

Facility Name & ID Number Wheaton Care Center

0039115 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 _____

	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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	3,769	177	2,553	6,500	8
9	SNF/PED					9
10	ICF	33,925	1,596		35,520	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	37,694	1,773	2,553	42,020	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.60%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 09/01/1993

J. Was the facility purchased or leased after January 1, 1978?

YES Date 09/01/1993 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 81 and days of care provided 2,553

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2013 Fiscal Year: 12/31/2013

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Wheaton Care Center

0039115

Report Period Beginning:

01/01/13

Ending:

12/31/13

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	269,324	32,260	3,751	305,335		305,335	5,663	310,998		1
2	Food Purchase		267,263		267,263		267,263	(82)	267,181		2
3	Housekeeping	140,341	41,973		182,314		182,314	585	182,899		3
4	Laundry	87,448	17,425		104,873		104,873		104,873		4
5	Heat and Other Utilities			164,204	164,204		164,204	772	164,976		5
6	Maintenance	77,901		193,900	271,801		271,801	12,309	284,110		6
7	Other (specify):*							4,967	4,967		7
8	TOTAL General Services	575,014	358,921	361,855	1,295,790		1,295,790	24,214	1,320,004		8
	B. Health Care and Programs										
9	Medical Director			19,200	19,200		19,200		19,200		9
10	Nursing and Medical Records	1,776,274	71,369	9,850	1,857,493		1,857,493	47,061	1,904,554		10
10a	Therapy	151,034			151,034		151,034		151,034		10a
11	Activities	116,961	18,320		135,281		135,281		135,281		11
12	Social Services	224,442	3,200		227,642		227,642	20,625	248,267		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							10,378	10,378		15
16	TOTAL Health Care and Programs	2,268,711	92,889	29,050	2,390,650		2,390,650	78,064	2,468,714		16
	C. General Administration										
17	Administrative	72,086			72,086		72,086	84,117	156,203		17
18	Directors Fees										18
19	Professional Services			386,031	386,031	(92)	385,939	(286,253)	99,686		19
20	Dues, Fees, Subscriptions & Promotions			25,938	25,938		25,938	(4,020)	21,918		20
21	Clerical & General Office Expenses	80,149	18,471	164,698	263,318		263,318	37,642	300,960		21
22	Employee Benefits & Payroll Taxes			455,577	455,577		455,577	(10,608)	444,969		22
23	Inservice Training & Education										23
24	Travel and Seminar			555	555		555	2,329	2,884		24
25	Other Admin. Staff Transportation			9,885	9,885		9,885	973	10,858		25
26	Insurance-Prop.Liab.Malpractice			143,096	143,096		143,096	1,897	144,993		26
27	Other (specify):*							37,546	37,546		27
28	TOTAL General Administration	152,235	18,471	1,185,780	1,356,486	(92)	1,356,394	(136,376)	1,220,018		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,995,960	470,281	1,576,685	5,042,926	(92)	5,042,834	(34,098)	5,008,736		29

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

Facility Name & ID Number

Wheaton Care Center

#0039115

Report Period Beginning:

01/01/13

Ending:

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			66,100	66,100		66,100	73,471	139,571			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,219	1,219		1,219	111,836	113,055			32
33	Real Estate Taxes			69,462	69,462	92	69,554	3,024	72,578			33
34	Rent-Facility & Grounds			660,000	660,000		660,000	(660,000)				34
35	Rent-Equipment & Vehicles			13,807	13,807		13,807	920	14,727			35
36	Other (specify):*											36
37	TOTAL Ownership			810,588	810,588	92	810,680	(470,749)	339,931			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		196,283	287,111	483,394		483,394	(7,150)	476,244			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			307,182	307,182		307,182		307,182			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		196,283	594,293	790,576		790,576	(7,150)	783,426			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,995,960	666,564	2,981,566	6,644,090		6,644,090	(511,997)	6,132,093			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center

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Report Period Beginning:

01/01/13

Ending:

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VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	24,371	30		9
10	Interest and Other Investment Income	(12,470)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(112)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,649)	21		18
19	Entertainment				19
20	Contributions	(550)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(88,278)	21		24
25	Fund Raising, Advertising and Promotional	(1,433)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(974)	20		28
29	Other-Attach Schedule	(19,067)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (101,162)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(410,835)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (410,835)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (511,997)		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Wheaton Care Center

ID# 0039115

Report Period Beginning: 01/01/13

Ending: 12/31/13

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Vending Income	\$ (454)	02	1
2	Patient Clothing	(600)	10	2
3	Collection Expense	(2,598)	21	3
4	Annual Reports	(250)	20	4
5	Filing Fees	(582)	20	5
6	Building Company - Bank Charges	(10)	21	6
7	Building Company - Filing Fee	(250)	20	7
8	Building Company - State Replacement Tax	(2,780)	21	8
9	Building Company - Amortization	(1,118)	36	9
10	Non-Allowable Legal	(7,138)	19	10
11	COPE Dues	(3,288)	20	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33			33
34			34
35			35
36			36
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	(19,067)	49

Wheaton Care Center

ID# 0039115

Report Period Beginning: 01/01/13

Ending: 12/31/13

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
50		\$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32

82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	Total		0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Wheaton Care Center# 0039115

