

Facility Name & ID Number Wheaton Care Center

0039115 Report Period Beginning: 01/01/09 Ending: 12/31/09

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	82	Skilled (SNF)	82	29,930	1
2		Skilled Pediatric (SNF/PED)			2
3	41	Intermediate (ICF)	41	14,965	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	123	TOTALS	123	44,895	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF	3,737	159	2,241	6,137	8
9	SNF/PED					9
10	ICF	33,634	1,430		35,064	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	37,371	1,589	2,241	41,201	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.77%

D. How many bed-hold days during this year were paid by the Department? 1,058 (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 9/1/1993

J. Was the facility purchased or leased after January 1, 1978?
YES Date 9/1/1993 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 2,070

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/2009

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

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/09 Ending: 12/31/09

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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	241,914	31,598	9,127	282,639		282,639	2,219	284,858		1
2	Food Purchase		190,944		190,944		190,944	378	191,322		2
3	Housekeeping	175,202	39,574		214,776		214,776	(2,875)	211,901		3
4	Laundry	43,786	17,318		61,104		61,104	(515)	60,589		4
5	Heat and Other Utilities			130,240	130,240		130,240	1,911	132,151		5
6	Maintenance	78,058		171,312	249,370		249,370	11,489	260,859		6
7	Other (specify):*							1,988	1,988		7
8	TOTAL General Services	538,960	279,434	310,679	1,129,073		1,129,073	14,595	1,143,668		8
	B. Health Care and Programs										
9	Medical Director			2,450	2,450		2,450		2,450		9
10	Nursing and Medical Records	1,690,439	76,994	97,935	1,865,368		1,865,368	13,919	1,879,287		10
10a	Therapy	87,276			87,276		87,276	1,406	88,682		10a
11	Activities	90,343	9,458		99,801		99,801		99,801		11
12	Social Services	179,578	1,521	15,163	196,262		196,262	7,407	203,669		12
13	CNA Training										13
14	Program Transportation			372	372		372		372		14
15	Other (specify):*							10,167	10,167		15
16	TOTAL Health Care and Programs	2,047,636	87,973	115,920	2,251,529		2,251,529	32,899	2,284,428		16
	C. General Administration										
17	Administrative	90,125		5,200	95,325		95,325	42,489	137,814		17
18	Directors Fees										18
19	Professional Services			300,679	300,679	(3,801)	296,878	(240,568)	56,310		19
20	Dues, Fees, Subscriptions & Promotions			36,617	36,617		36,617	(1,152)	35,465		20
21	Clerical & General Office Expenses	67,782	24,286	192,473	284,541		284,541	(6,844)	277,697		21
22	Employee Benefits & Payroll Taxes			401,510	401,510		401,510	(14,703)	386,807		22
23	Inservice Training & Education										23
24	Travel and Seminar			8,768	8,768		8,768	414	9,182		24
25	Other Admin. Staff Transportation			4,736	4,736		4,736	380	5,116		25
26	Insurance-Prop.Liab.Malpractice			218,464	218,464		218,464	1,010	219,474		26
27	Other (specify):*							27,841	27,841		27
28	TOTAL General Administration	157,907	24,286	1,168,447	1,350,640	(3,801)	1,346,839	(191,133)	1,155,706		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,744,503	391,693	1,595,046	4,731,242	(3,801)	4,727,441	(143,639)	4,583,802		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Wheaton Care Center

#0039115

Report Period Beginning:

01/01/09

Ending:

12/31/09

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			64,140	64,140		64,140	101,783	165,923			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,028	3,028		3,028	253,178	256,206			32
33	Real Estate Taxes			43,397	43,397	3,801	47,198	1,849	49,047			33
34	Rent-Facility & Grounds			660,000	660,000		660,000	(656,419)	3,581			34
35	Rent-Equipment & Vehicles			3,473	3,473		3,473	2,050	5,523			35
36	Other (specify):*											36
37	TOTAL Ownership			774,038	774,038	3,801	777,839	(297,559)	480,280			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		149,265	188,848	338,113		338,113	7,156	345,269			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			67,343	67,343		67,343		67,343			42
43	Other (specify):*			171	171		171	(171)				43
44	TOTAL Special Cost Centers		149,265	256,362	405,627		405,627	6,985	412,612			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,744,503	540,958	2,625,446	5,910,907		5,910,907	(434,212)	5,476,695			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

Wheaton Care CenterID# 0039115Report Period Beginning: 01/01/09Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Jury Duty Income	\$ (38)	10	1
2	Account Collection Expense	(204)	21	2
3	Prior Period Nursing Costs	(3,448)	10	3
4	Non-Allowable Office Expense	(54,800)	21	4
5	Annual Report Fees	(200)	20	5
6	Marketing Expenses	(171)	43	6
7	2010 Seminar	(450)	24	7
8	Non-Allowable Legal	(2,083)	19	8
9	Building Company Legal Expense	(15,622)	19	9
10	Building Company Filing Fees	(250)	21	10
11	Building Company Amortization	(3,723)	31	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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27				27
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30				30
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34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(80,989)		49

Wheaton Care Center

ID# 0039115

Report Period Beginning: 01/01/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
50		\$	1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
58			9
59			10
60			11
61			12
62			13
63			14
64			15
65			16
66			17
67			18
68			19
69			20
70			21
71			22
72			23
73			24
74			25
75			26
76			27
77			28
78			29
79			30
80			31
81			32
82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
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92			43
93			44
94			45
95			46
96			47
97			48
98			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Wheaton Care Center# 0039115

