

		FOR BHF USE				

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**2006**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2006)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

**I. IDPH Facility ID Number:** 0039115

**Facility Name:** Wheaton Care Center

**Address:** 1325 Manchester Road Wheaton 60187  
 Number City Zip Code

**County:** Dupage

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

**HFS ID Number:** 363905787001

**Date of Initial License for Current Owners:** 09/01/93

**Type of Ownership:**

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input checked="" type="checkbox"/> Partnership	<input type="checkbox"/> County
<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

**In the event there are further questions about this report, please contact:**  
**Name:** Steve Lavenda **Telephone Number:** (847) 236 - 1111

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/06 to 12/31/06 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) _____	
	(Title) _____	
<b>Paid Preparer</b>	(Signed) _____	(Date) _____
	(Print Name and Title) <u>Edward N. Slack, C.P.A.</u>	
	(Firm Name & Address) <u>Frost, Ruttenberg &amp; Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>	
	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center

# 0039115 Report Period Beginning: 01/01/06 Ending: 12/31/06

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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>3,954</u>	<u>146</u>	<u>1,915</u>	<u>6,015</u>	8
9	SNF/PED					9
10	ICF	<u>35,588</u>	<u>1,312</u>		<u>36,900</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>39,542</u>	<u>1,458</u>	<u>1,915</u>	<u>42,915</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.59%

D. How many bed-hold days during this year were paid by the Department? 822 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)  
None

F. Does the facility maintain a daily midnight census? Yes

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

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 09/01/1993

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

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 81 and days of care provided 1,809

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/06 Fiscal Year: 12/31/06

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

Facility Name & ID Number      Wheaton Care Center      #      0039115      Report Period Beginning:      01/01/06      Ending:      12/31/06

**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	
	<b>A. General Services</b>											
1	Dietary	233,013	27,197	7,972	268,182		268,182	3,530	271,712			1
2	Food Purchase		165,456		165,456		165,456	(1,829)	163,627			2
3	Housekeeping	153,337	27,023	809	181,169		181,169	(2,091)	179,078			3
4	Laundry	38,111	17,479		55,590		55,590	(12)	55,578			4
5	Heat and Other Utilities			139,901	139,901		139,901	1,754	141,655			5
6	Maintenance	63,652		162,293	225,945		225,945	36,214	262,159			6
7	Other (specify):*							6,703	6,703			7
8	<b>TOTAL General Services</b>	<b>488,113</b>	<b>237,155</b>	<b>310,975</b>	<b>1,036,243</b>		<b>1,036,243</b>	<b>44,269</b>	<b>1,080,512</b>			<b>8</b>
	<b>B. Health Care and Programs</b>											
9	Medical Director			1,850	1,850		1,850		1,850			9
10	Nursing and Medical Records	1,549,628	53,114	36,987	1,639,729		1,639,729	12,488	1,652,217			10
10a	Therapy	29,093		1,440	30,533		30,533	1,971	32,504			10a
11	Activities	72,389	7,798	2,352	82,539		82,539		82,539			11
12	Social Services	205,581	2,600		208,181		208,181	9,649	217,830			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							3,855	3,855			15
16	<b>TOTAL Health Care and Programs</b>	<b>1,856,691</b>	<b>63,512</b>	<b>42,629</b>	<b>1,962,832</b>		<b>1,962,832</b>	<b>27,963</b>	<b>1,990,795</b>			<b>16</b>
	<b>C. General Administration</b>											
17	Administrative	67,029			67,029		67,029	32,626	99,655			17
18	Directors Fees											18
19	Professional Services			279,142	279,142		279,142	(227,134)	52,008			19
20	Dues, Fees, Subscriptions & Promotions			29,841	29,841		29,841	(2,407)	27,434			20
21	Clerical & General Office Expenses	28,028	11,807	116,888	156,723		156,723	48,830	205,553			21
22	Employee Benefits & Payroll Taxes			334,196	334,196		334,196	(7,243)	326,953			22
23	Inservice Training & Education			47	47		47		47			23
24	Travel and Seminar			597	597		597	2,841	3,438			24
25	Other Admin. Staff Transportation			6,275	6,275		6,275	25	6,300			25
26	Insurance-Prop.Liab.Malpractice			127,516	127,516		127,516	(345)	127,171			26
27	Other (specify):*							27,214	27,214			27
28	<b>TOTAL General Administration</b>	<b>95,057</b>	<b>11,807</b>	<b>894,502</b>	<b>1,001,366</b>		<b>1,001,366</b>	<b>(125,593)</b>	<b>875,773</b>			<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,439,861</b>	<b>312,474</b>	<b>1,248,106</b>	<b>4,000,441</b>		<b>4,000,441</b>	<b>(53,360)</b>	<b>3,947,081</b>			<b>29</b>

\*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: 01/01/06 Ending: 12/31/06

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 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	
	<b>D. Ownership</b>											
30	Depreciation			81,229	81,229	81,229	105,254	186,483				30
31	Amortization of Pre-Op. & Org.											31
32	Interest						200,950	200,950				32
33	Real Estate Taxes			59,214	59,214	59,214	1,522	60,736				33
34	Rent-Facility & Grounds			660,000	660,000	660,000	(656,975)	3,025				34
35	Rent-Equipment & Vehicles			4,003	4,003	4,003	825	4,828				35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			804,446	804,446	804,446	(348,424)	456,022				37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		120,052	48,735	168,787	168,787	(8,912)	159,875				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			67,342	67,342	67,342		67,342				42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		120,052	116,077	236,129	236,129	(8,912)	227,217				44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,439,861	432,526	2,168,629	5,041,016	5,041,016	(410,696)	4,630,320				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:

01/01/06

Ending:

12/31/06

**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	(69,732)	30		9
10	Interest and Other Investment Income	(136,165)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(56)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2)	21		18
19	Entertainment				19
20	Contributions	(615)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(4,599)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(122,497)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (333,666)		\$	30

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)	(77,030)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (77,030)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (410,696)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY					
48		49	50	51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Wheaton Care Center  
 For 003915  
 Report Period Beginning: 01/01/06  
 Ending: 12/31/06  
 Sch. V Line

NON-ALLOWABLE EXPENSES		
	Amount	Reference
1	Other Income	8 (9,937) 21 1
2	Person Clothing	260 19 2
3	Related Party Interest	(30,000) 32 3
4	Collection Expense	000 21 4
5	COPY Dues	4,600 20 5
6	Non-Allowable Expense	(60,000) 21 6
7	Non-Allowable Professional Fee	(6,551) 19 7
8	Building Company Filing Fee	250 21 8
9	Non-Allowable Professional Fee	(6,551) 19 9
10	Non-Allowable Legal	(2,678) 19 10
11	Building Company Amortization	(4,503) 31 11
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101	Total	(122,497) 101