Report Period Beginning:

01/01/13

Ending:

12/31/13

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			274		7,021	(1,632)						5,663	1
2	Food Purchase	(566)		484									(82)	2
3	Housekeeping			485		100							585	3
4	Laundry													4
5	Heat and Other Utilities			640		132							772	5
6	Maintenance			4,178	8,083	48							12,309	6
7	Other (specify):*				3,900	1,067							4,967	7
8	TOTAL General Services	(566)		6,061	11,983	8,368	(1,632)						24,214	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(600)				47,661							47,061	10
10a	Therapy													10a
11	Activities													11
12	Social Services					20,625							20,625	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					10,378							10,378	15
16	TOTAL Health Care and Programs	(600)				78,664							78,064	16
	C. General Administration													
17	Administrative			3,204	17,685	63,228							84,117	17
18	Directors Fees													18
19	Professional Services	(7,138)		(185,335)		(93,780)							(286,253)	19
20	Fees, Subscriptions & Promotions	(7,327)	250	2,861		196							(4,020)	20
21	Clerical & General Office Expenses	(96,315)	2,790	13,522	109,645	8,000							37,642	21
22	Employee Benefits & Payroll Taxes				(10,608)								(10,608)	22
23	Inservice Training & Education													23
24	Travel and Seminar			367		1,962							2,329	24
25	Other Admin. Staff Transportation			973									973	25
26	Insurance-Prop.Liab.Malpractice			1,310		587							1,897	26
27	Other (specify):*				27,029	10,517							37,546	27
28	TOTAL General Administration	(110,779)	3,040	(163,098)	143,751	(9,290)							(136,376)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(111,945)	3,040	(157,037)	155,734	77,742	(1,632)						(34,098)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Wheaton Care Center# 0039115

Report Period Beginning:

01/01/13

Ending:

12/31/13

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	24,371	41,818	5,888		1,394							73,471	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(12,470)	92,753	1,612		29,941							111,836	32
33	Real Estate Taxes			2,508		516							3,024	33
34	Rent-Facility & Grounds		(660,000)										(660,000)	34
35	Rent-Equipment & Vehicles			920									920	35
36	Other (specify):*	(1,118)	1,118											36
37	TOTAL Ownership	10,783	(524,311)	10,928		31,851							(470,749)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(351)	(1,327)	(5,347)	(125)			(7,150)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers						(351)	(1,327)	(5,347)	(125)			(7,150)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(101,162)	(521,271)	(146,109)	155,734	109,593	(1,983)	(1,327)	(5,347)	(125)			(511,997)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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 Rent	\$ 660,000	Wheaton HC Properties, LLC	100.00%	\$	\$ (660,000)	1
2	V	33 Rent - Property Tax	69,463	Wheaton HC Properties, LLC	100.00%		(69,463)	2
3	V	21 Bank Charges		Wheaton HC Properties, LLC	100.00%	10	10	3
4	V	20 Filing Fee		Wheaton HC Properties, LLC	100.00%	250	250	4
5	V	21 State Replacement Tax		Wheaton HC Properties, LLC	100.00%	2,780	2,780	5
6	V	30 Depreciation		Wheaton HC Properties, LLC	100.00%	41,818	41,818	6
7	V	36 Amortization		Wheaton HC Properties, LLC	100.00%	1,118	1,118	7
8	V	33 Real Estate Tax Expense		Wheaton HC Properties, LLC	100.00%	69,463	69,463	8
9	V	32 Interest		Wheaton HC Properties, LLC	100.00%	92,753	92,753	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 729,463			\$ 208,192	\$ * (521,271)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	01 Dietary	\$	Extended Care Consulting, LLC	100.00%	\$ 274	\$	274	15
16	V	02 Food		Extended Care Consulting, LLC	100.00%	484		484	16
17	V	03 Housekeeping		Extended Care Consulting, LLC	100.00%	485		485	17
18	V	05 Utilities		Extended Care Consulting, LLC	100.00%	640		640	18
19	V	06 Maintenance		Extended Care Consulting, LLC	100.00%	4,178		4,178	19
20	V	17 Administrative		Extended Care Consulting, LLC	100.00%	3,204		3,204	20
21	V	19 Professional Fees	193,464	Extended Care Consulting, LLC	100.00%	8,129		(185,335)	21
22	V	20 Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	2,861		2,861	22
23	V	21 Office and Clerical		Extended Care Consulting, LLC	100.00%	13,522		13,522	23
24	V	24 Seminar and Travel		Extended Care Consulting, LLC	100.00%	367		367	24
25	V	25 Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	973		973	25
26	V	26 Insurance		Extended Care Consulting, LLC	100.00%	1,310		1,310	26
27	V	30 Depreciation		Extended Care Consulting, LLC	100.00%	5,888		5,888	27
28	V	32 Interest		Extended Care Consulting, LLC	100.00%	1,612		1,612	28
29	V	33 Real Estate Taxes		Extended Care Consulting, LLC	100.00%	2,508		2,508	29
30	V	35 Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	920		920	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		\$ 193,464			\$ 47,355	\$ *	(146,109)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	06 Maintenance (Pooled)		Extended Care Consulting, LLC	100.00%	7,966	\$	7,966	15
16	V	06 Maintenance (Direct)	20,097	Extended Care Consulting, LLC	100.00%	20,214		117	16
17	V	07 Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	817		817	17
18	V	07 Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	3,083		3,083	18
19	V								19
20	V								20
21	V	17 Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	17,685		17,685	21
22	V	21 Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	111,333		111,333	22
23	V	21 Office and Clerical (Direct)	16,835	Extended Care Consulting, LLC	100.00%	15,147		(1,688)	23
24	V	27 Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	24,098		24,098	24
25	V	27 Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	2,931		2,931	25
26	V	22 Employee Benefits	10,608	Extended Care Consulting, LLC	100.00%			(10,608)	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		\$ 47,540			\$ 203,274	\$ *	155,734	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	03 Housekeeping	\$	Extended Care Clinical, LLC	100.00%	\$ 100	\$	100	15
16	V	05 Utilities		Extended Care Clinical, LLC	100.00%	132		132	16
17	V	06 Maintenance		Extended Care Clinical, LLC	100.00%	48		48	17
18	V	19 Professional Fees	95,292	Extended Care Clinical, LLC	100.00%	1,512		(93,780)	18
19	V	20 Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	196		196	19
20	V	21 Office & Clerical		Extended Care Clinical, LLC	100.00%	2,030		2,030	20
21	V	24 Travel and Seminar		Extended Care Clinical, LLC	100.00%	1,962		1,962	21
22	V	26 Insurance		Extended Care Clinical, LLC	100.00%	587		587	22
23	V	30 Depreciation		Extended Care Clinical, LLC	100.00%	1,394		1,394	23
24	V	32 Interest		Extended Care Clinical, LLC	100.00%	29,941		29,941	24
25	V	33 Real Estate Taxes		Extended Care Clinical, LLC	100.00%	516		516	25
26	V	01 Dietary Salary		Extended Care Clinical, LLC	100.00%	7,021		7,021	26
27	V	07 Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	1,067		1,067	27
28	V	10 Nursing Salary		Extended Care Clinical, LLC	100.00%	47,661		47,661	28
29	V	12 Social Service Salary		Extended Care Clinical, LLC	100.00%	20,625		20,625	29
30	V	15 Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	10,378		10,378	30
31	V	17 Administration Salary		Extended Care Clinical, LLC	100.00%	63,228		63,228	31
32	V	21 Office Salary		Extended Care Clinical, LLC	100.00%	5,970		5,970	32
33	V	27 Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	10,517		10,517	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 95,292			\$ 204,885	\$ *	109,593	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 Dietary Supplies, Supplements	\$ 5,828	Care Centers Health Systems, Inc.	100.00%	\$ 4,196	\$ (1,632)
16	V	10 Nursing Supplies		Care Centers Health Systems, Inc.	100.00%		
17	V	39 Ancillary Expense	1,254	Care Centers Health Systems, Inc.	100.00%	903	(351)
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
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		\$ 7,082			\$ 5,099	\$ * (1,983)