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			203		3,518					(1,502)		2,219	1
2	Food Purchase	(73)		451									378	2
3	Housekeeping			421		46	(3,342)						(2,875)	3
4	Laundry						(515)						(515)	4
5	Heat and Other Utilities			1,726		111					74		1,911	5
6	Maintenance			2,679	6,562	14	(322)		2,500		56		11,489	6
7	Other (specify):*				1,478	510							1,988	7
8	TOTAL General Services	(73)		5,480	8,040	4,199	(4,179)		2,500		(1,372)		14,595	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(4,076)				23,950	(5,744)				(211)		13,919	10
10a	Therapy					1,377				29			1,406	10a
11	Activities													11
12	Social Services					7,407							7,407	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					10,167							10,167	15
16	TOTAL Health Care and Programs	(4,076)				42,901	(5,744)			29	(211)		32,899	16
	C. General Administration													
17	Administrative			1,976	7,165	31,240					2,108		42,489	17
18	Directors Fees													18
19	Professional Services	(17,705)	15,622	(171,763)		(66,938)			137		79		(240,568)	19
20	Fees, Subscriptions & Promotions	(2,881)		1,691		6					32		(1,152)	20
21	Clerical & General Office Expenses	(127,413)	250	13,842	107,765	7,005			(10,844)		2,551		(6,844)	21
22	Employee Benefits & Payroll Taxes				(3,410)	(11,293)							(14,703)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(450)		53		811							414	24
25	Other Admin. Staff Transportation			309					11		60		380	25
26	Insurance-Prop.Liab.Malpractice			679		40			141		150		1,010	26
27	Other (specify):*				21,494	5,427					920		27,841	27
28	TOTAL General Administration	(148,449)	15,872	(153,213)	133,014	(33,702)			(10,555)		5,900		(191,133)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(152,598)	15,872	(147,733)	141,054	13,398	(9,923)		(8,055)	29	4,317		(143,639)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Wheaton Care Center# 0039115

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	3,472	78,426	3,460		766			15,505		154		101,783	30
31	Amortization of Pre-Op. & Org.	(3,723)	3,723											31
32	Interest	(52,319)	242,663	50,855		9,256			2,723				253,178	32
33	Real Estate Taxes			1,668		181							1,849	33
34	Rent-Facility & Grounds		(660,000)	2,893							688		(656,419)	34
35	Rent-Equipment & Vehicles			2,043							7		2,050	35
36	Other (specify):*													36
37	TOTAL Ownership	(52,570)	(335,188)	60,919		10,203			18,228		849		(297,559)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(2,032)		(25,405)	34,621	(28)		7,156	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(171)											(171)	43
44	TOTAL Special Cost Centers	(171)					(2,032)		(25,405)	34,621	(28)		6,985	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(205,339)	(319,316)	(86,814)	141,054	23,601	(11,955)		(15,232)	34,650	5,138		(434,212)	45

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:	
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)	
1	V	34 Rental Income	\$ 660,000	Wheaton HC Properties	100.00%	\$	(660,000)	1
2	V	33 Real Estate Taxes	43,397	Wheaton HC Properties	100.00%	43,397		2
3	V	32 Interest Income	6,500	Wheaton HC Properties	100.00%		(6,500)	3
4	V	19 Legal Expense		Wheaton HC Properties	100.00%	15,622	15,622	4
5	V	21 Filing Fees		Wheaton HC Properties	100.00%	250	250	5
6	V	30 Depreciation Expense		Wheaton HC Properties	100.00%	78,426	78,426	6
7	V	31 Amortization Expense		Wheaton HC Properties	100.00%	3,723	3,723	7
8	V	32 Interest Expense		Wheaton HC Properties	100.00%	249,163	249,163	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 709,897			\$ 390,581	\$ * (319,316)	14