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Wheaton Care Center

# 0039115

Report Period Beginning:

01/01/06

Ending:

12/31/06

## 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)	
	<b>A. General Services</b>													
1	Dietary			363				2,967	215		(15)		3,530	1
2	Food Purchase	(56)							(1,773)				(1,829)	2
3	Housekeeping										(2,091)		(2,091)	3
4	Laundry										(12)		(12)	4
5	Heat and Other Utilities			1,656			74		24				1,754	5
6	Maintenance			2,512	4,293	29,057	49		38		(1)	266	36,214	6
7	Other (specify):*				621	5,575		507					6,703	7
8	<b>TOTAL General Services</b>	<b>(56)</b>		<b>4,531</b>	<b>4,914</b>	<b>34,632</b>	<b>123</b>	<b>3,474</b>	<b>(1,496)</b>		<b>(2,119)</b>	<b>266</b>	<b>44,269</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(260)						15,887			(3,139)		12,488	10
10a	Therapy							1,971					1,971	10a
11	Activities													11
12	Social Services				2,370			7,279					9,649	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				318			3,537					3,855	15
16	<b>TOTAL Health Care and Programs</b>	<b>(260)</b>			<b>2,688</b>			<b>28,674</b>			<b>(3,139)</b>		<b>27,963</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			1,617	3,587			27,051	371				32,626	17
18	Directors Fees													18
19	Professional Services	(15,777)		(147,618)			(63,750)		11				(227,134)	19
20	Fees, Subscriptions & Promotions	(6,904)		4,450			30		17				(2,407)	20
21	Clerical & General Office Expenses	(70,269)	250	9,298	101,959	(561)	23	7,625	505				48,830	21
22	Employee Benefits & Payroll Taxes					(5,284)				(1,959)			(7,243)	22
23	Inservice Training & Education													23
24	Travel and Seminar			2,809			32						2,841	24
25	Other Admin. Staff Transportation								25				25	25
26	Insurance-Prop.Liab.Malpractice			(399)			17		37				(345)	26
27	Other (specify):*				15,741	6,626		4,723	124				27,214	27
28	<b>TOTAL General Administration</b>	<b>(92,950)</b>	<b>250</b>	<b>(129,843)</b>	<b>121,287</b>	<b>781</b>	<b>(63,648)</b>	<b>39,399</b>	<b>1,090</b>	<b>(1,959)</b>			<b>(125,593)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(93,266)</b>	<b>250</b>	<b>(125,312)</b>	<b>128,889</b>	<b>35,413</b>	<b>(63,525)</b>	<b>71,547</b>	<b>(406)</b>	<b>(1,959)</b>	<b>(5,257)</b>	<b>266</b>	<b>(53,360)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Wheaton Care Center

# 0039115

Report Period Beginning:

01/01/06 Ending:

12/31/06

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(69,732)	163,284	7,992			220		8			3,482	105,254	30
31	Amortization of Pre-Op. & Org.	(4,503)	4,503											31
32	Interest	(166,165)	347,368	18,743			628		1			375	200,950	32
33	Real Estate Taxes			1,369			144		9				1,522	33
34	Rent-Facility & Grounds		(660,000)	3,025									(656,975)	34
35	Rent-Equipment & Vehicles			810					15				825	35
36	Other (specify):*													36
37	<b>TOTAL Ownership</b>	<b>(240,400)</b>	<b>(144,845)</b>	<b>31,939</b>			<b>992</b>		<b>33</b>			<b>3,857</b>	<b>(348,424)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers								(1,418)		66	(7,560)	(8,912)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	<b>TOTAL Special Cost Centers</b>								<b>(1,418)</b>		<b>66</b>	<b>(7,560)</b>	<b>(8,912)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(333,666)</b>	<b>(144,595)</b>	<b>(93,373)</b>	<b>128,889</b>	<b>35,413</b>	<b>(62,533)</b>	<b>71,547</b>	<b>(1,791)</b>	<b>(1,959)</b>	<b>(5,191)</b>	<b>(3,437)</b>	<b>(410,696)</b>	<b>45</b>

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Wheaton HC Properties		Building Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  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	34 Rent	\$ 660,000	Wheaton HC Properties	100.00%	\$	\$ (660,000)	1
2	V	21 Filing Fee		Wheaton HC Properties	100.00%	250	250	2
3	V	30 Depreciation		Wheaton HC Properties	100.00%	163,284	163,284	3
4	V	31 Amortization		Wheaton HC Properties	100.00%	4,503	4,503	4
5	V	32 Interest		Wheaton HC Properties	100.00%	347,368	347,368	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		\$ 660,000			\$ 515,405	\$ * (144,595)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/06 Ending: 12/31/06

## 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 Amount	5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item			Name of Related Organization					
15	V	01	Dietary	\$	Care Centers, Inc.	100.00%	\$ 363	363	15	
16	V	05	Utilities		Care Centers, Inc.	100.00%	1,656	1,656	16	
17	V	06	Maintenance		Care Centers, Inc.	100.00%	2,512	2,512	17	
18	V								18	
19	V	17	Administration		Care Centers, Inc.	100.00%	1,617	1,617	19	
20	V	19	Professional Fees	159,884	Care Centers, Inc.	100.00%	12,266	(147,618)	20	
21	V	20	Dues and Subscriptions		Care Centers, Inc.	100.00%	4,450	4,450	21	
22	V	21	Office & Clerical		Care Centers, Inc.	100.00%	9,298	9,298	22	
23	V	24	Travel and Seminar		Care Centers, Inc.	100.00%	2,809	2,809	23	
24	V	26	Insurance		Care Centers, Inc.	100.00%	(399)	(399)	24	
25	V	30	Depreciation		Care Centers, Inc.	100.00%	7,992	7,992	25	
26	V	32	Interest		Care Centers, Inc.	100.00%	18,743	18,743	26	
27	V	33	Real Estate Taxes		Care Centers, Inc.	100.00%	1,369	1,369	27	
28	V	34	Rent - Building		Care Centers, Inc.	100.00%	3,025	3,025	28	
29	V	35	Rent - Equipment and Auto		Care Centers, Inc.	100.00%	810	810	29	
30	V	25	Bus Reimbursement		Care Centers, Inc.	100.00%			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			\$ 159,884			\$ 66,511	\$ * (93,373)	39	

