	21	CLERICAL & GENERAL OFFIC	Direct Allocation						9
10	22	EMPLOYEE BENEFITS	Direct Allocation					460	10
11	39	ANCILLARY	Direct Allocation					13,119	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				\$	\$		\$ 57,604	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center

0039115 Report Period Beginning: 01/01/03

Ending: 12/31/03

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center

0039115 Report Period Beginning: 01/01/03

Ending: 12/31/03

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center

0039115 Report Period Beginning: 01/01/03

Ending: 12/31/03

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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		8	9	10									
						Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES							NO	Original				Balance
	A. Directly Facility Related																		
	Long-Term																		
1						\$	\$			\$	1								
2											2								
3											3								
4											4								
5	See Supplemental Schedule										5								
	Working Capital																		
6	CIB Bank		X	Line of Credit			137,054			11,318	6								
7	Diawa		X							1,983	7								
8	See Supplemental Schedule									11,815	8								
9	TOTAL Facility Related					\$	\$ 137,054			\$ 25,116	9								
	B. Non-Facility Related*																		
10											10								
11	Interest Income		X							(25,116)	11								
12											12								
13	See Supplemental Schedule										13								
14	TOTAL Non-Facility Related					\$	\$			\$ (25,116)	14								
15	TOTALS (line 9+line14)					\$	\$ 137,054			\$	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 0.00 Line # _____

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

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

Facility Name & ID Number **Wheaton Care Center**

0039115

Report Period Beginning:

01/01/03

Ending:

12/31/03

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

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

	1	2	3	4	5	6		7	8	9	10									
						Name of Lender	Related**					Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES								NO	Original				Balance
A. Directly Facility Related																				
Long-Term																				
1						\$	\$			\$	1									
2											2									
3											3									
4											4									
5											5									
6											6									
7	TOTAL Long-Term																			
Working Capital																				
8	Care Center Allocation		X			\$	\$			\$	11,815									
9											9									
10											10									
11											11									
12											12									
13											13									
14	TOTAL Working Capital																			
B. Non-Facility Related*																				
15						\$	\$			\$	15									
16											16									
17											17									
18											18									
19											19									
20	TOTAL Non-Facility Related																			

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

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

Facility Name & ID Number **Wheaton Care Center**# **0039115** Report Period Beginning: **01/01/03** Ending: **12/31/03****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																							
1.	Real Estate Tax accrual used on 2002 report.			\$	51,864	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.)			\$	52,233	2																			
3.	Under or (over) accrual (line 2 minus line 1).			\$	369	3																			
4.	Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	53,087	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.			\$	53,456	7																			
Real Estate Tax History:																									
Real Estate Tax Bill for Calendar Year:		1998	50,100	8	<table border="1"> <tr> <td colspan="3">FOR OHF USE ONLY</td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2002</td> <td>\$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td>\$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6</td> <td>\$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td>\$</td> <td>16</td> </tr> </table>		FOR OHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2002	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
FOR OHF USE ONLY																									
13	FROM R. E. TAX STATEMENT FOR 2002	\$	13																						
14	PLUS APPEAL COST FROM LINE 5	\$	14																						
15	LESS REFUND FROM LINE 6	\$	15																						
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																						
		1999	49,738	9																					
		2000	50,704	10																					
		2001	49,393	11																					
		2002	50,559	12																					
Real Estate Tax Accrual - \$50,559*1.05=\$53,087																									
Care Center Allocation - \$1,674																									

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.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 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 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Wheaton Care Center COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0039115

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2002 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 2002.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>05-17-114-010</u>	<u>Long Term Care Property</u>	\$ <u>50,558.94</u>	\$ <u>50,558.94</u>
2. <u>See Attached</u>	<u>Home Office Allocation</u>	\$ <u>68,681.49</u>	\$ <u>1,674.37</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>119,240.43</u>	\$ <u>52,233.31</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

IMPORTANT NOTICE

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

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

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

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

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Wheaton Care Center COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0039115

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

Facility Name & ID Number Wheaton Care Center# 0039115 Report Period Beginning:01/01/03 Ending:12/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 30,000 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 2C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NoneF. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:1. Total Amount Incurred: 4,212 2. Number of Years Over Which it is Being Amortized: _____3. Current Period Amortization: 798 4. Dates Incurred: _____Nature of Costs: Organization Costs