* 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	\$	Extended Care Consulting, LLC	100.00%	\$ 203	\$	203	15
16	V	02 Food		Extended Care Consulting, LLC	100.00%	451		451	16
17	V	03 Housekeeping		Extended Care Consulting, LLC	100.00%	421		421	17
18	V	05 Utilities		Extended Care Consulting, LLC	100.00%	1,726		1,726	18
19	V	06 Maintenance		Extended Care Consulting, LLC	100.00%	2,679		2,679	19
20	V	17 Administrative		Extended Care Consulting, LLC	100.00%	1,976		1,976	20
21	V	19 Professional Fees	180,311	Extended Care Consulting, LLC	100.00%	8,548		(171,763)	21
22	V	20 Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	1,691		1,691	22
23	V	21 Office and Clerical		Extended Care Consulting, LLC	100.00%	13,842		13,842	23
24	V	24 Seminar and Travel		Extended Care Consulting, LLC	100.00%	53		53	24
25	V	25 Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	309		309	25
26	V	26 Insurance		Extended Care Consulting, LLC	100.00%	679		679	26
27	V	30 Depreciation		Extended Care Consulting, LLC	100.00%	3,460		3,460	27
28	V	32 Interest		Extended Care Consulting, LLC	100.00%	50,855		50,855	28
29	V	33 Real Estate Taxes		Extended Care Consulting, LLC	100.00%	1,668		1,668	29
30	V	34 Rent - Building		Extended Care Consulting, LLC	100.00%	2,893		2,893	30
31	V	35 Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	2,043		2,043	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 180,311			\$ 93,497	\$ *	(86,814)	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 Maintenance (Pooled)		Extended Care Consulting, LLC	100.00%	6,562	\$	6,562	15
16	V	06 Maintenance (Direct)	2,857	Extended Care Consulting, LLC	100.00%	2,857			16
17	V	07 Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	1,123		1,123	17
18	V	07 Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	355		355	18
19	V	17 Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	7,165		7,165	19
20	V	21 Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	107,765		107,765	20
21	V	21 Office and Clerical (Direct)	24,617	Extended Care Consulting, LLC	100.00%	24,617			21
22	V	27 Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	18,438		18,438	22
23	V	27 Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	3,056		3,056	23
24	V	22 Employee Benefits	3,410	Extended Care Consulting, LLC	100.00%			(3,410)	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		\$ 30,884			\$ 171,938	\$ *	141,054	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	03 Housekeeping	\$	Extended Care Clinical, LLC	100.00%	\$ 46	\$ 46	15
16	V	05 Utilities		Extended Care Clinical, LLC	100.00%	111	111	16
17	V	06 Maintenance		Extended Care Clinical, LLC	100.00%	14	14	17
18	V	19 Professional Fees	67,899	Extended Care Clinical, LLC	100.00%	961	(66,938)	18
19	V	20 Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	6	6	19
20	V	21 Office & Clerical		Extended Care Clinical, LLC	100.00%	817	817	20
21	V	24 Travel and Seminar		Extended Care Clinical, LLC	100.00%	811	811	21
22	V	26 Insurance		Extended Care Clinical, LLC	100.00%	40	40	22
23	V	30 Depreciation		Extended Care Clinical, LLC	100.00%	766	766	23
24	V	32 Interest		Extended Care Clinical, LLC	100.00%	9,256	9,256	24
25	V	33 Real Estate Taxes		Extended Care Clinical, LLC	100.00%	181	181	25
26	V	01 Dietary Salary		Extended Care Clinical, LLC	100.00%	3,518	3,518	26
27	V	07 Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	510	510	27
28	V	10 Nursing Salary	30,879	Extended Care Clinical, LLC	100.00%	54,829	23,950	28
29	V	10a Rehab Salary		Extended Care Clinical, LLC	100.00%	1,377	1,377	29
30	V	12 Social Service Salary	15,163	Extended Care Clinical, LLC	100.00%	22,570	7,407	30
31	V	15 Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	10,167	10,167	31
32	V	17 Administration Salary		Extended Care Clinical, LLC	100.00%	31,240	31,240	32
33	V	21 Office Salary		Extended Care Clinical, LLC	100.00%	6,188	6,188	33
34	V	27 Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	5,427	5,427	34
35	V	22 Employee Benefits	11,293	Extended Care Clinical, LLC	100.00%		(11,293)	35
36	V							36
37	V							37
38	V							38
39	Total		\$ 125,234			\$ 148,835	\$ * 23,601	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	1 Dietary	\$	Xcel Supply, LLC	100.00%	\$		15
16	V	3 Housekeeping	36,392	Xcel Supply, LLC	100.00%	33,050	(3,342)	16
17	V	4 Laundry	5,609	Xcel Supply, LLC	100.00%	5,094	(515)	17
18	V	6 Repairs & Maintenance	3,505	Xcel Supply, LLC	100.00%	3,183	(322)	18
19	V	10 Nursing	62,548	Xcel Supply, LLC	100.00%	56,804	(5,744)	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 And Subscriptions		Xcel Supply, LLC	100.00%			22
23	V	21 Office And Clerical		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	22,128	Xcel Supply, LLC	100.00%	20,096	(2,032)	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		\$ 130,181			\$ 118,226	\$ * (11,955)	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	22 Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 111,523	\$ 111,523	15
16	V							16
17	V							17
18	V							18
19	V	22 Employee Health Insurance	111,523	CCS Employee Benefits Group	100.00%		(111,523)	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		\$ 111,523			\$ 111,523	\$ *	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%	\$ 2,500	\$ 2,500
16	V	19 Professional Fees		Vent Lease, LLC.	100.00%	137	137
17	V	21 Office and Clerical		Vent Lease, LLC.	100.00%	212	212
18	V	25 Auto Expense / Travel		Vent Lease, LLC.	100.00%	11	11
19	V	26 Insurance		Vent Lease, LLC.	100.00%	141	141
20	V	30 Depreciation		Vent Lease, LLC.	100.00%	6,506	6,506
21	V	32 Interest		Vent Lease, LLC.	100.00%	1,096	1,096
22	V	30 Depreciation - Matrix		Vent Lease, LLC.	100.00%	8,999	8,999
23	V	32 Interest - Matrix		Vent Lease, LLC.	100.00%	1,627	1,627
24	V	21 Office and Clerical	11,056	Vent Lease, LLC.	100.00%		(11,056)
25	V	39 Ancillary	25,405	Vent Lease, LLC.	100.00%		(25,405)
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 36,461			\$ 21,229	\$ * (15,232)

* 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	39 THERAPY	\$ 135,348	TRICARE		\$ 169,969	\$ 34,621	15
16	V	10A REHAB				29	29	16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 135,348			\$ 169,998	\$ * 34,650	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	\$	Care Centers Health Systems, Inc.	100.00%	\$ 971	\$	971	15
16	V	03 Housekeeping		Care Centers Health Systems, Inc.	100.00%				16
17	V	05 Heat and Other Utilities		Care Centers Health Systems, Inc.	100.00%	74		74	17
18	V	06 Maintenance		Care Centers Health Systems, Inc.	100.00%	56		56	18
19	V	19 Professional Fees		Care Centers Health Systems, Inc.	100.00%	79		79	19
20	V	20 Dues, Fees, Subscriptions		Care Centers Health Systems, Inc.	100.00%	32		32	20
21	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	399		399	21
22	V	25 Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%	60		60	22
23	V	26 Insurance		Care Centers Health Systems, Inc.	100.00%	150		150	23
24	V	30 Depreciation		Care Centers Health Systems, Inc.	100.00%	154		154	24
25	V	32 Interest		Care Centers Health Systems, Inc.	100.00%				25
26	V	33 Real Estate Taxes		Care Centers Health Systems, Inc.	100.00%				26
27	V	34 Rent - Building		Care Centers Health Systems, Inc.	100.00%	688		688	27
28	V	35 Rent - Equipment		Care Centers Health Systems, Inc.	100.00%	7		7	28
29	V	01 Dietary	4,116	Care Centers Health Systems, Inc.	100.00%	1,643		(2,473)	29
30	V	02 Food		Care Centers Health Systems, Inc.	100.00%				30
31	V	03 Housekeeping		Care Centers Health Systems, Inc.	100.00%				31
32	V	10 Nursing	351	Care Centers Health Systems, Inc.	100.00%	140		(211)	32
33	V	22 Employee Benefits		Care Centers Health Systems, Inc.	100.00%				33
34	V	25 Other Admin. Staff Transport.		Care Centers Health Systems, Inc.	100.00%				34
35	V	39 Ancillary	47	Care Centers Health Systems, Inc.	100.00%	19		(28)	35
36	V	17 Administrative		Care Centers Health Systems, Inc.	100.00%	2,108		2,108	36
37	V	21 Clerical and General Office		Care Centers Health Systems, Inc.	100.00%	2,152		2,152	37
38	V	27 Employee Benefits		Care Centers Health Systems, Inc.	100.00%	920		920	38
39	Total		\$ 4,514			\$ 9,652	\$ *	5,138	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		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

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

Facility Name & ID Number

Wheaton Care Center

0039115

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	3.00%	Mgmt Fees	\$ 5,200	17-3	1
2	Mark Steinberg	Relative	Administrative	0.00%	See Attached	1.65	3.00%	AI Fee/AI Sal	4,986	17-7	2
3	Adam Vales	Shareholder	Clerical	4.07%	See Attached	0.65	1.63%	Alloc Salary	1,170	22-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 11,356		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:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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.