\* 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	06	Maintenance Salary	Care Centers, Inc.	100.00%	4,293	4,293	15	
16	V	07	Emp. Ben. - Gen. Serv.	Care Centers, Inc.	100.00%	621	621	16	
17	V	10	Nursing Salary	Care Centers, Inc.	100.00%			17	
18	V	10a	Rehab Salary	Care Centers, Inc.	100.00%			18	
19	V	12	Social Service Salary	Care Centers, Inc.	100.00%	2,370	2,370	19	
20	V	15	Emp. Ben. - Healthcare	Care Centers, Inc.	100.00%	318	318	20	
21	V	17	Administration Salary	Care Centers, Inc.	100.00%	3,587	3,587	21	
22	V	21	Office Salary	Care Centers, Inc.	100.00%	101,959	101,959	22	
23	V	27	Emp. Ben. - Gen. Admin.	Care Centers, Inc.	100.00%	15,741	15,741	23	
24	V							24	
25	V							25	
26	V							26	
27	V							27	
28	V							28	
29	V							29	
30	V							30	
31	V							31	
32	V							32	
33	V							33	
34	V							34	
35	V							35	
36	V							36	
37	V							37	
38	V							38	
39	Total		\$			\$ 128,889	\$ * 128,889	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: 01/01/06 Ending: 12/31/06

## 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		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	4 Amount	Name of Related Organization					
15	V	06	Maintenance Salary	4,225	Care Centers, Inc.	100.00%	33,282	29,057	15
16	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	5,575	5,575	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V	17	Administration Salary		Care Centers, Inc.	100.00%			21
22	V	21	Office Salary	30,743	Care Centers, Inc.	100.00%	30,182	(561)	22
23	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	6,626	6,626	23
24	V								24
25	V	22	Employee Benefits	5,284				(5,284)	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			\$ 40,252			\$ 75,665	\$ * 35,413	39

\* 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	19	Professional Fees	\$ 64,068	Care Centers Clinical, Inc.	100.00%	\$ 318	\$ (63,750)	15
16	V	20	Dues and Subscriptions		Care Centers Clinical, Inc.	100.00%	30	30	16
17	V	21	Office and Clerical		Care Centers Clinical, Inc.	100.00%	23	23	17
18	V	24	Travel and Seminar		Care Centers Clinical, Inc.	100.00%	32	32	18
19	V	30	Depreciation		Care Centers Clinical, Inc.	100.00%	220	220	19
20	V	32	Interest		Care Centers Clinical, Inc.	100.00%	628	628	20
21	V	05	Utilities		Care Centers Clinical, Inc.	100.00%	74	74	21
22	V	06	Maintenance		Care Centers Clinical, Inc.	100.00%	49	49	22
23	V	26	Insurance		Care Centers Clinical, Inc.	100.00%	17	17	23
24	V	33	Real Estate Taxes		Care Centers Clinical, Inc.	100.00%	144	144	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		\$ 64,068				\$ 1,535	\$ * (62,533)	39

\* 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 Salary	\$	Care Centers Clinical, Inc.	100.00%	\$ 2,967	\$ 2,967	15
16	V	07	Emp. Ben. - Gen. Serv.		Care Centers Clinical, Inc.	100.00%	507	507	16
17	V	10	Nursing Salary		Care Centers Clinical, Inc.	100.00%	15,887	15,887	17
18	V	10a	Rehab Salary		Care Centers Clinical, Inc.	100.00%	1,971	1,971	18
19	V	12	Social Service Salary		Care Centers Clinical, Inc.	100.00%	7,279	7,279	19
20	V	15	Emp. Ben. - Healthcare		Care Centers Clinical, Inc.	100.00%	3,537	3,537	20
21	V	17	Administration Salary		Care Centers Clinical, Inc.	100.00%	27,051	27,051	21
22	V	21	Office Salary		Care Centers Clinical, Inc.	100.00%	7,625	7,625	22
23	V	27	Emp. Ben. - Gen. Admin.		Care Centers Clinical, Inc.	100.00%	4,723	4,723	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		\$				\$ 71,547	\$ * 71,547	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: 01/01/06 Ending: 12/31/06

## 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 Amount	5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
		Item			Name of Related Organization						
15	V	01	Dietary	\$		Care Centers Health Systems	100.00%	\$ 215	\$ 215	15	
16	V	02	Food		2,017	Care Centers Health Systems	100.00%	244	(1,773)	16	
17	V	05	Utilities			Care Centers Health Systems	100.00%	24	24	17	
18	V	06	Maintenance			Care Centers Health Systems	100.00%	38	38	18	
19	V	17	Administration			Care Centers Health Systems	100.00%	56	56	19	
20	V	19	Professional Fees			Care Centers Health Systems	100.00%	11	11	20	
21	V	20	Dues & Subscriptions			Care Centers Health Systems	100.00%	17	17	21	
22	V	21	Office & Clerical			Care Centers Health Systems	100.00%	35	35	22	
23	V	25	Auto Expenses			Care Centers Health Systems	100.00%	25	25	23	
24	V	26	Insurance			Care Centers Health Systems	100.00%	37	37	24	
25	V	30	Depreciation			Care Centers Health Systems	100.00%	8	8	25	
26	V	32	Interest Expense			Care Centers Health Systems	100.00%	1	1	26	
27	V	33	Real Estate Taxes			Care Centers Health Systems	100.00%	9	9	27	
28	V	35	Rent - Equipment & Auto			Care Centers Health Systems	100.00%	15	15	28	
29	V	39	Ancillary Enteral Supplies		3,729	Care Centers Health Systems	100.00%	2,311	(1,418)	29	
30	V	17	Administrative-Salary			Care Centers Health Systems	100.00%	315	315	30	
31	V	21	Office & Clerical-Salary			Care Centers Health Systems	100.00%	470	470	31	
32	V	27	Emp. Ben. - Gen. Admin.			Care Centers Health Systems	100.00%	124	124	32	
33	V									33	
34	V									34	
35	V									35	
36	V									36	
37	V									37	
38	V									38	
39	Total			\$	5,746			\$ 3,955	\$ *	(1,791)	39