* 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 Ventilator Equipment	6,400	Vent Lease LLC	100.00%	5,073	\$ (1,327)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
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		\$ 6,400			\$ 5,073	\$ * (1,327)

* 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	\$ 276,336	Tri Care Rehab	100.00%	\$ 270,989	\$ (5,347)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
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		\$ 276,336			\$ 270,989	\$ * (5,347)

* 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 Ancillary Expense	14,042	Reliable Medical of the Midwest, LLC	100.00%	13,917	\$	(125)	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		\$ 14,042			\$ 13,917	\$ *	(125)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22 Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 102,955	\$ 102,955	15
16	V							16
17	V							17
18	V							18
19	V	22 Employee Health Insurance	102,955	CCS Employee Benefits Group	100.00%		(102,955)	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		\$ 102,955			\$ 102,955	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	ADAM VALES ACCUMULATION TRUST	4.0650%	AVENUE CARE NURSING AND REHABILITATION CENTER,LLC	CHICAGO	WHEATON HEALTHCARE PROPERTIES, LLC		BUILDING CO.	1
2	DANIEL ROTHNER ACCUMULATION TRUST	4.0650%	BEECHER MANOR NURSING AND REHABILITATION CENTER, LLC BEECHER		EXTENDED CARE CONSULTING	EVANSTON	MANAGEMENT/BOOKKEEP	2
3	ERIC ROTHNER	38.2114%	BOULEVARD CARE NURSING AND REHABILITATION CENTER,LLC	CHICAGO	EXTENDED CARE CLINICAL	EVANSTON	ADMINISTRATIVE	3
4	ILANA KLEIN REICH	0.8130%	BRIAR PLACE LTD	INDIAN HEAD PARK	CARE CENTER HEALTH SYSTE	DES PLAINES	DIETARY & FOOD SUPPLEN	4
5	JUDITH FREEMAN	1.6260%	CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	5
6	KATHRYN VALES ACCUMULATION TRUST	4.0650%	COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	ROTHNER VENTS LLC	EVANSTON	VENTILATOR RENTAL	6
7	KIMBERLY RICHMOND ACCUMULATION TRUST	4.0650%	DYER NURSING & REHAB	DYER, IN	TRICARE REHAB	HILLSIDE	THERAPY	7
8	MELISSA ROTHNER ACCUMULATION TRUST	4.0650%	GRASMERE PLACE, LLC	CHICAGO	HARBOR LIGHT	GLEN ELLYN	HOSPICE	8
9	MICHELLE KLEIN	0.8130%	LAKE COUNTY NURSING & REHAB	EAST CHICAGO, IN	RELIABLE MEDICAL SUPPLY	DES PLAINES	MEDICAL SUPPLY	9
10	NATHAN & SHIRLEY ROTHNER FAMILY TRUST	26.8292%	LAKWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD	CARE CENTER BUILDING LLC	EVANSTON	BLDG COMPANY	10
11	NEAL ROTHNER	1.6260%	LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT				11
12	NWOS, INC.	1.6262%	MCKINLEY HEALTH CARE CENTER	CANTON, OH				12
13	RACHEL ROTHNER ACCUMULATION TRUST	4.0650%	OAK PARK HEALTHCARE CENTER, L.L.C.	OAK PARK				13
14	WILLIAM ROTHNER ACCUMULATION TRUST	4.0650%	PARC AT JOLIET LLC	JOLIET				14
15			PARK HOUSE NURSING AND REHABILITATION CENTER,LLC	CHICAGO				15
16			PRAIRIE MANOR NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO HEIGHTS				16
17			PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				17
18			RAINBOW BEACH QOC, L.L.C.	CHICAGO				18
19			SEBOS NURSING & REHAB	HOLBART, IN				19
20			SHEFFIELD MANOR	DYER, IN				20
21			SHERIDAN SHORES CARE & REHABILITATION CENTER, INC.	CHICAGO				21
22			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				22
23			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				23
24			TRI-STATE NURSING & REHABILITATION CENTER, INC.	LANSING				24
25			WHEATON CARE CENTER	WHEATON				25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Wheaton Care Center