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:

01/01/09

Ending: 12/31/09

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 Extended Care Consulting LLC
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

1	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	30	\$ 6,770	\$	41,201	\$ 203	1
2	02	Food	Patient Days	30	15,058		41,201	451	2
3	03	Housekeeping	Patient Days	30	14,059		41,201	421	3
4	05	Utilities	Patient Days	30	57,646		41,201	1,726	4
5	06	Maintenance	Patient Days	30	89,465		41,201	2,679	5
6	17	Administrative	Patient Days	30	66,000		41,201	1,976	6
7	19	Professional Fees	Patient Days	30	285,482		41,201	8,548	7
8	20	Dues and Subscriptions	Patient Days	30	56,488		41,201	1,691	8
9	21	Office and Clerical	Patient Days	30	462,313		41,201	13,842	9
10	24	Seminar and Travel	Patient Days	30	1,768		41,201	53	10
11	25	Other Staff Admin. Trans.	Patient Days	30	10,309		41,201	309	11
12	26	Insurance	Patient Days	30	22,668		41,201	679	12
13	30	Depreciation	Patient Days	30	115,549		41,201	3,460	13
14	32	Interest	Patient Days	30	1,698,489		41,201	50,855	14
15	33	Real Estate Taxes	Patient Days	30	55,709		41,201	1,668	15
16	34	Rent - Building	Patient Days	30	96,636		41,201	2,893	16
17	35	Rent - Equipment & Auto	Patient Days	30	68,244		41,201	2,043	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 3,122,653	\$		\$ 93,497	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center

0039115

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 Extended Care Consulting LLC
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

1	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 (Pooled)	Patient Days	30	219,177	219,177	41,201	6,562	1
2	06	Maintenance (Direct)	Direct	30	82,905	82,905		2,857	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	30	37,501		41,201	1,123	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct	30	8,464	8,464		355	4
5	17	Administrative (Pooled)	Patient Days	30	239,303	239,303	41,201	7,165	5
6	21	Office and Clerical (Pooled)	Patient Days	30	3,599,211	3,599,211	41,201	107,765	6
7	21	Office and Clerical (Direct)	Direct	30	654,174			24,617	7
8	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	30	615,819	615,819	41,201	18,438	8
9	27	Emp. Ben. - Gen. Admin. (Direct)	Direct	30	73,650	73,650	41,201	3,056	9
10	22	Employee Benefits							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				\$ 5,530,203	\$ 4,838,529		\$ 171,938	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center

0039115

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 Extended Care Clinical LLC
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

1	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	03	Housekeeping	Patient Days	1,376,056	30	\$ 1,549	\$ 41,201	\$ 46	1
2	05	Utilities	Patient Days	1,376,056	30	3,693	41,201	111	2
3	06	Maintenance	Patient Days	1,376,056	30	477	41,201	14	3
4	19	Professional Fees	Patient Days	1,376,056	30	32,105	41,201	961	4
5	20	Dues and Subscriptions	Patient Days	1,376,056	30	213	41,201	6	5
6	21	Office & Clerical	Patient Days	1,376,056	30	27,296	41,201	817	6
7	24	Travel and Seminar	Patient Days	1,376,056	30	27,079	41,201	811	7
8	26	Insurance	Patient Days	1,376,056	30	1,342	41,201	40	8
9	30	Depreciation	Patient Days	1,376,056	30	25,586	41,201	766	9
10	32	Interest	Patient Days	1,376,056	30	309,136	41,201	9,256	10
11	33	Real Estate Taxes	Patient Days	1,376,056	30	6,053	41,201	181	11
12	01	Dietary Salary	Patient Days	1,376,056	30	117,506	41,201	3,518	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	1,376,056	30	17,040	41,201	510	13
14	10	Nursing Salary	Patient Days	1,376,056	30	799,889	41,201	23,950	14
15	10a	Rehab Salary	Patient Days	1,376,056	30	45,993	41,201	1,377	15
16	12	Social Service Salary	Patient Days	1,376,056	30	247,396	41,201	7,407	16
17	15	Emp. Ben. - Healthcare	Patient Days	1,376,056	30	158,537	41,201	4,747	17
18	17	Administration Salary	Patient Days	1,376,056	30	1,043,375	41,201	31,240	18
19	21	Office Salary	Patient Days	1,376,056	30	206,680	41,201	6,188	19
20	27	Emp. Ben. - Gen. Admin.	Patient Days	1,376,056	30	181,271	41,201	5,427	20
21	10	Nursing Salary	Direct Allocation			494,488	41,201	30,879	21
22	12	Social Service Salary	Direct Allocation			196,033		15,163	22
23	15	Emp. Ben. - Healthcare	Direct Allocation			82,560		5,420	23
24									24
25	TOTALS					\$ 4,025,296	\$ 3,151,360	\$ 148,835	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center

0039115

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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	Dietary	Direct Allocation		\$	\$		\$	1
2	3	Housekeeping	Direct Allocation					33,050	2
3	4	Laundry	Direct Allocation					5,094	3
4	6	Repairs & Maintenance	Direct Allocation					3,183	4
5	10	Nursing	Direct Allocation					56,804	5
6	11	Activities	Direct Allocation						6
7	12	Social Service	Direct Allocation						7
8	20	Dues, Fees And Subscriptions	Direct Allocation						8
9	21	Office And Clerical	Direct Allocation						9
10	22	Employee Benefits	Direct Allocation						10
11	24	Seminars & Education	Direct Allocation						11
12	39	Ancillary	Direct Allocation					20,096	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				\$	\$		\$	118,226

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center

0039115

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization CCS Employee Benefits Group, Inc.
 Street Address 2201 Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847)905-4000
 Fax Number (847)905-4040

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.