\* 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	22 EMPLOYEE HEALTH INSURANCE	\$	CCS EMPLOYEE BENEFIT GROUP	100.00%	\$ 96,759	\$ 96,759	15
16	V							16
17	V							17
18	V							18
19	V	22 EMPLOYEE HEALTH INSURANCE	98,719	CCS EMPLOYEE BENEFIT GROUP	100.00%		(98,719)	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		\$ 98,719			\$ 96,759	\$ * (1,959)	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	\$ 187	Xcel Supply, LLC	100.00%	\$ 172	\$ (15)	15
16	V	03 Housekeeping	25,788	Xcel Supply, LLC	100.00%	23,696	(2,091)	16
17	V	04 Laundry	142	Xcel Supply, LLC	100.00%	131	(12)	17
18	V	06 Repairs & Maintenance	9	Xcel Supply, LLC	100.00%	8	(1)	18
19	V	10 Nursing	38,701	Xcel Supply, LLC	100.00%	35,563	(3,139)	19
20	V	11 Activities		Xcel Supply, LLC	100.00%			20
21	V	12 Social Service		Xcel Supply, LLC	100.00%			21
22	V	20 Dues, Fees, Subscriptions & Promotions		Xcel Supply, LLC	100.00%			22
23	V	21 Clerical & General Office		Xcel Supply, LLC	100.00%			23
24	V	22 Employee Benefits		Xcel Supply, LLC	100.00%			24
25	V	24 Seminars & Education		Xcel Supply, LLC	100.00%			25
26	V	39 Ancillary	(817)	Xcel Supply, LLC	100.00%	(751)	66	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		\$ 64,009			\$ 58,818	\$ * (5,191)	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	06 Repairs	\$	Vent Lease, LLC.	100.00%	\$ 266	\$ 266	15
16	V	30 Depreciation		Vent Lease, LLC.	100.00%	3,482	3,482	16
17	V	32 Interest		Vent Lease, LLC.	100.00%	375	375	17
18	V	39 Vent/Ancillary Reimbursement	7,560	Vent Lease, LLC.	100.00%		(7,560)	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		\$ 7,560			\$ 4,123	\$ * (3,437)	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: 01/01/06 Ending: 12/31/06

## 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	Shareholder	Administrative	38.21%	See Attached	0.90	1.95%	Alloc. Salary	\$ 1,471	17-7	1
2	Gale Rothner	Relative	Administrative		See Attached	0.94	2.69%	Alloc. Salary	2,102	17-7	2
3	Mark Steinberg	Relative	Administrative		See Attached	1.48	2.69%	Alloc. Salary	3,599	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 7,172		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:

01/01/06

Ending: 12/31/06

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:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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	1,592,658	31	\$ 13,468	\$ 42,915	\$ 363	1
2	05	Utilities	Patient Days	1,592,658	31	61,456	42,915	1,656	2
3	06	Maintenance	Patient Days	1,592,658	31	93,209	42,915	2,512	3
4									4
5	17	Administration	Patient Days	1,592,658	31	60,000	42,915	1,617	5
6	19	Professional Fees	Patient Days	1,592,658	31	455,203	42,915	12,266	6
7	20	Dues and Subscriptions	Patient Days	1,592,658	31	165,158	42,915	4,450	7
8	21	Office & Clerical	Patient Days	1,592,658	31	345,085	42,915	9,298	8
9	24	Travel and Seminar	Patient Days	1,592,658	31	104,250	42,915	2,809	9
10	26	Insurance	Patient Days	1,592,658	31	(14,814)	42,915	(399)	10
11	30	Depreciation	Patient Days	1,592,658	31	296,584	42,915	7,992	11
12	32	Interest	Patient Days	1,592,658	31	695,586	42,915	18,743	12
13	33	Real Estate Taxes	Patient Days	1,592,658	31	50,799	42,915	1,369	13
14	34	Rent - Building	Patient Days	1,592,658	31	112,256	42,915	3,025	14
15	35	Rent - Equipment & Auto	Patient Days	1,592,658	31	30,066	42,915	810	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,468,306	\$	\$ 66,511	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center

# 0039115

Report Period Beginning: 01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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	06	Maintenance Salary	Patient Days	1,592,658	31	159,318	159,318	42,915	4,293	1
2	07	Emp. Ben. - Gen. Serv.	Patient Days	1,592,658	31	23,038		42,915	621	2
3	10	Nursing Salary	Patient Days	1,592,658	31			42,915		3
4	10a	Rehab Salary	Patient Days	1,592,658	31			42,915		4
5	12	Social Service Salary	Patient Days	1,592,658	31	87,938	87,938	42,915	2,370	5
6	15	Emp. Ben. - Healthcare	Patient Days	1,592,658	31	11,794		42,915	318	6
7	17	Administration Salary	Patient Days	1,592,658	31	133,122	133,122	42,915	3,587	7
8	21	Office Salary	Patient Days	1,592,658	31	3,783,895	3,783,895	42,915	101,959	8
9	27	Emp. Ben. - Gen. Admin.	Patient Days	1,592,658	31	584,195		42,915	15,741	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					\$ 4,783,299	\$ 4,164,272		\$ 128,889	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center

# 0039115

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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	06	Maintenance Salary	Direct Allocation	26	366,540	366,540		33,282	1
2	07	Emp. Ben. - Gen. Serv.	Direct Allocation	26	60,795			5,575	2
3									3
4									4
5									5
6									6
7									7
8	21	Office Salary	Direct Allocation	23	418,249	418,249		30,182	8
9	27	Emp. Ben. - Gen. Admin.	Direct Allocation	23	70,744			6,626	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				\$ 916,329	\$ 784,790		\$ 75,665	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center

# 0039115

Report Period Beginning: 01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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	19	Professional Fees	Patient Days	1,592,658	30	\$ 11,820	\$ 42,915	\$ 318	1
2	20	Dues and Subscriptions	Patient Days	1,592,658	30	1,118	42,915	30	2
3	21	Office and Clerical	Patient Days	1,592,658	30	847	42,915	23	3
4	24	Travel and Seminar	Patient Days	1,592,658	30	1,201	42,915	32	4
5	30	Depreciation	Patient Days	1,592,658	30	8,167	42,915	220	5
6	32	Interest	Patient Days	1,592,658	30	23,321	42,915	628	6
7	05	Utilities	Patient Days	1,592,658	30	2,749	42,915	74	7
8	06	Maintenance	Patient Days	1,592,658	30	1,817	42,915	49	8
9	26	Insurance	Patient Days	1,592,658	30	623	42,915	17	9
10	33	Real Estate Taxes	Patient Days	1,592,658	30	5,358	42,915	144	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					\$ 57,020	\$	\$ 1,535	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center

# 0039115

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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 Salary	Patient Days	1,592,658	30	110,093	110,093	42,915	2,967	1
2	07	Emp. Ben. - Gen. Serv.	Patient Days	1,592,658	30	18,826	18,826	42,915	507	2
3	10	Nursing Salary	Patient Days	1,592,658	30	589,608		42,915	15,887	3
4	10a	Rehab Salary	Patient Days	1,592,658	30	73,158	73,158	42,915	1,971	4
5	12	Social Service Salary	Patient Days	1,592,658	30	270,126	270,126	42,915	7,279	5
6	15	Emp. Ben. - Healthcare	Patient Days	1,592,658	30	131,280		42,915	3,537	6
7	17	Administration Salary	Patient Days	1,592,658	30	1,003,912		42,915	27,051	7
8	21	Office Salary	Patient Days	1,592,658	30	282,969	282,969	42,915	7,625	8
9	27	Emp. Ben. - Gen. Admin.	Patient Days	1,592,658	30	175,293		42,915	4,723	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,655,265	\$ 755,172		\$ 71,547	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center