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>2201 Main LLC Allocation</u>			\$ <u>12,394</u>	1
2					2
3	TOTALS			\$ <u>12,394</u>	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center

0039115

Report Period Beginning:

01/01/03

Ending:

12/31/03

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1993		41,331		20	2,067	2,067	21,395	9
10	Various		1994		104,965		20	5,250	5,250	50,802	10
11	Various		1995		16,968		20	849	849	7,440	11
12	Various		1996		158,287		20	7,915	(7,915)	59,527	12
13	Various		1997		103,690		20	5,187	5,187	34,155	13
14	Various		1998		56,873		20	2,846	2,846	15,286	14
15	Various		1999		21,286		20	1,066	1,066	4,832	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

*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

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	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 12-BLDG & 12A-BLDG)									67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		46,881	1,568		1,568		1,610		68
69	Financial Statement Depreciation			84,312			(84,312)			69
70	TOTAL (lines 4 thru 69)		\$ 550,281	\$ 85,880		\$ 26,748	\$ (74,962)	\$ 195,047		70

SEE ACCOUNTANTS' COMPILATION REPORT

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

STATE OF ILLINOIS

Page 12B

Facility Name & ID Number Wheaton Care Center

0039115

Report Period Beginning:

01/01/03

Ending:

12/31/03

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12A, Carried Forward	\$ 550,281	\$ 85,880		\$ 26,748	\$ (59,132)	\$ 195,047		1
2	Carpeting	2000 7,597		20	380	380	1,520		2
3	Remove Water Softner	2000 1,500		20	75	75	294		3
4	A/C Renov/Plumbing	2000 599		20	30	30	110		4
5	Tree Removal	2000 4,850		20	243	243	870		5
6	A/C Renov	2000 1,286		20	64	64	230		6
7	A/C Renov	2000 1,877		20	94	94	329		7
8	Hot Water Pump	2000 862		20	43	43	147		8
9	Hot Water Pump	2000 1,032		20	52	52	177		9
10	Hvac	2000 637		20	32	32	109		10
11	Drapes	2000 1,838		20	92	92	307		11
12	Carpeting	2000 4,682		20	234	234	780		12
13	Piping Renov	2000 2,945		20	147	147	491		13
14	A/C Renov	2000 998		20	50	50	167		14
15	Water Renov	2000 1,248		20	62	62	208		15
16	Motor Renov	2000 672		20	34	34	112		16
17	A/C Renov/Plumbing	2000 2,025		20	101	101	329		17
18	A/C Renov/Plumbing	2000 777		20	39	39	127		18
19	A/C Renov/Plumbing	2000 3,346		20	167	167	544		19
20	Shingles	2000 2,200		20	110	110	348		20
21	A/C Renov/Plumbing	2000 756		20	38	38	120		21
22	Doors	2000 544		20	14	14	53		22
23	Water Heater Renov	2000 5,985		20	153	153	544		23
24	Water Heater Renov	2000 665		20	17	17	59		24
25	Faucets	2000 818		20	21	21	66		25
26	Nurse Call System	2000 6,800		20	849	849	4,676		26
27	Phone Sys Voice Mail	2001 4,582		20	229	229	687		27
28	Faucet And Sink	2001 780		20	39	39	117		28
29	Wall Mount Overlap C	2001 3,798		20	190	190	570		29
30	Exhaust Duct Work	2001 832		20	42	42	125		30
31	Nurse Call System	2001 1,800		20	90	90	270		31
32	Power Rod Maine Line	2001 813		20	41	41	122		32
33	Fan, Motor, Zoom Spt	2001 529		20	26	26	79		33
34	TOTAL (lines 1 thru 33)	\$ 619,954	\$ 85,880		\$ 30,546	\$ (55,334)	\$ 209,734		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

STATE OF ILLINOIS

Page 12C

Facility Name & ID Number Wheaton Care Center

0039115

Report Period Beginning:

01/01/03

Ending:

12/31/03

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 619,954	\$ 85,880		\$ 30,546	\$ (55,334)	\$ 209,734	1
2	Hot Water Supply Rep	2001	1,434		20	72	72	209	2
3	Voice Mail Supply Re	2001	2,488		20	124	124	363	3
4	Phone System	2001	4,234		20	212	212	617	4
5	Drapes	2001	10,722		20	536	536	1,563	5
6	Fire/Alarm Equip-Win	2001	3,013		20	151	151	427	6
7	Install New Drapes &	2001	1,920		20	96	96	272	7
8	Sprinkler System Rep	2001	1,250		20	63	63	178	8
9	Sewer Line	2001	2,165		20	108	108	298	9
10	Electrical Work	2001	599		20	30	30	83	10
11	Boiler Room Flow Val	2001	825		20	41	41	114	11
12	Grounds Cleanup	2001	1,200		20	60	60	165	12
13	Electrical Renovatio	2001	943		20	47	47	125	13
14	Door Closers	2001	569		20	28	28	76	14
15	Wascomat Compuer Rep	2001	545		20	27	27	73	15
16	Electrical Renovatio	2001	550		20	28	28	74	16
17	Repr/Damg/Mising Shg	2001	500		20	25	25	67	17
18	Install Key Cylinder	2001	1,041		20	52	52	139	18
19	Hvac	2001	981		20	49	49	131	19
20	Plumbing	2001	1,563		20	78	78	202	20
21	Painting	2001	719		20	36	36	93	21
22	Wining	2001	575		20	29	29	73	22
23	Plumbing	2001	691		20	35	35	87	23
24	P/A System	2001	1,199		20	60	60	150	24
25	A/C Repair	2001	669		20	67	67	162	25
26	Masonry	2001	1,600		20	80	80	180	26
27	Hvac	2001	691		20	35	35	78	27
28	Plumbing	2001	1,240		20	62	62	140	28
29	Hvac	2001	641		20	32	32	72	29
30	Gutters	2001	575		20	58	58	125	30
31	Pa System	2001	1,096		20	110	110	283	31
32	Plumbing	2002	3,707		20	371	371	741	32
33	Door Systems	2002	2,810		20	281	281	562	33
34	TOTAL (lines 1 thru 33)		\$ 672,709	\$ 85,880		\$ 33,629	\$ (52,251)	\$ 217,656	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Wheaton Care Center

0039115

Report Period Beginning:

01/01/03

Ending:

12/31/03

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 672,709	\$ 85,880		\$ 33,629	\$ (52,251)	\$ 217,656	1
2	Plumbing	2002	921		20	92	92	177	2
3	Paint	2002	628		20	63	63	120	3
4	Cabinets	2002	2,976		20	198	198	364	4
5	Boiler	2002	1,716		20	172	172	300	5
6	Hvac	2002	759		20	76	76	108	6
7	Carpeting	2002	1,526		20	218	218	291	7
8	Boiler	2002	700		20	58	58	73	8
9	Hvac	2003	683		20	68	68	68	9
10	Freezer Relay Switch	2003	517		20	34	34	34	10
11	Repair Emergency Electric System	2003	595		20	25	25	25	11
12	Fire Alarm Repair	2003	522		20	56	56	56	12
13	Elijer Wall Mount Toilet	2003	525		20	20	20	20	13
14	Walk-In Freezer	2003	698		20	23	23	23	14
15	Sprinkler Repair	2003	679		20	57	57	57	15
16	A/C Repair	2003	941		20	46	46	46	16
17	Hvac	2003	2,396		20	240	240	240	17
18	Sprinkler Svstem Repair	2003	878		20	11	11	11	18
19	6Ft High Fence	2003	6,126		20	153	153	153	19
20	Sprinkler System Repair	2003	2,160		20	51	51	51	20
21	Cement Drain And Pit	2003	1,580		20	26	26	26	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)		\$ 700,235	\$ 85,880		\$ 35,316	\$ (50,564)	\$ 219,899	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 700,235	\$ 85,880		\$ 35,316	\$ (50,564)	\$ 219,899	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)		\$ 700,235	\$ 85,880		\$ 35,316	\$ (50,564)	\$ 219,899	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 700,235	\$ 85,880		\$ 35,316	\$ (50,564)	\$ 219,899	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)		\$ 700,235	\$ 85,880		\$ 35,316	\$ (50,564)	\$ 219,899	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Wheaton Care Center