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		\$	\$		\$ 111,523	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				\$	\$		\$ 111,523	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center

0039115

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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	821,185	26	\$ 80,807	\$ 25,405	\$ 2,500	1
2	19	Professional Fees	Direct Billing	821,185	26	4,427	25,405	137	2
3	21	Office and Clerical	Direct Billing	821,185	26	6,852	25,405	212	3
4	25	Auto Expense / Travel	Direct Billing	821,185	26	356	25,405	11	4
5	26	Insurance	Direct Billing	821,185	26	4,573	25,405	141	5
6	30	Depreciation	Direct Billing	821,185	26	218,810	25,405	6,506	6
7	32	Interest	Direct Billing	821,185	26	35,420	25,405	1,096	7
8	30	Depreciation - Matrix	Patient Days	1,376,056	30	300,546	41,201	8,999	8
9	32	Interest - Matrix	Patient Days	1,376,056	30	54,323	41,201	1,627	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					\$ 706,114	\$	\$ 21,229	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center

0039115

Report Period Beginning:

01/01/09

Ending: 12/31/09

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 TriCare Rehab
 Street Address 150 Fencil Lane
 City / State / Zip Code Hillside, IL 60162
 Phone Number (773) 449-9400
 Fax Number (773) 449-9700

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	39	THERAPY	DIRECT ALLOCATION		\$	\$		\$ 169,969	1
2	10A	REHAB	DIRECT ALLOCATION					29	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				\$	\$		\$ 169,998	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center

0039115

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Care Centers Health Systems, Inc.
 Street Address 200 Howard
 City / State / Zip Code Des Plaines, Illinois 60018
 Phone Number (224) 612-5662
 Fax Number (224) 612-5862

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	01	Dietary	Gross Billable Income	3,421,940	26	72,652	45,711	971	1	
2	03	Housekeeping	Gross Billable Income	3,421,940	26		45,711		2	
3	05	Heat and Other Utilities	Gross Billable Income	3,421,940	26	5,507	45,711	74	3	
4	06	Maintenance	Gross Billable Income	3,421,940	26	4,211	45,711	56	4	
5	19	Professional Fees	Gross Billable Income	3,421,940	26	5,880	45,711	79	5	
6	20	Dues, Fees, Subscriptions	Gross Billable Income	3,421,940	26	2,401	45,711	32	6	
7	21	Clerical and General Office	Gross Billable Income	3,421,940	26	29,869	45,711	399	7	
8	25	Other Admin. Staff Transport.	Gross Billable Income	3,421,940	26	4,509	45,711	60	8	
9	26	Insurance	Gross Billable Income	3,421,940	26	11,210	45,711	150	9	
10	30	Depreciation	Gross Billable Income	3,421,940	26	11,528	45,711	154	10	
11	32	Interest	Gross Billable Income	3,421,940	26		45,711		11	
12	33	Real Estate Taxes	Gross Billable Income	3,421,940	26		45,711		12	
13	34	Rent - Building	Gross Billable Income	3,421,940	26	51,522	45,711	688	13	
14	35	Rent - Equipment	Gross Billable Income	3,421,940	26	547	45,711	7	14	
15	01	Dietary	Direct Billable Income	206,522	26	82,445	4,116	1,643	15	
16	02	Food	Direct Billable Income	2,784	26	1,111			16	
17	03	Housekeeping	Direct Billable Income		26				17	
18	10	Nursing	Direct Billable Income	5,466	26	2,182	351	140	18	
19	22	Employee Benefits	Direct Billable Income	411	26	164			19	
20	25	Other Admin. Staff Transport.	Direct Billable Income		26				20	
21	39	Ancillary	Direct Billable Income	3,206,757	26	1,280,152	47	19	21	
22	17	Administrative	Gross Billable Income	3,421,940	26	157,769	157,769	45,711	2,108	22
23	21	Clerical and General Office	Gross Billable Income	3,421,940	26	161,081	161,081	45,711	2,152	23
24	27	Employee Benefits	Gross Billable Income	3,421,940	26	68,860	45,711	920	24	
25	TOTALS					\$ 1,953,599	\$ 318,850	\$ 9,652	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center

0039115

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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.

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:

01/01/09

Ending:

12/31/09

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2	3	4	5	6	7	8	9	10											
											Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
												YES	NO				Original	Balance			
	A. Directly Facility Related																				
	Long-Term																				
1	CIB		X	Mortgage			\$	\$ 1,521,341			\$ 99,453	1									
2												2									
3												3									
4												4									
5	See Supplemental Schedule											5									
	Working Capital																				
6	DAIWA		X	Line of Credit							2,387	6									
7	Xerox		X	Copiers				4,962			641	7									
8	See Supplemental Schedule							1,103,048			152,433	8									
9	TOTAL Facility Related						\$	\$ 2,629,351			\$ 254,914	9									
	B. Non-Facility Related*																				
10	Interest Income		X								(52,319)	10									
11	Interest Income- Bldg Co.		X								(6,500)	11									
12	Allocated From EC Consulting		X								50,855	12									
13	See Supplemental Schedule										9,256	13									
14	TOTAL Non-Facility Related						\$	\$			\$ 1,292	14									
15	TOTALS (line 9+line14)						\$	\$ 2,629,351			\$ 256,206	15									