# 0039115

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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	Billable Income	2,455,454	33	91,698	5,746	215	1
2	02	Food	Billable Income	2,455,454	33	104,128	5,746	244	2
3	05	Utilities	Billable Income	2,455,454	33	10,245	5,746	24	3
4	06	Maintenance	Billable Income	2,455,454	33	16,367	5,746	38	4
5	17	Administration	Billable Income	2,455,454	33	24,000	5,746	56	5
6	19	Professional Fees	Billable Income	2,455,454	33	4,618	5,746	11	6
7	20	Dues & Subscriptions	Billable Income	2,455,454	33	7,167	5,746	17	7
8	21	Office & Clerical	Billable Income	2,455,454	33	15,126	5,746	35	8
9	25	Auto Expenses	Billable Income	2,455,454	33	10,605	5,746	25	9
10	26	Insurance	Billable Income	2,455,454	33	15,802	5,746	37	10
11	30	Depreciation	Billable Income	2,455,454	33	3,557	5,746	8	11
12	32	Interest Expense	Billable Income	2,455,454	33	392	5,746	1	12
13	33	Real Estate Taxes	Billable Income	2,455,454	33	3,660	5,746	9	13
14	35	Rent - Equipment & Auto	Billable Income	2,455,454	33	6,478	5,746	15	14
15	39	Ancillary Enteral Supplies	Billable Income	2,455,454	33	987,356	5,746	2,311	15
16	17	Administrative-Salary	Billable Income	2,455,454	33	134,802	5,746	315	16
17	21	Office & Clerical-Salary	Billable Income	2,455,454	33	200,852	200,852	470	17
18	27	Emp. Ben. - Gen. Admin.	Billable Income	2,455,454	33	52,885	52,885	124	18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,689,738	\$ 253,738	\$ 3,955	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center

# 0039115

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization CCS EMPLOYEE BENEFITS GROUP, INC.  
 Street Address 2201 MAIN STREET  
 City / State / Zip Code EVANSTON, IL 60202  
 Phone Number ( 847)905-4000  
 Fax Number ( 847)905-4040

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	22	EMPLOYEE HEALTH INSURANCE	DIRECT ALLOCATION		\$	\$		\$ 96,759	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				\$	\$		\$ 96,759	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center

# 0039115

Report Period Beginning: 01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	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						172	1
2	03	Housekeeping						23,696	2
3	04	Laundry						131	3
4	06	Repairs & Maintenance						8	4
5	10	Nursing						35,563	5
6	11	Activities							6
7	12	Social Service							7
8	20	Dues, Fees, Subscriptions & Prom							8
9	21	Clerical & General Office							9
10	22	Employee Benefits							10
11	24	Seminars & Education							11
12	39	Ancillary						(751)	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							58,818	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center

# 0039115

Report Period Beginning: 01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Vent Lease, LLC  
 Street Address 2201 W. Main Street  
 City / State / Zip Code Evanston, Illinois 60202  
 Phone Number ( 847) 674-1180  
 Fax Number ( 847) 673-7741

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	06	Repairs	Direct Billing	868,537	31	\$ 30,521	\$ 7,560	\$ 266	1
2	30	Depreciation	Direct Billing	868,537	31	400,000	7,560	3,482	2
3	32	Interest	Direct Billing	868,537	31	43,063	7,560	375	3
4	39	Vent/Ancillary Reimbursement							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					\$ 473,584	\$	\$ 4,123	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	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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	CIB		X	Mortgage			\$	1,615,309		\$	120,595	1								
2												2								
3												3								
4												4								
5	See Supplemental Schedule											5								
<b>Working Capital</b>																				
6	Manchester Manor		X	Loan				1,475,908			196,773	6								
7	Wheaton Convalescent	X		Loan							30,000	7								
8	See Supplemental Schedule										(10,253)	8								
9	TOTAL Facility Related						\$	3,091,217		\$	337,115	9								
<b>B. Non-Facility Related*</b>																				
10	Interest Income		X								(136,165)	10								
11												11								
12												12								
13	See Supplemental Schedule											13								
14	TOTAL Non-Facility Related						\$			\$	(136,165)	14								
15	TOTALS (line 9+line14)						\$	3,091,217		\$	200,950	15								

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Wheaton Care Center

# 0039115

Report Period Beginning:

01/01/06

Ending:

12/31/06

**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
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1							\$	\$			\$	1								
2												2								
3												3								
4												4								
5												5								
6												6								
7	<b>TOTAL Long-Term</b>											7								
<b>Working Capital</b>																				
8	Alloc. From Care Centers		X				\$	\$			\$ 19,372	8								
9	Alloc. From Vent Lease		X								375	9								
10	Less: Related Party Interest										(30,000)	10								
11												11								
12												12								
13												13								
14	<b>TOTAL Working Capital</b>										(10,253)	14								
<b>B. Non-Facility Related*</b>																				
15							\$	\$			\$	15								
16												16								
17												17								
18												18								
19												19								
20	<b>TOTAL Non-Facility Related</b>											20								

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

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

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

**B. Real Estate Taxes**

<p><b>Important</b>, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2005 report.		\$ <b>55,967</b>	<b>1</b>
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.)		\$ <b>57,703</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$ <b>1,736</b>	<b>3</b>
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ <b>59,000</b>	<b>4</b>
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	<b>5</b>
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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ <b>60,736</b>	<b>7</b>
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2001	<u>49,393</u>	<u>8</u>
	2002	<u>50,559</u>	<u>9</u>
	2003	<u>50,622</u>	<u>10</u>
	2004	<u>53,302</u>	<u>11</u>
	2005	<u>56,181</u>	<u>12</u>
<b>2006 Accrual= \$56,181 X 1.05 = \$59,000</b>			
<b>Allocation From Care Centers- \$1,522</b>			

	<b>FOR BHF USE ONLY</b>	
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2005 \$	<b>13</b>
<b>14</b>	PLUS APPEAL COST FROM LINE 5 \$	<b>14</b>
<b>15</b>	LESS REFUND FROM LINE 6 \$	<b>15</b>
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION \$	<b>16</b>

**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:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2006 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 Bureau of Health Finance at (217) 782-1630.

**2005 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 2005 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 2005.