0039115

Report Period Beginning:

01/01/13

Ending:

12/31/13

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/13 Ending: 12/31/13

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	Adam Vales	Relative	Clerical	N/A	See Attached	0.96	2.40%	Alloc Sal.	\$ 1,676	22-07	1
2	Mark Steinberg	Relative	Administrative	N/A	See Attached	2.77	4.92%	Alloc Fee/Sal	9,685	17-07	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	\$ 11,361		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: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center

0039115

Report Period Beginning:

01/01/13

Ending: 12/31/13

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 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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,101,784	30	\$ 7,195	\$ 42,020	\$ 274	1
2	02	Food	Patient Days	1,101,784	30	12,684	42,020	484	2
3	03	Housekeeping	Patient Days	1,101,784	30	12,707	42,020	485	3
4	05	Utilities	Patient Days	1,101,784	30	16,778	42,020	640	4
5	06	Maintenance	Patient Days	1,101,784	30	109,559	42,020	4,178	5
6	17	Administrative	Patient Days	1,101,784	30	84,000	42,020	3,204	6
7	19	Professional Fees	Patient Days	1,101,784	30	213,139	42,020	8,129	7
8	20	Dues and Subscriptions	Patient Days	1,101,784	30	75,016	42,020	2,861	8
9	21	Office and Clerical	Patient Days	1,101,784	30	354,548	42,020	13,522	9
10	24	Seminar and Travel	Patient Days	1,101,784	30	9,615	42,020	367	10
11	25	Other Staff Admin. Trans.	Patient Days	1,101,784	30	25,510	42,020	973	11
12	26	Insurance	Patient Days	1,101,784	30	34,345	42,020	1,310	12
13	30	Depreciation	Patient Days	1,101,784	30	154,393	42,020	5,888	13
14	32	Interest	Patient Days	1,101,784	30	42,261	42,020	1,612	14
15	33	Real Estate Taxes	Patient Days	1,101,784	30	65,749	42,020	2,508	15
16	35	Rent - Equipment & Auto	Patient Days	1,101,784	30	24,117	42,020	920	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,241,615	\$	\$ 47,355	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center

0039115 Report Period Beginning: 01/01/13 Ending: 12/31/13

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6		
1	06	Maintenance (Pooled)	Patient Days	1,101,784	30	208,870	208,870	42,020	7,966	1
2	06	Maintenance (Direct)	Direct		30	331,520	331,520		20,214	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,101,784	30	21,409		42,020	817	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		30	37,937			3,083	4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,101,784	30	463,710	463,710	42,020	17,685	7
8	21	Office and Clerical (Pooled)	Patient Days	1,101,784	30	2,919,199	2,919,199	42,020	111,333	8
9	21	Office and Clerical (Direct)	Direct		30	328,534	328,534		15,147	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,101,784	30	631,850		42,020	24,098	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		30	55,508			2,931	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 4,998,538	\$ 4,251,833		\$ 203,274	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center

0039115

Report Period Beginning:

01/01/13

Ending: 12/31/13

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

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	03	Housekeeping	Patient Days	610,520	17	\$ 1,450	\$ 42,020	\$ 100	1
2	05	Utilities	Patient Days	610,520	17	1,914	42,020	132	2
3	06	Maintenance	Patient Days	610,520	17	698	42,020	48	3
4	19	Professional Fees	Patient Days	610,520	17	21,974	42,020	1,512	4
5	20	Dues and Subscriptions	Patient Days	610,520	17	2,847	42,020	196	5
6	21	Office & Clerical	Patient Days	610,520	17	29,496	42,020	2,030	6
7	24	Travel and Seminar	Patient Days	610,520	17	28,507	42,020	1,962	7
8	26	Insurance	Patient Days	610,520	17	8,533	42,020	587	8
9	30	Depreciation	Patient Days	610,520	17	20,257	42,020	1,394	9
10	32	Interest	Patient Days	610,520	17	435,028	42,020	29,941	10
11	33	Real Estate Taxes	Patient Days	610,520	17	7,502	42,020	516	11
12	01	Dietary Salary	Patient Days	610,520	17	102,014	102,014	7,021	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	610,520	17	15,504	42,020	1,067	13
14	10	Nursing Salary	Patient Days	610,520	17	692,482	692,482	47,661	14
15	12	Social Service Salary	Patient Days	610,520	17	299,672	299,672	20,625	15
16	15	Emp. Ben. - Healthcare	Patient Days	610,520	17	150,791	42,020	10,378	16
17	17	Administration Salary	Patient Days	610,520	17	918,652	918,652	63,228	17
18	21	Office Salary	Patient Days	610,520	17	86,739	86,739	5,970	18
19	27	Emp. Ben. - Gen. Admin.	Patient Days	610,520	17	152,803	42,020	10,517	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,976,862	\$ 2,099,559	\$ 204,885	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center

0039115

Report Period Beginning:

01/01/13

Ending: 12/31/13

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	1	Dietary Supplies, Supplements	Direct Allocation			\$		\$ 4,196	1
2	10	Nursing Supplies	Direct Allocation						2
3	39	Ancillary Expense	Direct Allocation					903	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				\$	\$		\$ 5,099	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center

0039115

Report Period Beginning:

01/01/13

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	Ventilator Equipment	Direct Allocation					5,073	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				\$	\$		\$ 5,073	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center

0039115

Report Period Beginning:

01/01/13

Ending: 12/31/13

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 TriCare Rehab
 Street Address 240 Fencil Lane
 City / State / Zip Code Hillside, IL 60162
 Phone Number (773) 449-9400
 Fax Number (773) 449-9700

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	39	Therapy	Direct Allocation		\$	\$		\$ 270,989	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				\$	\$		\$ 270,989	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center

0039115

Report Period Beginning:

01/01/13

Ending: 12/31/13

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 Reliable Medical of the Midwest, LLC
 Street Address 200 Howard Avenue
 City / State / Zip Code Des Plaines, Illinois 60018-5909
 Phone Number (847) 566-0800
 Fax Number ()

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	39	Ancillary Expense	Direct Allocation					13,917	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				\$	\$		\$ 13,917	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center

0039115 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	22	Employee Health Insurance	Direct Allocation		\$	\$		\$ 102,955	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				\$	\$		\$ 102,955	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center

0039115 Report Period Beginning: 01/01/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Wheaton Care Center

0039115

Report Period Beginning:

01/01/13

Ending:

12/31/13

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	Name of Lender	2		3	4	5	6		8	9	10						
		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			\$	\$ 500,933			\$ 37,442	1					
2												2					
3												3					
4												4					
5												5					
Working Capital																	
6	Xerox		X	Copiers							1,219	6					
7	Manchester Manor		X	Loan				315,430			55,311	7					
8	See Supplemental Schedule										31,553	8					
9	TOTAL Facility Related						\$	\$ 816,363			\$ 125,525	9					
B. Non-Facility Related*																	
10	Interest Income		X								(12,470)	10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$ (12,470)	14					
15	TOTALS (line 9+line14)						\$	\$ 816,363			\$ 113,055	15					

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

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

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

Facility Name & ID Number Wheaton Care Center

0039115

Report Period Beginning:

01/01/13

Ending:

12/31/13

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	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					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							\$	\$			\$					
2																
3																
4																
5																
6																
7	TOTAL Long-Term															
	Working Capital															
8	Alloc from Extended Care Consulting	X					\$	\$			\$ 1,612					
9	Alloc from Extended Care Clinical	X									29,941					
10																
11																
12																
13																
14	TOTAL Working Capital										31,553					
	B. Non-Facility Related*															
15							\$	\$			\$					
16																
17																
18																
19																
20	TOTAL Non-Facility Related															

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																	
1. Real Estate Tax accrual used on 2012 report.		\$	60,476	1															
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	66,409	2															
3. Under or (over) accrual (line 2 minus line 1).		\$	5,933	3															
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	66,554	4															
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	92	5															
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6															
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	72,579	7															
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2008	<u>53,561</u>	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2012 \$</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td style="text-align: center;">16</td> </tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2012 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
FOR BHF USE ONLY																			
13	FROM R. E. TAX STATEMENT FOR 2012 \$	13																	
14	PLUS APPEAL COST FROM LINE 5 \$	14																	
15	LESS REFUND FROM LINE 6 \$	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																	
	2009	<u>54,933</u>	9																
	2010	<u>56,589</u>	10																
	2011	<u>57,597</u>	11																
	2012	<u>63,385</u>	12																
2013 Accrual = \$63,385 x 1.05 = \$66,554																			
Allocated from Extended Care Consulting LLC \$2,508																			
Allocated from Extended Care Clinical LLC \$516																			