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Wheaton Care Center

0039115

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1										1										
2										2										
3										3										
4										4										
5										5										
6										6										
7	TOTAL Long-Term									7										
Working Capital																				
8	Manchester Manor		X	Loan			\$	\$ 1,103,048		\$ 149,710	8									
9	Allocated From Vent Lease		X							2,723	9									
10											10									
11											11									
12											12									
13											13									
14	TOTAL Working Capital							1,103,048		152,433	14									
B. Non-Facility Related*																				
15	Allocated From EC Clinical		X				\$	\$		\$ 9,256	15									
16											16									
17											17									
18											18									
19											19									
20	TOTAL Non-Facility Related									9,256	20									

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 3,000 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>	<u>1</u>
2	<u>Allocation From EC Consulting 2201 Main/EC Clinical 2201 Main</u>			<u>10,988</u>	<u>2</u>
3	TOTALS			\$ 839,169	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center

0039115

Report Period Beginning:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Various		1993	41,331		20	2,067	2,067	33,795	9
10	Various		1994	104,965		20	5,250	5,250	82,285	10
11	Various		1995	16,968		20	849	849	12,531	11
12	Various		1996	158,287		20	7,915	7,915	107,013	12
13	Various		1997	103,690		20	5,187	5,187	65,262	13
14	Various		1998	56,873		20	2,846	2,846	32,347	14
15	Various		1999	21,286		20	1,066	1,066	11,216	15
16	Various		2000	57,068		20	2,292	2,292	29,116	16
17	Various		2001	48,282		20	2,534	2,534	22,398	17
18	Various		2002	15,743		20	1,456	1,456	11,836	18
19	Various		2003	18,300		20	1,567	1,567	12,366	19
20	Various		2004	134,064		20	12,918	12,918	82,147	20
21	Various		2005	38,153		20	3,284	3,284	15,784	21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center

0039115

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	Related Building Company (Pages 12F & 12G)	1,548,078	41,818		39,694	(2,124)	180,255	67
68	Related Party Allocations (Pages 12H & 12I)	43,479	2,971		2,971		18,088	68
69	Financial Statement Depreciation		60,503			(60,503)		69
70	TOTAL (lines 4 thru 69)	\$ 2,406,567	\$ 105,292		\$ 91,896	\$ (13,396)	\$ 716,439	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:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,406,567	\$ 105,292		\$ 91,896	\$ (13,396)	\$ 716,439	1
2	Home Office Payroll	2006	1,781		20	178	178	549	2
3	Hi Grade-Sappanos Paint	2006	1,399		20	140	140	560	3
4	Hi Grade-Sappanos Paint	2006	1,255		20	126	126	502	4
5	Home Office Payroll Painting	2006	21,066		20	2,107	2,107	8,251	5
6	Sappano'S-Hi Grade Painting Supplies	2006	4,176		20	418	418	1,636	6
7	Home Office Payroll	2006	3,518		20	352	352	1,349	7
8	Home Office Payroll Painting	2006	2,739		20	274	274	1,027	8
9	Home Office Payroll Painting	2006	1,136		20	114	114	417	9
10	U.S. Paving	2006	8,900		20	890	890	3,189	10
11	Home Office Payroll Painting	2006	477		20	48	48	171	11
12	Greenview Const	2006	12,428		20	1,243	1,243	4,350	12
13	Repair 3 Duct Systems	2006	3,500		20	350	350	1,167	13
14	Replace 8 Interior Doors	2006	2,840		20	284	284	947	14
15	Gutter Replacement	2006	3,023		20	302	302	957	15
16	Painting	2006	2,695		20	270	270	853	16
17	Repair 3 Duct Systems	2006	3,500		20	350	350	1,079	17
18	Heavy Duty Aluminum Rails	2006	2,770		20	277	277	854	18
19	Gutter Renovation	2006	4,800		20	240	240	740	19
20	Front Balcony Renovation	2006	13,580		20	679	679	2,094	20
21	Major Plumbing Renovation	2007	8,924		20	892	892	2,677	21
22	Plumbing Renovation	2007	2,590		20	259	259	712	22
23	Mini Split Heating Units	2007	23,500		20	2,350	2,350	6,071	23
24	New Camera System W Bracket	2007	15,566		20	2,224	2,224	5,745	24
25	Painting Front Of Building	2007	12,600		20			12,600	25
26	Install New Doors	2007	6,500		20	650	650	1,408	26
27	Supply & Install New Flood Lighting	2007	6,500		20	650	650	1,408	27
28	Remodel 2 Bathrooms	2008	11,500		20	1,150	1,150	2,013	28
29	Install Power Line	2008	6,625		20	663	663	1,159	29
30	Improve Heating System	2008	2,700		20	270	270	338	30
31	Sprinkler System Repair	2008	2,535		20	254	254	296	31
32	Repair Broken Water Pipe	2008	5,870		20	587	587	685	32
33	Sealcoating	2008	2,550		20	128	128	213	33
34	TOTAL (lines 1 thru 33)		\$ 2,610,110	\$ 105,292		\$ 110,615	\$ 5,323	\$ 782,456	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	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		\$ 2,610,110	\$ 105,292		\$ 110,615	\$ 5,323	\$ 782,456	1
2	2009	6,303		20	2,626	2,626	2,626	2
3	2009	5,577		20	232	232	232	3
4	2009	2,721		20	23	23	23	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)	\$ 2,624,711	\$ 105,292		\$ 113,496	\$ 8,204	\$ 785,337	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	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		\$ 2,624,711	\$ 105,292		\$ 113,496	\$ 8,204	\$ 785,337
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (lines 1 thru 33)	\$ 2,624,711	\$ 105,292		\$ 113,496	\$ 8,204	\$ 785,337

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:

01/01/09

Ending:

12/31/09

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		\$ 2,624,711	\$ 105,292		\$ 113,496	\$ 8,204	\$ 785,337
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (lines 1 thru 33)	\$ 2,624,711	\$ 105,292		\$ 113,496	\$ 8,204	\$ 785,337

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3	123 Beds	1972	1,548,078	41,818	39	39,694	(2,124)	180,255	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	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		\$	\$		\$	\$	\$	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 (12F & 12G lines 1 thru 33)	\$ 1,548,078	\$ 41,818		\$ 39,694	\$ (2,124)	\$ 180,255	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated From Extended Care Consulting 2201 Main	2002	13,640	350	39	350		2,550	3
4	Allocated From Extended Care Clinical 2201 Main	2002	1,503	39	39	39		281	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated From Extended Care Consulting	2007	138	2	20	2		16	9
10	Allocated From Extended Care Consulting	2009	82	4	20	4		4	10
11									11
12	Allocated From Extended Care Consulting 2201 Main	2002	11,268	1,030	20	1,030		6,188	12
13	Allocated From Extended Care Consulting 2201 Main	2003	13,279	1,214	20	1,214		7,293	13
14	Allocated From Extended Care Consulting 2201 Main	2005	660	70	20	70		238	14
15	Allocated From Extended Care Consulting 2201 Main	2009	119	6	20	6		6	15
16									16
17	Allocated From Extended Care Clinical 2201 Main	2002	1,241	113	20	113		682	17
18	Allocated From Extended Care Clinical 2201 Main	2003	1,463	134	20	134		803	18
19	Allocated From Extended Care Clinical 2201 Main	2005	73	8	20	8		26	19
20	Allocated From Extended Care Clinical 2201 Main	2009	13	1	20	1		1	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

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	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								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 (12H & 12I lines 1 thru 33)	\$ 43,479	\$ 2,971		\$ 2,971	\$	\$ 18,088	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:

01/01/09

Ending:

12/31/09

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	\$ 554,620	\$ 56,217	\$ 51,343	\$ (4,874)	10	\$ 445,732	71
72	Current Year Purchases	10,314	284	426	142	10	426	72
73	Fully Depreciated Assets	248,076				10	248,076	73
74								74
75	TOTALS	\$ 813,010	\$ 56,501	\$ 51,769	\$ (4,732)		\$ 694,234	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	\$	\$	\$	5	\$ 19,994	76
77		Alloc. From EC Consult	2009	9,628	150	150		5	9,177	77
78		Alloc. From EC Clinical	2009	2,152	430	430		5	1,268	78
79		Alloc From EC Health Systems	2009	391	78	78		5	118	79
80	TOTALS			\$ 32,165	\$ 658	\$ 658	\$		\$ 30,557	80

E. Summary of Care-Related Assets

	1	2		
	Reference	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)	\$ 4,309,055	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 162,451	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 165,923	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 3,472	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,510,128	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

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	<u>Allocated From Extended Care Consulting</u>			<u>2,893</u>			5
6	<u>Allocated From Extended Care Health Systems</u>			<u>688</u>			6
7	TOTAL			\$ <u>3,581</u>			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

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: \$ 5,523 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

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.	<u>/2009</u>	\$ _____
13.	<u>/2010</u>	\$ _____
14.	<u>/2011</u>	\$ _____

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

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

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)							
			Units of Service	Cost	Units	Cost						
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	55,809	\$		\$	55,809	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				16,133				16,133	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				75,815				75,815	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39 - 02	# of prescrpts					97,764			97,764	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify):											12
13	Other (specify): <u>See Supplemental</u>						41,091	51,501			92,592	13
14	TOTAL			\$		\$	188,848	\$	149,265	\$	338,113	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: 01/01/09Ending: 12/31/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 1,100	\$ 28,434	1
2	Cash-Patient Deposits	62,996	62,996	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	669,988	669,988	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	267,894	267,894	6
7	Other Prepaid Expenses	1,524	1,524	7
8	Accounts Receivable (owners or related parties)	10,700	1,239,169	8
9	Other(specify): <u>See Attached Schedule</u>	1,035,245	1,186,245	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,049,447	\$ 3,456,250	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		828,181	13
14	Buildings, at Historical Cost		1,496,317	14
15	Leasehold Improvements, at Historical Cost	954,212	1,005,973	15
16	Equipment, at Historical Cost	474,075	805,347	16
17	Accumulated Depreciation (book methods)	(1,152,708)	(1,637,375)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	1,234,469	1,265,125	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,510,048	\$ 3,763,568	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,559,495	\$ 7,219,818	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 751,739	\$ 751,738	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	35,359	35,359	28
29	Short-Term Notes Payable	4,962	4,962	29
30	Accrued Salaries Payable	167,070	167,070	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,473	7,473	31
32	Accrued Real Estate Taxes(Sch.IX-B)	56,239	56,239	32
33	Accrued Interest Payable		19,653	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	1,266,526	1,266,526	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,289,368	\$ 2,309,020	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable		1,103,048	39
40	Mortgage Payable		1,521,341	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 2,624,389	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,289,368	\$ 4,933,409	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,270,127	\$ 2,286,409	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,559,495	\$ 7,219,818	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,668,141	1
2	Restatements (describe):		2
3	Dividends	(2,464,806)	3
4	Rounding Adjustment	(2)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,203,333	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	66,794	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)	\$ 66,794	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,270,127	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center# 0039115Report Period Beginning: 01/01/09Ending: 12/31/09**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.****Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,865,378	1
2	Discounts and Allowances for all Levels	(567,424)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,297,954	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	457,099	6
7	Oxygen	26,556	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 483,655	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	99,849	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	16,572	19
20	Radiology and X-Ray	2,866	20
21	Other Medical Services	24,448	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 143,735	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	52,319	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 52,319	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	38	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 38	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,977,701	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,129,073	31
32	Health Care	2,251,529	32
33	General Administration	1,350,640	33
B. Capital Expense			
34	Ownership	774,038	34
C. Ancillary Expense			
35	Special Cost Centers	338,284	35
36	Provider Participation Fee	67,343	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,910,907	40
41	Income before Income Taxes (line 30 minus line 40)**	66,794	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 66,794	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:

01/01/09

Ending:

12/31/09

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	2,022	2,272	\$ 92,114	\$ 40.54	1
2	Assistant Director of Nursing	859	998	33,602	33.67	2
3	Registered Nurses	11,040	12,516	365,270	29.18	3
4	Licensed Practical Nurses	17,281	19,026	493,241	25.92	4
5	CNAs & Orderlies	49,449	54,663	659,833	12.07	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,454	5,157	87,276	16.92	8
9	Activity Director	1,989	2,331	35,218	15.11	9
10	Activity Assistants	6,138	6,678	55,125	8.25	10
11	Social Service Workers	9,144	10,357	177,564	17.14	11
12	Dietician	1,495	1,771	28,925	16.33	12
13	Food Service Supervisor	2,088	2,258	50,321	22.29	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,048	6,015	65,154	10.83	15
16	Dishwashers	11,359	12,333	97,514	7.91	16
17	Maintenance Workers	3,903	4,341	78,058	17.98	17
18	Housekeepers	15,506	18,217	175,202	9.62	18
19	Laundry	4,273	4,725	43,786	9.27	19
20	Administrator	2,018	2,140	90,125	42.11	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,044	5,462	67,782	12.41	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,820	2,378	30,987	13.03	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	1,777	1,844	17,406	9.44	33
34	TOTAL (lines 1 - 33)	156,707	175,483	\$ 2,744,503 *	\$ 15.64	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	184	\$ 9,127	01-03	35
36	Medical Director	Monthly	2,450	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	32	1,520	10-03	38
39	Pharmacist Consultant	Monthly	1,740	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48	<u>See Attached</u>		46,042		48
49	TOTAL (lines 35 - 48)	216	\$ 60,879		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	316	\$ 18,684	10-03	50
51	Licensed Practical Nurses	1,111	44,596	10-03	51
52	Certified Nurse Assistants/Aides	15	516	10-03	52
53	TOTAL (lines 50 - 52)	1,442	\$ 63,796		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center# 0039115Report Period Beginning: 01/01/09Ending: 12/31/09**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
<u>Lolita Munsayac (12/11/09-12/31/09)</u>	<u>Administrator</u>	<u>0.00%</u>	<u>\$ 3,578</u>	<u>Workers' Compensation Insurance</u>	<u>\$ 79,046</u>	<u>IDPH License Fee</u>	<u>\$ 1,990</u>	
<u>Joseph Javier (1/1/09-12/11/09)</u>	<u>Administrator</u>	<u>0.00%</u>	<u>86,547</u>	<u>Unemployment Compensation Insurance</u>	<u>17,089</u>	<u>Advertising: Employee Recruitment</u>	<u>13,763</u>	
				<u>FICA Taxes</u>	<u>204,247</u>	<u>Health Care Worker Background Check</u>	<u>1,915</u>	
				<u>Employee Health Insurance</u>	<u>69,493</u>	<u>(Indicate # of checks performed <u>90</u>)</u>		
				<u>Employee Meals</u>		<u>Patient Background Checks</u>	<u>86</u> <u>900</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Licenses, Inspections & Permits</u>	<u>1,503</u>	
				<u>Employee Physicals</u>	<u>4,954</u>	<u>Dues & Subscriptions</u>	<u>13,665</u>	
				<u>Other Employee Welfare</u>	<u>10,183</u>	<u>Advertising & Promotions</u>	<u>2,681</u>	
				<u>Holiday Expense</u>	<u>1,795</u>	<u>Allocated From Ext. Care Consulting</u>	<u>1,691</u>	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 90,125			<u>See Supplemental Schedule</u>	<u>38</u>	
(List each licensed administrator separately.)						<u>Less: Public Relations Expense</u>	<u>()</u>	
B. Administrative - Other						<u>Non-allowable advertising</u>	<u>(2,681)</u>	
						<u>Yellow page advertising</u>	<u>()</u>	
Description			Amount					
<u>Eric Rothner Management Fees</u>			<u>\$ 5,200</u>					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 5,200	TOTAL (agree to Schedule V,	\$ 386,807	TOTAL (agree to Sch. V,	\$ 35,465	
(Attach a copy of any management service agreement)				line 22, col.8)		line 20, col. 8)		
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
<u>Frost, Ruttenberg & Rothblatt</u>	<u>Accounting</u>		<u>\$ 19,600</u>				<u>Out-of-State Travel</u>	<u>\$</u>
<u>Personnel Planners</u>	<u>Unemployment Consult</u>		<u>695</u>					
<u>See Attached</u>	<u>Legal</u>		<u>6,021</u>					
<u>Paycor</u>	<u>Payroll Services</u>		<u>8,810</u>				<u>In-State Travel</u>	
<u>ADP</u>	<u>Payroll Services</u>		<u>759</u>					
<u>E-Health Data Solutions</u>	<u>Data Processing</u>		<u>2,385</u>					
<u>National Datacare Corp.</u>	<u>Data Processing</u>		<u>2,057</u>					
<u>XK Zero</u>	<u>Computer Services</u>		<u>179</u>					
<u>Prospect Resources</u>	<u>Natural Gas Procurement</u>		<u>760</u>				<u>Seminar Expense</u>	<u>8,318</u>
<u>Chad Cournaya</u>	<u>Medicare Consultant</u>		<u>50</u>				<u>Allocated From Ext. Care Consulting</u>	<u>53</u>
<u>Allegiance</u>	<u>Employee Compliance</u>		<u>56</u>				<u>Allocated From Ext. Care Clinical</u>	<u>811</u>
<u>See Supplemental Schedule</u>			<u>259,307</u>				<u>Entertainment Expense</u>	<u>()</u>
TOTAL (agree to Schedule V, line 19, column 3)			\$ 300,679	TOTAL		\$	(agree to Sch. V,	
(If total legal fees exceed \$5,000, attach copy of invoices.)							line 24, col. 8)	\$ 9,182

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center# 0039115Report Period Beginning: 01/01/09Ending: 12/31/09**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. ILCLTC \$10,978
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 17,490 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 67,343
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, 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. \$ No Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln14
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? N/A
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.