(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>56,180.60</u>	\$ <u>56,180.60</u>
2. <u>See Attached</u>	<u>Home Office Allocation</u>	\$ <u>116,388.47</u>	\$ <u>1,349.66</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>172,569.07</u>	\$ <u>57,530.26</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 original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

**IMPORTANT NOTICE**

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

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

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

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

**2000 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Wheaton Care Center COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0039115

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

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

(A)	(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. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ _____	\$ _____

**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:

01/01/06 Ending:

12/31/06

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 30,000 B. General Construction Type: Exterior Brick Frame \_\_\_\_\_ Number of Stories 2

C. Does the Operating Entity?  (a) Own the Facility  (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, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs: \_\_\_\_\_

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>2005</u>	\$ <u>828,181</u>	1
2	<u>Alloc. From Care Centers</u>		<u>2002</u>	<u>9,509</u>	2
3	<b>TOTALS</b>			\$ <b>837,690</b>	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center

# 0039115

Report Period Beginning:

01/01/06

Ending:

12/31/06

**XI. OWNERSHIP COSTS (continued)**

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Various			1993	41,331		20	2,067	2,067	27,595	9
10	Various			1994	104,965		20	5,250	5,250	66,545	10
11	Various			1995	16,968		20	849	849	9,986	11
12	Various			1996	158,287		20	7,915	7,915	83,271	12
13	Various			1997	103,690		20	5,187	5,187	49,714	13
14	Various			1998	56,873		20	2,846	2,846	23,816	14
15	Various			1999	21,286		20	1,066	1,066	8,025	15
16	Various			2000	57,068		20	2,946	2,946	21,916	16
17	Various			2001	48,282		20	2,534	2,534	14,808	17
18	Various			2002	15,743		20	1,529	1,529	7,323	18
19											19
20											20
21											21
22											22
23											23
24											24
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31											31
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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

Facility Name & ID Number Wheaton Care Center

# 0039115

Report Period Beginning:

01/01/06

Ending:

12/31/06

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
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62								62
63								63
64								64
65								65
66								66
67		1,548,078	41,818		40,955	(863)	81,910	67
68		37,319	1,057		1,548	491	6,158	68
69			81,229			(81,229)		69
70		\$ 2,209,890	\$ 124,104		\$ 74,692	\$ (49,412)	\$ 401,067	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Wheaton Care Center

**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	<b>Totals from Page 12A, Carried Forward</b>		\$ 2,209,890	\$ 124,104		\$ 74,692	\$ (49,412)	\$ 401,067	1
2	Hvac	2003	683		20	68	68	273	2
3	Freezer Relay Switch	2003	517		20	34	34	138	3
4	Repair Emergency Electric System	2003	595		20	30	30	114	4
5	Fire Alarm Repair	2003	522		20	75	75	280	5
6	Elijer Wall Mount Toilet	2003	525		20	26	26	98	6
7	Walk-In Freezer	2003	698		20	35	35	128	7
8	Sprinkler Repair	2003	679		20	97	97	348	8
9	A/C Repair	2003	941		20	78	78	281	9
10	Hvac	2003	2,396		20	479	479	1,677	10
11	Sprinkler System Repair	2003	878		20	44	44	143	11
12	6Ft High Fence	2003	6,126		20	613	613	1,991	12
13	Sprinkler System Repair	2003	2,160		20	309	309	977	13
14	Cement Drain And Pit	2003	1,580		20	158	158	500	14
15	3 New Doors	2004	2,880		20	288	288	864	15
16	Pyro-Chem Kitchen System	2004	1,985		20	199	199	596	16
17	Smoke Detectors	2004	1,059		20	212	212	635	17
18	Repair Boiler	2004	895		20	179	179	537	18
19	Generator Repair	2004	540		20	108	108	324	19
20	Ceiling Radiation Fire Dampers	2004	845		20	169	169	507	20
21	Three Fire Dampers	2004	500		20	50	50	142	21
22	Gutters	2004	4,100		20	410	410	1,162	22
23	Exhaust System	2004	3,290		20	329	329	932	23
24	Landscaping	2004	14,000		20	933	933	2,333	24
25	Repair Limestone	2004	2,055		20	206	206	548	25
26	Interior Hand Rail	2004	1,636		20	164	164	436	26
27	Exterior Hand Rail	2004	9,600		20	960	960	2,560	27
28	Keypad	2004	587		20	59	59	157	28
29	Fire Alarm System	2004	43,000		20	4,300	4,300	11,467	29
30	Solenoid Valve	2004	1,180		20	79	79	203	30
31	Diesel Generator	2004	5,667		20	1,133	1,133	2,833	31
32	Cubicle Curtains	2004	589		20	118	118	294	32
33	Wire Mesh	2004	1,750		20	175	175	423	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,324,348	\$ 124,104		\$ 86,809	\$ (37,295)	\$ 434,968	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Wheaton Care Center

# 0039115

Report Period Beginning:

01/01/06

Ending:

12/31/06

**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	<b>Totals from Page 12B, Carried Forward</b>		\$ 2,324,348	\$ 124,104		\$ 86,809	\$ (37,295)	\$ 434,968	1
2	Sidewalk	2004	1,400		20	93	93	226	2
3	Diesel Generator	2004	5,667		20	1,133	1,133	2,739	3
4	Kitchen Grease Trap	2004	2,200		20	220	220	513	4
5	Generator Project	2004	5,667		20	1,133	1,133	2,644	5
6	Sales Tax On Generator	2004	810		20	162	162	378	6
7	Sign	2004	775		20	155	155	362	7
8	Electric Generator	2004	5,921		20	592	592	1,382	8
9	Plumbing Repair	2004	2,201		20	220	220	495	9
10	Repair Cooler In Kitchen	2004	1,025		20	205	205	461	10
11	Installation Of Generator	2004	5,146		20	515	515	1,072	11
12	Sprinkler System Service	2004	615		20	62	62	128	12
13	Sprinkler Repair	2004	2,100		20	210	210	438	13
14	Sprinkler Repair	2004	2,500		20	250	250	521	14
15	Generator Service	2004	762		20	152	152	318	15
16	Paint	2004	553		20	28	28	78	16
17	Paint	2004	564		20	28	28	66	17
18	Payment On Generator	2005	5,146		20	515	515	1,029	18
19	New Fire Alarm System	2005	3,000		20	300	300	600	19
20	New Fire Alarm System	2005	3,000		20	300	300	600	20
21	New Fire Alarm System	2005	3,000		20	300	300	600	21
22	New Fire Alarm System	2005	3,000		20	300	300	600	22
23	Hvac Modification	2005	7,400		20	740	740	1,418	23
24	Abatement	2005	2,950		20	295	295	320	24
25	A/C Repair	2005	2,090		20	105	105	165	25
26	Hot Water Tank Repair	2005	1,855		20	93	93	139	26
27	Walk-In Freezer Compressor Repair	2005	2,855		20	143	143	214	27
28	Laundry Tub	2005	2,100		20	105	105	149	28
29	Emergency Panels	2005	1,757		20	88	88	103	29
30	Home Office Payroll	2006	1,781		20	15	15	15	30
31	Hi Grade-Sappanos Paint	2006	1,399		20	140	140	140	31
32	Hi Grade-Sappanos Paint	2006	1,255		20	126	126	126	32
33	Home Office Payroll Painting	2006	21,066		20	1,931	1,931	1,931	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,425,908	\$ 124,104		\$ 97,463	\$ (26,641)	\$ 454,938	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

**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		\$ 2,425,908	\$ 124,104		\$ 97,463	\$ (26,641)	\$ 454,938	1
2	Sappano'S-Hi Grade Painting Supplies	2006	4,176		20	383	383	383	2
3	Home Office Payroll Painting	2006	3,518		20	293	293	293	3
4	Home Office Payroll Painting	2006	2,739		20	205	205	205	4
5	Home Office Payroll Painting	2006	1,136		20	76	76	76	5
6	Paving	2006	8,900		20	519	519	519	6
7	Home Office Payroll Painting	2006	477		20	28	28	28	7
8	Greenview Const	2006	12,428		20	621	621	621	8
9	Repair 3 Duct Systems	2006	3,500		20	117	117	117	9
10	Replace 8 Interior Doors	2006	2,840		20	95	95	95	10
11	Gutter Replacement	2006	3,023		20	50	50	50	11
12	Painting	2006	2,695		20	45	45	45	12
13	Repair 3 Duct Systems	2006	3,500		20	29	29	29	13
14	Heavy Duty Aluminum Rails	2006	2,770		20	23	23	23	14
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,477,610	\$ 124,104		\$ 99,947	\$ (24,157)	\$ 457,422	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:

01/01/06

Ending:

12/31/06

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	
1		\$ 2,477,610	\$ 124,104		\$ 99,947	\$ (24,157)	\$ 457,422	1
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32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 2,477,610	\$ 124,104		\$ 99,947	\$ (24,157)	\$ 457,422	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:

01/01/06

Ending:

12/31/06

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	\$ 2,477,610	\$ 124,104		\$ 99,947	\$ (24,157)	\$ 457,422		1
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32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 2,477,610	\$ 124,104		\$ 99,947	\$ (24,157)	\$ 457,422		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

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	\$ 2,477,610	\$ 124,104		\$ 99,947	\$ (24,157)	\$ 457,422		1
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32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 2,477,610	\$ 124,104		\$ 99,947	\$ (24,157)	\$ 457,422		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:

01/01/06

Ending:

12/31/06

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	
1		\$ 2,477,610	\$ 124,104		\$ 99,947	\$ (24,157)	\$ 457,422	1
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32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 2,477,610	\$ 124,104		\$ 99,947	\$ (24,157)	\$ 457,422	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:

01/01/06

Ending:

12/31/06

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	
1		\$ 2,477,610	\$ 124,104		\$ 99,947	\$ (24,157)	\$ 457,422	1
2								2
3								3
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32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 2,477,610	\$ 124,104		\$ 99,947	\$ (24,157)	\$ 457,422	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:

01/01/06

Ending:

12/31/06

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		\$ 2,477,610	\$ 124,104		\$ 99,947	\$ (24,157)	\$ 457,422	1
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33									33
34	TOTAL (lines 1 thru 33)		\$ 2,477,610	\$ 124,104		\$ 99,947	\$ (24,157)	\$ 457,422	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:

01/01/06

Ending:

12/31/06

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	\$ 2,477,610	\$ 124,104		\$ 99,947	\$ (24,157)	\$ 457,422		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 2,477,610	\$ 124,104		\$ 99,947	\$ (24,157)	\$ 457,422		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:

01/01/06

Ending:

12/31/06

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	
1		\$ 2,477,610	\$ 124,104		\$ 99,947	\$ (24,157)	\$ 457,422	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 2,477,610	\$ 124,104		\$ 99,947	\$ (24,157)	\$ 457,422	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:

01/01/06

Ending:

12/31/06

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	
1		\$ 2,477,610	\$ 124,104		\$ 99,947	\$ (24,157)	\$ 457,422	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 2,477,610	\$ 124,104		\$ 99,947	\$ (24,157)	\$ 457,422	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:

01/01/06

Ending:

12/31/06

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 12M, Carried Forward	\$ 2,477,610	\$ 124,104		\$ 99,947	\$ (24,157)	\$ 457,422		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 2,477,610	\$ 124,104		\$ 99,947	\$ (24,157)	\$ 457,422		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:

01/01/06

Ending:

12/31/06

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	
1		\$ 2,477,610	\$ 124,104		\$ 99,947	\$ (24,157)	\$ 457,422	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 2,477,610	\$ 124,104		\$ 99,947	\$ (24,157)	\$ 457,422	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:

01/01/06

Ending:

12/31/06

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	
1		\$ 2,477,610	\$ 124,104		\$ 99,947	\$ (24,157)	\$ 457,422	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 2,477,610	\$ 124,104		\$ 99,947	\$ (24,157)	\$ 457,422	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:

01/01/06

Ending:

12/31/06

**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 12P, Carried Forward		\$ 2,477,610	\$ 124,104		\$ 99,947	\$ (24,157)	\$ 457,422	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,477,610	\$ 124,104		\$ 99,947	\$ (24,157)	\$ 457,422	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:

01/01/06

Ending:

12/31/06

**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	123		2005	1972	\$ 1,496,317	\$ 38,367	39	\$ 38,367	\$	\$ 76,734	4
5											5
6											6
7											7
8											8
<b>Improvement Type**</b>											
9											9
10		Wheaton Healthcare Properties Site Improvements	2005		51,761	3,451	20	2,588	(863)	5,176	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

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:

01/01/06

Ending:

12/31/06

**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)	\$ 1,548,078	\$ 41,818		\$ 40,955	\$ (863)	\$ 81,910	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

**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		Allocation From Care Centers Health Systems	2002	2002	\$ 74	\$ 2	39	\$ 2	\$	\$ 8	4
5		Allocation From Care Centers Clinical	2002	2002	1,243	32	39	32		137	5
6		Allocation From Care Centers, Inc. 2201 Main	2002	2002	11,787	302	39	302		1,297	6
7											7
8											8
		<b>Improvement Type**</b>									
9		Allocation From Care Centers Health Systems		2002	61	3	20	3		14	9
10		Allocation From Care Centers Health Systems		2003	72	1	20	4	3	13	10
11		Allocation From Care Centers Health Systems		2005	4	-	20	-		-	11
12											12
13		Allocation From Care Centers Clinical		2002	1,027	43	20	51	8	231	13
14		Allocation From Care Centers Clinical		2003	1,210	23	20	61	38	212	14
15		Allocation From Care Centers Clinical		2005	60	3	20	3		4	15
16											16
17		Allocation From Care Centers, Inc. 2201 Main		2002	9,737	405	20	487	82	2,191	17
18		Allocation From Care Centers, Inc. 2201 Main		2003	11,474	218	20	574	356	2,008	18
19		Allocation From Care Centers, Inc. 2201 Main		2005	570	25	20	29	4	43	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

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

**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	<b>TOTAL (lines 4 thru 69)</b>	\$ 37,319	\$ 1,057		\$ 1,548	\$ 491	\$ 6,158	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: 01/01/06 Ending: 12/31/06

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 723,133	\$ 131,757	\$ 81,057	\$ (50,700)	10	\$ 367,841	71
72	Current Year Purchases	2,894	39	478	439	10	478	72
73	Fully Depreciated Assets	39,829				10	39,829	73
74								74
75	TOTALS	\$ 765,856	\$ 131,796	\$ 81,535	\$ (50,261)		\$ 408,148	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	\$	\$ 3,331	\$ 3,331	5	\$ 14,998	76
77		Alloc. From Care Centers	1900	20,556	315	1,670	1,355	5	13,941	77
78										78
79										79
80	TOTALS			\$ 40,550	\$ 315	\$ 5,001	\$ 4,686		\$ 28,939	80

E. Summary of Care-Related Assets

	1	Reference	2	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)		\$ 4,121,706	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 256,215	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 186,483	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ (69,732)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 894,509	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	Certificate of Need	\$ 6,000	92
93			93
94			94
95		\$ 6,000	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center

# 0039115

Report Period Beginning: 01/01/06

Ending: 12/31/06

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6	Allocation From Care Centers				3,025			6
7	TOTAL				\$ 3,025			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.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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: \$ 4,827      Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

<p>1. HAVE YOU TRAINED CNAs 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. <u>CLASSROOM PORTION:</u></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 CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
  - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 6,999	\$ 216		\$ 7,215	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			663			663	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			36,867	722		37,589	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				106,831		106,831	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <u>See Supplemental</u>					4,206	12,283		16,489	13
14	<b>TOTAL</b>			\$		\$ 48,735	\$ 120,052		\$ 168,787	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center# 0039115Report Period Beginning: 01/01/06

Ending:

12/31/06**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/06

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$	\$ 55,678	1
2	Cash-Patient Deposits	27,782	27,782	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	720,555	720,555	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	139,380	139,380	6
7	Other Prepaid Expenses	8,512	8,512	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	2,242,180	1,744,580	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 3,138,409	\$ 2,696,487	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		828,181	13
14	Buildings, at Historical Cost		1,496,317	14
15	Leasehold Improvements, at Historical Cost	815,821	867,582	15
16	Equipment, at Historical Cost	440,946	772,218	16
17	Accumulated Depreciation (book methods)	(918,973)	(1,124,970)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		35,074	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(6,004)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	1,234,469	1,234,469	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,572,263	\$ 4,102,867	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,710,672	\$ 6,799,354	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 532,387	\$ 532,387	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	20,751	20,751	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	115,567	115,567	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,691	3,691	31
32	Accrued Real Estate Taxes(Sch.IX-B)	59,000	59,000	32
33	Accrued Interest Payable		25,670	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>See Attached Schedule</u>	1,228,469		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,959,865	\$ 757,066	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable		1,475,908	39
40	Mortgage Payable		1,615,309	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>See Attached Schedule</u>			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 3,091,217	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,959,865	\$ 3,848,283	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 2,750,807	\$ 2,951,071	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,710,672	\$ 6,799,354	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,579,670	1
2	Restatements (describe):		2
3	Purchase Option Fee	(307,500)	3
4	Interest Expense	(333)	4
5	Rounding	1	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,271,838	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	478,969	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)	\$ 478,969	17
	<b>B. Transfers (Itemize):</b>		
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)	\$ 2,750,807	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center# 0039115Report Period Beginning: 01/01/06Ending: 12/31/06**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,366,252	1
2	Discounts and Allowances for all Levels	(378,656)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,987,596	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	234,291	6
7	Oxygen	1,929	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 236,220	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	107,945	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	39,805	19
20	Radiology and X-Ray	950	20
21	Other Medical Services	1,367	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 150,067	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	136,165	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 136,165	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	9,937	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 9,937	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,519,985	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,036,243	31
32	Health Care	1,962,832	32
33	General Administration	1,001,366	33
<b>B. Capital Expense</b>			
34	Ownership	804,446	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	168,787	35
36	Provider Participation Fee	67,342	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,041,016	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	478,969	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 478,969	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:

01/01/06

Ending:

12/31/06

**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	2,014	2,225	\$ 73,388	\$ 32.98	1
2	Assistant Director of Nursing	1,821	1,960	56,271	28.71	2
3	Registered Nurses	8,613	9,614	273,042	28.40	3
4	Licensed Practical Nurses	16,477	18,078	465,687	25.76	4
5	CNAs & Orderlies	47,281	51,845	656,835	12.67	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,795	2,088	29,093	13.93	8
9	Activity Director	1,824	2,020	21,517	10.65	9
10	Activity Assistants	5,003	5,339	50,872	9.53	10
11	Social Service Workers	11,646	12,832	205,581	16.02	11
12	Dietician					12
13	Food Service Supervisor	1,945	2,171	38,939	17.94	13
14	Head Cook					14
15	Cook Helpers/Assistants	4,045	4,258	38,787	9.11	15
16	Dishwashers	15,263	16,815	155,287	9.24	16
17	Maintenance Workers	4,468	4,631	63,652	13.74	17
18	Housekeepers	16,540	17,961	153,337	8.54	18
19	Laundry	4,115	4,471	38,111	8.52	19
20	Administrator	2,059	2,237	67,029	29.96	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,979	3,164	28,028	8.86	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	1,720	1,950	24,405	12.52	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	<b>TOTAL (lines 1 - 33)</b>	<b>149,608</b>	<b>163,659</b>	<b>\$ 2,439,861 *</b>	<b>\$ 14.91</b>	<b>34</b>

\* 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	179	\$ 7,972	01-03	35
36	Medical Director	Monthly	1,850	09-03	36
37	Medical Records Consultant	Monthly	4,679	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,819	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	48	2,352	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	<u>Therapy Consultant</u>	60	1,440	10a-03	47
48	<u>URC Consultant</u>	Monthly	129	10-03	48
49	<b>TOTAL (lines 35 - 48)</b>	<b>287</b>	<b>\$ 20,241</b>		<b>49</b>

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	426	\$ 21,106	10-03	50
51	Licensed Practical Nurses	270	9,254	10-03	51
52	Certified Nurse Assistants/Aides				52
53	<b>TOTAL (lines 50 - 52)</b>	<b>696</b>	<b>\$ 30,360</b>		<b>53</b>

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 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2003	6 FY2004	7 FY2005	8 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 FY2011
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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. ICLTC \$6,593
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,561 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 67,342  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 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? N/A
- g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) 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