0039115

Report Period Beginning:

01/01/03

Ending:

12/31/03

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 700,235	\$ 85,880		\$ 35,316	\$ (50,564)	\$ 219,899	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)		\$ 700,235	\$ 85,880		\$ 35,316	\$ (50,564)	\$ 219,899	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12G, Carried Forward	\$ 700,235	\$ 85,880		\$ 35,316	\$ (50,564)	\$ 219,899		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)	\$ 700,235	\$ 85,880		\$ 35,316	\$ (50,564)	\$ 219,899		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 700,235	\$ 85,880		\$ 35,316	\$ (50,564)	\$ 219,899	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)		\$ 700,235	\$ 85,880		\$ 35,316	\$ (50,564)	\$ 219,899	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Wheaton Care Center

0039115

Report Period Beginning:

01/01/03

Ending:

12/31/03

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 700,235	\$ 85,880		\$ 35,316	\$ (50,564)	\$ 219,899	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)		\$ 700,235	\$ 85,880		\$ 35,316	\$ (50,564)	\$ 219,899	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 700,235	\$ 85,880		\$ 35,316	\$ (50,564)	\$ 219,899	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)		\$ 700,235	\$ 85,880		\$ 35,316	\$ (50,564)	\$ 219,899	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											9
10											10	
11											11	
12											12	
13											13	
14											14	
15											15	
16											16	
17											17	
18											18	
19											19	
20											20	
21											21	
22											22	
23											23	
24											24	
25											25	
26											26	
27											27	
28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36											36	

*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-BLDG, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	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									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$	\$		\$	\$	\$	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Wheaton Care Center

0039115

Report Period Beginning:

01/01/03

Ending:

12/31/03

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF 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				2002	\$ 17,080	\$ 427	35	\$ 427		\$ 403	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
10		Care Center, Inc. Allocation		2002	15,814	791	35	791		857	10
11		Care Center, Inc. Allocation		2003	13,987	350	35	350		350	11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*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-REP, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	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										67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 46,881	\$ 1,568		\$ 1,568	\$	\$ 1,610		70

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 322,842	\$ 2,301	\$ 30,897	\$ 28,596	10	\$ 196,050	71
72	Current Year Purchases	7,246	203	562	359	10	562	72
73	Fully Depreciated Assets	7,875				10	7,875	73
74								74
75	TOTALS	\$ 337,963	\$ 2,504	\$ 31,459	\$ 28,955		\$ 204,487	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		VAN	2003	\$ 19,994	\$ 3,060	\$ 2,999	\$ (61)	5	\$ 2,999	76
77		AUTO		17,790	134	1,920	1,786	5	1,920	77
78										78
79										79
80	TOTALS			\$ 37,784	\$ 3,194	\$ 4,919	\$ 1,725		\$ 4,919	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)	\$ 1,088,376	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 91,578	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 71,694	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (19,884)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 429,305	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NWOS General Partnership

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 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		123		\$ 662,160			3
4	Additions							4
5								5
6	Allocation from Care Centers				2,771			6
7	TOTAL		123		\$ 664,931			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. _____/2004 \$ _____
13. _____/2005 \$ _____
14. _____/2006 \$ _____

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: \$ 4,685

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.

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

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

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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	Nurse Aide 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 aides from other facilities.

\$

D. NUMBER OF AIDES 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 aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
			Units	Cost												
1	Licensed Occupational Therapist	39 - 03	hrs	\$			\$	7,156	\$			\$	7,156		1	
2	Licensed Speech and Language Development Therapist	39 - 03	hrs					27					27		2	
3	Licensed Recreational Therapist		hrs												3	
4	Licensed Physical Therapist	39 - 03	hrs					14,487					14,487		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 prescripts							15,309			15,309		9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs												10	
11	Academic Education		hrs												11	
12	Exceptional Care Program														12	
13	Other (specify): See Supplemental				2,519					22,653			25,172		13	
14	TOTAL			\$	2,519		\$	21,670	\$	37,962		\$	62,151		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 nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Wheaton Care Center