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Wheaton Care Center COUNTY Dupage
 FACILITY IDPH LICENSE NUMBER 0039115
 CONTACT PERSON REGARDING THIS REPORT Steve Lavenda
 TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2012 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2012.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>05-17-114-010</u>	<u>Long Term Care Property</u>	\$ <u>63,384.76</u>	\$ <u>63,384.76</u>
2. <u>See Attached</u>	<u>Alloc from Extended Care Consult</u>	\$ <u>133,178.74</u>	\$ <u>2,384.05</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>196,563.50</u></u>	\$ <u><u>65,768.81</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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

4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

Facility Name & ID Number Wheaton Care Center

0039115 Report Period Beginning:

01/01/13 Ending:

12/31/13

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>2005</u>	<u>\$ 828,181</u>	<u>1</u>
2	<u>Allocated from 2201 Main/Care Center Building/EC Clinical</u>			<u>14,679</u>	<u>2</u>
3	TOTALS			\$ 842,860	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	123		1972	\$ 1,548,078	\$ 41,818	39	\$ 39,694	\$ (2,124)	\$ 339,031	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Various		1993	41,331		20	1,419	1,419	41,331	9
10	Various		1994	104,965		20	5,240	5,240	103,271	10
11	Various		1995	16,968		20	848	848	15,924	11
12	Various		1996	158,287		20	7,914	7,914	138,669	12
13	Various		1997	103,690		20	5,185	5,185	86,000	13
14	Various		1998	56,873		20	2,844	2,844	43,721	14
15	Various		1999	21,286		20	1,064	1,064	15,473	15
16	Various		2000	57,068		20	2,292	2,292	38,284	16
17	Various		2001	48,282		20	2,297	2,297	31,953	17
18	Various		2002	15,745		20	257	257	15,073	18
19	Various		2003	18,300		20	839	839	16,782	19
20	Various		2004	134,063		20	10,368	10,368	123,615	20
21	Various		2005	38,153		20	3,282	3,282	28,914	21
22	Various		2006	95,583		20	8,639	8,639	65,248	22
23	Various		2007	76,180		20	7,025	7,025	58,722	23
24	Various		2008	31,780		20	3,051	3,051	16,904	24
25	Various		2009	9,024		20	272	272	7,414	25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68			59,585	4,048		4,048		40,331
69				66,100			(66,100)	
70			\$ 2,635,241	\$ 111,966		\$ 106,578	\$ (5,388)	\$ 1,226,659

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:

01/01/13

Ending:

12/31/13

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,635,241	\$ 111,966		\$ 106,578	\$ (5,388)	\$ 1,226,659	1
2	Plater- Paint & Fix Various Walls	2010	4,050		20	405	405	1,249	2
3	Replace 16 Burners At Make Up Air Unit	2010	2,592		20	259	259	799	3
4	3 Ductless Mini Splits Cooling	2011	25,500		20	2,550	2,550	7,013	4
5	New Soffit-Dry Wall, Cover Holes	2011	4,550		20	455	455	1,251	5
6	Roof Repairs	2011	3,000		20	300	300	775	6
7	Fire Alarm Repair	2011	6,624		20	662	662	1,656	7
8	Attach Ac Units To Em Panel	2011	4,600		20	460	460	1,150	8
9	New 5 Ton Ac Unit	2011	6,175		20	618	618	1,441	9
10	Dry Wall, Cover Pipes	2011	3,400		20	87	87	200	10
11	Install Of New Double Doors	2011	2,570		20	66	66	146	11
12	Roof Work	2011	3,585		20	92	92	203	12
13	Generator Work	2011	2,896		20	74	74	164	13
14	Painting	2011	2,512		20	126	126	304	14
15	Painting	2011	2,940		20	147	147	306	15
16	Duct Installation	2012	5,600		20	560	560	1,120	16
17	Supply Duct Distribution System	2012	33,000		20	3,300	3,300	6,600	17
18	Exhaust Fan & Duct Work	2012	7,300		20	730	730	1,217	18
19	Elevator Renovation - Install 6 Inch Cylinder For 2 Stop Hydraulic	2012	35,183		20	3,518	3,518	5,864	19
20	Elevator Renovation - Replace Passenger Elevator Hydraulic Cylir	2012	28,575		20	2,858	2,858	5,477	20
21	Installation Of A 24 Channel Cable System	2012	14,328		20	1,433	1,433	1,910	21
22	Running Conduit	2012	5,848		20	585	585	780	22
23	Complete Remodel Of Basement Bathroom-New Walls, Tile, Toilet	2012	3,471		20	347	347	405	23
24	New Grease Trap	2013	7,800		20	780	780	780	24
25	Flooring Installation	2013	3,890		20	389	389	389	25
26	Water Heater	2013	2,557		20	256	256	256	26
27	New Compressor	2013	13,954		20	465	465	465	27
28	Re-Do Parking Lot	2013	53,518		20	892	892	892	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,925,260	\$ 111,966		\$ 128,991	\$ 17,025	\$ 1,269,469	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:

01/01/13

Ending:

12/31/13

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		\$ 2,925,260	\$ 111,966		\$ 128,991	\$ 17,025	\$ 1,269,469		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 2,925,260	\$ 111,966		\$ 128,991	\$ 17,025	\$ 1,269,469		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:

01/01/13

Ending:

12/31/13

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		\$ 2,925,260	\$ 111,966		\$ 128,991	\$ 17,025	\$ 1,269,469	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 2,925,260	\$ 111,966		\$ 128,991	\$ 17,025	\$ 1,269,469	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:

01/01/13

Ending:

12/31/13

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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 12D, Carried Forward		\$ 2,925,260	\$ 111,966		\$ 128,991	\$ 17,025	\$ 1,269,469	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,925,260	\$ 111,966		\$ 128,991	\$ 17,025	\$ 1,269,469	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:

01/01/13

Ending:

12/31/13

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	Building Company Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									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:

01/01/13

Ending:

12/31/13

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		\$	\$		\$	\$	\$	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:

01/01/13

Ending:

12/31/13

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from 2201 Main/Care Center Building LLC	2002	16,774	430	20	430		4,857	3
4	Allocated from Extended Care Clinical LLC	2002	3,454	89	20	89		1,000	4
5									5
6									6
7									7
8	Leasehold Information								8
9	Allocated from Extended Care Consulting LLC	2007	175	9	20	9		61	9
10	Allocated from Extended Care Consulting LLC	2009	105	5	20	5		26	10
11	Allocated from Extended Care Consulting LLC	2010	1,029	51	20	51		206	11
12	Allocated from Extended Care Consulting LLC	2011	370	19	20	19		56	12
13	Allocated from Extended Care Consulting LLC	2012	122	6	20	6		12	13
14									14
15	Allocated from 2201 Main/Care Center Building LLC	2002	13,857	1,266	20	1,266		12,676	15
16	Allocated from 2201 Main/Care Center Building LLC	2003	16,329	1,492	20	1,492		14,938	16
17	Allocated from 2201 Main/Care Center Building LLC	2005	811	86	20	86		637	17
18	Allocated from 2201 Main/Care Center Building LLC	2009	146	7	20	7		37	18
19									19
20	Allocated from Extended Care Clinical LLC	2002	2,853	261	20	261		2,610	20
21	Allocated from Extended Care Clinical LLC	2003	3,363	307	20	307		3,076	21
22	Allocated from Extended Care Clinical LLC	2005	167	18	20	18		131	22
23	Allocated from Extended Care Clinical LLC	2009	30	2	20	2		8	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

Facility Name & ID Number Wheaton Care Center

0039115

Report Period Beginning:

01/01/13

Ending:

12/31/13

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	Related Party Information Continued		\$	\$		\$	\$	\$	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)		\$ 59,585	\$ 4,048		\$ 4,048	\$	\$ 40,331	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 156,650	\$ 394	\$ 6,923	\$ 6,529	10	\$ 135,368	71
72	Current Year Purchases	12,056	75	892	817	10	892	72
73	Fully Depreciated Assets	401,410	2,057	2,057		10	360,556	73
74								74
75	TOTALS	\$ 570,116	\$ 2,526	\$ 9,872	\$ 7,346		\$ 496,816	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		VAN	2003	\$ 19,994	\$	\$	\$	5	\$ 19,994	76
77		Allocated from Extended Care C	2013	5,911				5	5,911	77
78		Allocated from Extended Care C	2013	3,536	707	707		5	1,045	78
79										79
80	TOTALS			\$ 29,441	\$ 707	\$ 707	\$		\$ 26,950	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,367,677	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 115,199	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 139,570	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 24,371	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,793,236	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								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12. _____ /2014 \$ _____

13. _____ /2015 \$ _____

14. _____ /2016 \$ _____

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: \$ 14,727 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

COMPLETED		
1. From this facility		
2. From other facilities (f)		
DROP-OUTS		
1. From this facility		
2. From other facilities (f)		
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		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	110,265	\$		\$	110,265	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				5,881				5,881	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				160,190				160,190	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					122,208			122,208	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>						10,775	74,075			84,850	13
14	TOTAL			\$		\$	287,111	\$	196,283	\$	483,394	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

0039115

Report Period Beginning: 01/01/13

Ending:

12/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/13 (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	\$ 78,969	\$ 339,220	1
2	Cash-Patient Deposits	14,315	14,315	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	250,630	250,630	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	184,548	184,548	6
7	Other Prepaid Expenses	5,796	5,796	7
8	Accounts Receivable (owners or related parties)	1,261	1,231,375	8
9	Other(specify): <u>See Attached Schedule</u>	646,031	789,597	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,181,550	\$ 2,815,481	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	1,229,392	1,281,153	15
16	Equipment, at Historical Cost	502,469	833,741	16
17	Accumulated Depreciation (book methods)	(1,390,334)	(2,071,255)	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>	1,228,469	1,246,838	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,569,996	\$ 3,614,975	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,751,546	\$ 6,430,456	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 808,979	\$ 808,979	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	23,959	23,959	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	255,566	255,566	30
31	Accrued Taxes Payable (excluding real estate taxes)	12,056	12,056	31
32	Accrued Real Estate Taxes(Sch.IX-B)	66,554	66,554	32
33	Accrued Interest Payable		6,014	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	1,248,999	1,282,965	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,416,113	\$ 2,456,093	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable		315,430	39
40	Mortgage Payable		500,933	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 816,363	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,416,113	\$ 3,272,456	46
47	TOTAL EQUITY(page 18, line 24)	\$ 335,433	\$ 3,158,000	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,751,546	\$ 6,430,456	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 941,796	1
2	Restatements (describe):		2
3	Prior Year Bad Debt / Allowance Adjustment	(3,288)	3
4	Prior Year Dividend / LOC Adjustment	(200,000)	4
5	Rounding	(3)	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 738,505	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(203,072)	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	(200,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (403,072)	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)	\$ 335,433	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,328,649	1
2	Discounts and Allowances for all Levels	(1,182,508)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,146,141	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,071,942	6
7	Oxygen	1,541	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,073,483	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	122,136	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	13,076	19
20	Radiology and X-Ray	3,180	20
21	Other Medical Services	70,078	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 208,470	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	12,470	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 12,470	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	454	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 454	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,441,018	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,295,790	31
32	Health Care	2,390,650	32
33	General Administration	1,356,486	33
B. Capital Expense			
34	Ownership	810,588	34
C. Ancillary Expense			
35	Special Cost Centers	483,394	35
36	Provider Participation Fee	307,182	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,644,090	40
41	Income before Income Taxes (line 30 minus line 40)**	(203,072)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (203,072)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 4,713,078	44
45	Private Pay - Net Inpatient Revenue	288,283	45
46	Medicare - Net Inpatient Revenue	67,443	46
47	Other-(specify) <u>Hospice</u>	77,337	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,146,141	49

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center

0039115

Report Period Beginning:

01/01/13

Ending:

12/31/13

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	2,087	2,189	\$ 103,231	\$ 47.16	1
2	Assistant Director of Nursing	1,257	1,434	49,640	34.62	2
3	Registered Nurses	10,851	11,926	360,516	30.23	3
4	Licensed Practical Nurses	18,449	19,807	498,417	25.16	4
5	CNAs & Orderlies	51,111	55,970	705,757	12.61	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,685	7,297	151,034	20.70	8
9	Activity Director	1,966	2,203	34,953	15.87	9
10	Activity Assistants	7,408	8,118	81,842	10.08	10
11	Social Service Workers	10,859	11,894	224,442	18.87	11
12	Dietician	2,599	2,810	62,267	22.16	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	6,343	7,208	94,483	13.11	15
16	Dishwashers	11,257	11,913	112,574	9.45	16
17	Maintenance Workers	4,094	4,599	77,901	16.94	17
18	Housekeepers	11,309	12,788	140,341	10.97	18
19	Laundry	7,615	8,397	87,448	10.41	19
20	Administrator	2,078	2,190	72,086	32.92	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,103	6,682	80,149	11.99	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	1,946	2,179	33,850	15.53	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	1,373	1,463	25,029	17.11	33
34	TOTAL (lines 1 - 33)	165,390	181,067	\$ 2,995,960 *	\$ 16.55	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	77	\$ 3,751	01-03	35
36	Medical Director	Monthly	19,200	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	9,850	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	77	\$ 32,801		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	
Stephani Rucker	Administrator	0.00%	\$ 50,292	Workers' Compensation Insurance	\$ 106,582	IDPH License Fee	\$ 1,557	
David Taylor	Administrator	0.00%	21,794	Unemployment Compensation Insurance	50,615	Advertising: Employee Recruitment		
				FICA Taxes	220,120	Health Care Worker Background Check	908	
				Employee Health Insurance	57,042	(Indicate # of checks performed <u>28</u>)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues and Subscriptions	14,689	
				Employee Physicals	3,323	License and Permits	1,707	
				Other Employee Welfare	4,869	Alloc from Extended Care Consulting	2,861	
				Holiday Expense	2,418	Alloc from Extended Care Clinical	196	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 72,086					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Description			Amount				Less: Public Relations Expense ()	
			\$				Non-allowable advertising ()	
							Yellow page advertising ()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$					
(Attach a copy of any management service agreement)								
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	
Frost, Rothblatt, Ruttenberg	Accounting	\$ 29,083			\$	Out-of-State Travel	\$	
Personnel Planners	Unemployment Consultant	620						
Pro Payroll Solutions	Data Processing	17,299						
E-Health Data Solutions	Data Processing	3,180				In-State Travel		
AIS Assessment & Intelligence	Data Processing	1,033						
Ability Network	Medicare Billing	161						
National Datacare Corporation	Resident Fund Processing	2,231				Seminar Expense	555	
Online MSDS	MSDS Management	637				Alloc from Extended Care Consulting	367	
Pinnacle Quality Insight	Customer Satisfaction	2,731				Alloc from Extended Care Clinical	1,962	
See Attached	Legal	20,297						
Prospect Resources	Natural Gas Procurement	1,306				Entertainment Expense	()	
See Supplemental Schedule		307,451				(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			\$	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 386,031					2,884

* 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	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
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# 0039115

Report Period Beginning:

01/01/13

Ending:

12/31/13**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IL Council on Long Term Care \$12,325
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 23,267 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 307,182
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.

SEE ACCOUNTANTS' COMPILATION REPORT

- (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% Ln 14
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? N/A
- (19) 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? Yes
Attach invoices and a summary of services for all architect and appraisal fees.