0039115

Report Period Beginning: 01/01/03

Ending:

12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/03

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 47,270	\$	1
2	Cash-Patient Deposits	33,806		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	438,269		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	161,898		6
7	Other Prepaid Expenses	12,290		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	1,479,053		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,172,586	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	603,655		15
16	Equipment, at Historical Cost	370,861		16
17	Accumulated Depreciation (book methods)	(461,105)		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	307,813		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 821,224	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,993,810	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 290,254	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	30,978		28
29	Short-Term Notes Payable	137,054		29
30	Accrued Salaries Payable	175,125		30
31	Accrued Taxes Payable (excluding real estate taxes)	8,289		31
32	Accrued Real Estate Taxes(Sch.IX-B)	53,087		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	800		35
	Other Current Liabilities(specify):			
36	See Attached Schedule			36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 695,587	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 695,587	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,298,223	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,993,810	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,978,166	1
2	Restatements (describe):		2
3	Depreciation Adjustment	75	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,978,241	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	319,982	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 319,982	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)	\$ 2,298,223	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center

0039115

Report Period Beginning: 01/01/03

Ending:

12/31/03

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,793,019	1
2	Discounts and Allowances for all Levels	(88,097)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,704,922	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	90,157	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 90,157	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide 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	16,195	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,068	19
20	Radiology and X-Ray	80	20
21	Other Medical Services	685	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 29,028	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	62,057	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 62,057	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule		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)	\$ 4,886,164	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	874,283	31
32	Health Care	1,762,668	32
33	General Administration	982,810	33
B. Capital Expense			
34	Ownership	816,927	34
C. Ancillary Expense			
35	Special Cost Centers	62,151	35
36	Provider Participation Fee	67,343	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,566,182	40
41	Income before Income Taxes (line 30 minus line 40)**	319,982	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 319,982	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Wheaton Care Center**

0039115

Report Period Beginning: **01/01/03**

Ending:

12/31/03

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	334	334	\$ 9,326	\$ 27.92	1
2	Assistant Director of Nursing	2,472	2,262	67,733	29.94	2
3	Registered Nurses	10,332	10,985	292,975	26.67	3
4	Licensed Practical Nurses	14,019	15,570	349,386	22.44	4
5	Nurse Aides & Orderlies	45,053	48,719	581,628	11.94	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	157	157	2,519	16.04	7
8	Rehab/Therapy Aides	2,468	2,925	39,788	13.60	8
9	Activity Director	1,869	2,188	30,891	14.12	9
10	Activity Assistants	5,776	5,995	49,947	8.33	10
11	Social Service Workers	14,473	15,629	200,584	12.83	11
12	Dietician					12
13	Food Service Supervisor	1,983	2,197	41,566	18.92	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,326	18,982	173,362	9.13	15
16	Dishwashers					16
17	Maintenance Workers	3,033	3,149	43,226	13.73	17
18	Housekeepers	15,647	16,639	121,730	7.32	18
19	Laundry	7,961	8,581	69,927	8.15	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,566	8,117	75,437	9.29	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	1,820	2,038	22,290	10.94	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	152,289	164,467	\$ 2,172,315 *	\$ 13.21	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	271	\$ 11,170	01-03	35
36	Medical Director	Monthly	1,460	09-03	36
37	Medical Records Consultant	Monthly	4,128	10-03	37
38	Nurse Consultant	10	497	10-03	38
39	Pharmacist Consultant	Monthly	1,476	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	66	2,304	11-03	44
45	Social Service Consultant	62	2,184	12-03	45
46	Other(specify)				46
47	<u>CCI Salary</u>		66,017	Various	47
48					48
49	TOTAL (lines 35 - 48)	409	\$ 89,236		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	39	\$ 2,163	10-03	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	39	\$ 2,163		53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
 (See instructions.)

1	2	3	4	5										
				6										
1	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year									
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	
2														
3														
4														
5														
6														
7														
8														
9														
10														
11														
12														
13														
14														
15														
16														
17														
18														
19														
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IL Council on LTC - \$5,678.92
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 3,376 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 67,343
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, 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. \$ _____
- (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. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? None
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?
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. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT