



Facility Name & ID Number Wheaton Care Center

# 0039115 Report Period Beginning: 01/01/14 Ending: 12/31/14

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds

N/A

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>3,788</u>	<u>112</u>	<u>2,984</u>	<u>6,884</u>	8
9	SNF/PED					9
10	ICF	<u>34,089</u>	<u>1,008</u>		<u>35,097</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>37,877</u>	<u>1,120</u>	<u>2,984</u>	<u>41,981</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.51%

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 2,885

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2014 Fiscal Year: 12/31/2014

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

Facility Name &amp; ID Number

Wheaton Care Center

# 0039115

Report Period Beginning:

01/01/14

Ending:

12/31/14

**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
	<b>A. General Services</b>										
1	Dietary	287,703	33,454	3,971	325,128		325,128	4,328	329,456		1
2	Food Purchase		268,639		268,639		268,639	537	269,176		2
3	Housekeeping	150,573	43,180		193,753		193,753	541	194,294		3
4	Laundry	79,017	12,433		91,450		91,450		91,450		4
5	Heat and Other Utilities			153,546	153,546		153,546	1,185	154,731		5
6	Maintenance	72,611		201,113	273,724		273,724	(13,987)	259,737		6
7	Other (specify):*							3,532	3,532		7
8	<b>TOTAL General Services</b>	589,904	357,706	358,630	1,306,240		1,306,240	(3,864)	1,302,376		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			19,200	19,200		19,200		19,200		9
10	Nursing and Medical Records	1,818,844	105,485	11,685	1,936,014		1,936,014	38,623	1,974,637		10
10a	Therapy	164,694			164,694		164,694		164,694		10a
11	Activities	132,610	18,538		151,148		151,148		151,148		11
12	Social Services	239,765	3,338		243,103		243,103	17,496	260,599		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							6,406	6,406		15
16	<b>TOTAL Health Care and Programs</b>	2,355,913	127,361	30,885	2,514,159		2,514,159	62,525	2,576,684		16
	<b>C. General Administration</b>										
17	Administrative	95,048			95,048		95,048	79,169	174,217		17
18	Directors Fees										18
19	Professional Services			380,862	380,862		380,862	(295,338)	85,524		19
20	Dues, Fees, Subscriptions & Promotions			34,087	34,087		34,087	(8,840)	25,247		20
21	Clerical & General Office Expenses	68,109	23,369	240,438	331,916		331,916	(25,233)	306,683		21
22	Employee Benefits & Payroll Taxes			484,102	484,102		484,102	(12,098)	472,004		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,872	2,872		2,872	1,405	4,277		24
25	Other Admin. Staff Transportation			16,902	16,902		16,902	1,022	17,924		25
26	Insurance-Prop.Liab.Malpractice			2,151,285	2,151,285		2,151,285	(1,998,296)	152,989		26
27	Other (specify):*							31,778	31,778		27
28	<b>TOTAL General Administration</b>	163,157	23,369	3,310,548	3,497,074		3,497,074	(2,226,431)	1,270,643		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,108,974	508,436	3,700,063	7,317,473		7,317,473	(2,167,770)	5,149,703		29

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

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

Facility Name & ID Number Wheaton Care Center

#0039115

Report Period Beginning:

01/01/14

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	
	<b>D. Ownership</b>											
30	Depreciation			65,730	65,730	65,730	66,386	132,116				30
31	Amortization of Pre-Op. & Org.											31
32	Interest						52,783	52,783				32
33	Real Estate Taxes			66,808	66,808	66,808	2,639	69,447				33
34	Rent-Facility & Grounds			480,000	480,000	480,000	(480,000)					34
35	Rent-Equipment & Vehicles			1,807	1,807	1,807	676	2,483				35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			614,345	614,345	614,345	(357,516)	256,829				37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		234,278	283,922	518,200	518,200	(22,913)	495,287				39
40	Barber and Beauty Shops		186		186	186		186				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			299,384	299,384	299,384		299,384				42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		234,464	583,306	817,770	817,770	(22,913)	794,857				44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,108,974	742,900	4,897,714	8,749,588	8,749,588	(2,548,199)	6,201,389				45

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

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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	19,655	30		9
10	Interest and Other Investment Income	(14,876)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(72)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,774)	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	(144,697)	21		24
25	Fund Raising, Advertising and Promotional	(1,230)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(495)	20		28
29	Other-Attach Schedule	(2,147,571)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (2,291,060)		\$	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)	(257,139)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (257,139)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (2,548,199)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY						
48		49		50		51
						52

Wheaton Care Center

Report Period Beginning: 01/01/14  
 Ending: 12/31/14

ID# 0039115

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Other Income	\$ (30)	21	1
2	Collections	(2,712)	21	2
3	Annual Report	(250)	20	3
4	COPE Dues	(6,812)	20	4
5	Out of Period Auto & Travel	(129)	25	5
6	Out of Period Expense	(2,362)	21	6
7	Capitalized R&M	(5,711)	06	7
8	Building Company - Amortization	(3,182)	36	8
9	Building Company - Management Fees	(1,538)	17	9
10	Building Company - Filing Fee	(650)	20	10
11	Building Company - Donation	(100,000)	20	11
12	Non-Allowable Legal	(4,244)	19	12
13	Non-Allowable Expense	(2,000,000)	26	13
14	Additional Capitalized R&M	(19,952)	06	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	<b>Total</b>	(2,147,571)		49

Wheaton Care Center

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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	<b>Total</b>		0	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Wheaton Care Center# 0039115

Report Period Beginning:

01/01/14

Ending:

12/31/14

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary			136		4,192							4,328	1
2	Food Purchase	(72)		609									537	2
3	Housekeeping			455		86							541	3
4	Laundry													4
5	Heat and Other Utilities			1,027		158							1,185	5
6	Maintenance	(25,663)		4,240	7,306	130							(13,987)	6
7	Other (specify):*				3,053	479							3,532	7
8	<b>TOTAL General Services</b>	<b>(25,735)</b>		<b>6,467</b>	<b>10,359</b>	<b>5,045</b>							<b>(3,864)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records					38,623							38,623	10
10a	Therapy													10a
11	Activities													11
12	Social Services					17,496							17,496	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					6,406							6,406	15
16	<b>TOTAL Health Care and Programs</b>					<b>62,525</b>							<b>62,525</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	(1,538)	1,538	2,818	15,235	61,116							79,169	17
18	Directors Fees													18
19	Professional Services	(4,244)		(216,941)		(74,153)							(295,338)	19
20	Fees, Subscriptions & Promotions	(111,211)	100,650	1,497		224							(8,840)	20
21	Clerical & General Office Expenses	(149,800)		10,250	89,389	24,928							(25,233)	21
22	Employee Benefits & Payroll Taxes				(12,098)								(12,098)	22
23	Inservice Training & Education													23
24	Travel and Seminar			234		1,171							1,405	24
25	Other Admin. Staff Transportation	(129)		1,151									1,022	25
26	Insurance-Prop.Liab.Malpractice	(2,000,000)		1,237		467							(1,998,296)	26
27	Other (specify):*				22,103	9,675							31,778	27
28	<b>TOTAL General Administration</b>	<b>(2,266,922)</b>	<b>102,188</b>	<b>(199,754)</b>	<b>114,629</b>	<b>23,428</b>							<b>(2,226,431)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(2,292,657)</b>	<b>102,188</b>	<b>(193,287)</b>	<b>124,988</b>	<b>90,998</b>							<b>(2,167,770)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Wheaton Care Center

# 0039115

Report Period Beginning:

01/01/14

Ending:

12/31/14

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)	
	<b>D. Ownership</b>													
30	Depreciation	19,655	41,818	3,812		1,101							66,386	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(14,876)	35,586	872		31,201							52,783	32
33	Real Estate Taxes		(1)	2,222		418							2,639	33
34	Rent-Facility & Grounds		(480,000)										(480,000)	34
35	Rent-Equipment & Vehicles			676									676	35
36	Other (specify):*	(3,182)	3,182											36
37	<b>TOTAL Ownership</b>	<b>1,597</b>	<b>(399,415)</b>	<b>7,582</b>		<b>32,720</b>							<b>(357,516)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(482)	(19,735)			(2,697)		(22,913)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	<b>TOTAL Special Cost Centers</b>						<b>(482)</b>	<b>(19,735)</b>			<b>(2,697)</b>		<b>(22,913)</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(2,291,060)</b>	<b>(297,227)</b>	<b>(185,705)</b>	<b>124,988</b>	<b>123,718</b>	<b>(482)</b>	<b>(19,735)</b>			<b>(2,697)</b>		<b>(2,548,199)</b>	<b>45</b>

**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	\$ 480,000	Wheaton HC Properties, LLC	100.00%	\$	\$ (480,000)	1
2	V	33 Rent - Property Tax	66,807	Wheaton HC Properties, LLC	100.00%		(66,807)	2
3	V	17 Management Fee		Wheaton HC Properties, LLC	100.00%	1,538	1,538	3
4	V	21 Bank Charges		Wheaton HC Properties, LLC	100.00%			4
5	V	20 Filing Fee		Wheaton HC Properties, LLC	100.00%	650	650	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%	3,182	3,182	7
8	V	33 Real Estate Tax Expense		Wheaton HC Properties, LLC	100.00%	66,806	66,806	8
9	V	32 Interest		Wheaton HC Properties, LLC	100.00%	35,586	35,586	9
10	V	20 Donation		Wheaton HC Properties, LLC	100.00%	100,000	100,000	10
11	V							11
12	V							12
13	V							13
14	<b>Total</b>		\$ 546,807			\$ 249,580	\$ * (297,227)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	01 Dietary	\$	Extended Care Consulting, LLC	100.00%	\$ 136	\$	136	15
16	V	02 Food		Extended Care Consulting, LLC	100.00%	609		609	16
17	V	03 Housekeeping		Extended Care Consulting, LLC	100.00%	455		455	17
18	V	05 Utilities		Extended Care Consulting, LLC	100.00%	1,027		1,027	18
19	V	06 Maintenance		Extended Care Consulting, LLC	100.00%	4,240		4,240	19
20	V	17 Administrative		Extended Care Consulting, LLC	100.00%	2,818		2,818	20
21	V	19 Professional Fees	224,976	Extended Care Consulting, LLC	100.00%	8,035		(216,941)	21
22	V	20 Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	1,497		1,497	22
23	V	21 Office and Clerical		Extended Care Consulting, LLC	100.00%	10,250		10,250	23
24	V	24 Seminar and Travel		Extended Care Consulting, LLC	100.00%	234		234	24
25	V	25 Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	1,151		1,151	25
26	V	26 Insurance		Extended Care Consulting, LLC	100.00%	1,237		1,237	26
27	V	30 Depreciation		Extended Care Consulting, LLC	100.00%	3,812		3,812	27
28	V	32 Interest		Extended Care Consulting, LLC	100.00%	872		872	28
29	V	33 Real Estate Taxes		Extended Care Consulting, LLC	100.00%	2,222		2,222	29
30	V	35 Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	676		676	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 224,976			\$ 39,271	\$ *	(185,705)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	06 Maintenance (Pooled)		Extended Care Consulting, LLC	100.00%	7,306	\$	7,306	15
16	V	06 Maintenance (Direct)	15,599	Extended Care Consulting, LLC	100.00%	15,599			16
17	V	07 Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	693		693	17
18	V	07 Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	2,360		2,360	18
19	V								19
20	V								20
21	V	17 Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	15,235		15,235	21
22	V	21 Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	89,389		89,389	22
23	V	21 Office and Clerical (Direct)	24,728	Extended Care Consulting, LLC	100.00%	24,728			23
24	V	27 Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	19,271		19,271	24
25	V	27 Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	2,832		2,832	25
26	V	22 Employee Benefits	12,098	Extended Care Consulting, LLC	100.00%			(12,098)	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		\$ 52,425			\$ 177,413	\$ *	124,988	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	03 Housekeeping	\$	Extended Care Clinical, LLC	100.00%	\$ 86	\$	86	15
16	V	05 Utilities		Extended Care Clinical, LLC	100.00%	158		158	16
17	V	06 Maintenance		Extended Care Clinical, LLC	100.00%	130		130	17
18	V	19 Professional Fees	74,988	Extended Care Clinical, LLC	100.00%	835		(74,153)	18
19	V	20 Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	224		224	19
20	V	21 Office & Clerical		Extended Care Clinical, LLC	100.00%	1,289		1,289	20
21	V	24 Travel and Seminar		Extended Care Clinical, LLC	100.00%	1,171		1,171	21
22	V	26 Insurance		Extended Care Clinical, LLC	100.00%	467		467	22
23	V	30 Depreciation		Extended Care Clinical, LLC	100.00%	1,101		1,101	23
24	V	32 Interest		Extended Care Clinical, LLC	100.00%	31,201		31,201	24
25	V	33 Real Estate Taxes		Extended Care Clinical, LLC	100.00%	418		418	25
26	V	01 Dietary Salary		Extended Care Clinical, LLC	100.00%	4,192		4,192	26
27	V	07 Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	479		479	27
28	V	10 Nursing Salary		Extended Care Clinical, LLC	100.00%	38,623		38,623	28
29	V	12 Social Service Salary		Extended Care Clinical, LLC	100.00%	17,496		17,496	29
30	V	15 Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	6,406		6,406	30
31	V	17 Administration Salary		Extended Care Clinical, LLC	100.00%	61,116		61,116	31
32	V	21 Office Salary		Extended Care Clinical, LLC	100.00%	23,639		23,639	32
33	V	27 Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	9,675		9,675	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 74,988			\$ 198,706	\$ *	123,718	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	39 Various Equipment	5,410	Vent Lease LLC	100.00%	4,928	\$	(482)	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		\$ 5,410			\$ 4,928	\$ *	(482)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	39 Therapy	\$ 276,958	Tri Care Rehab	100.00%	\$ 257,223	\$ (19,735)
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		\$ 276,958			\$ 257,223	\$ * (19,735)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	22 Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 148,717	\$ 148,717
16	V						
17	V						
18	V						
19	V	22 Employee Health Insurance	148,717	CCS Employee Benefits Group	100.00%		(148,717)
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		\$ 148,717			\$ 148,717	\$ *

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary Supplies, Supplements	\$ 5,780	Care Centers Health Systems, Inc.	100.00%	\$ 5,780	\$	15
16	V	39 Ancillary Expense	1,373	Care Centers Health Systems, Inc.	100.00%	1,373		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	<b>Total</b>		\$ 7,153			\$ 7,153	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	39 Ancillary Expense	9,577	Reliable Medical of the Midwest, LLC	100.00%	6,880	\$ (2,697)
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		\$ 9,577			\$ 6,880	\$ * (2,697)

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

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

Facility Name & ID Number

Wheaton Care Center

# 0039115

Report Period Beginning:

01/01/14

Ending:

12/31/14

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

Facility Name & ID Number

Wheaton Care Center

# 0039115

Report Period Beginning:

01/01/14

Ending:

12/31/14

VII. RELATED PARTIES

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

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

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/14 Ending: 12/31/14

## 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	1.28	3.20%	Alloc. Sal.	\$ 2,368	22-07	1
2	Mark Steinberg	Relative	Administrative	N/A	See Attached	2.47	4.49%	Alloc Fee/Sal	8,983	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	\$ 11,351		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Wheaton Care Center

# 0039115 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Wheaton Care Center

# 0039115

Report Period Beginning:

01/01/14

Ending: 12/31/14

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	1,251,572	31	\$ 4,057	\$ 41,981	\$ 136	1
2	02	Food	Patient Days	1,251,572	31	18,150	41,981	609	2
3	03	Housekeeping	Patient Days	1,251,572	31	13,578	41,981	455	3
4	05	Utilities	Patient Days	1,251,572	31	30,626	41,981	1,027	4
5	06	Maintenance	Patient Days	1,251,572	31	126,400	41,981	4,240	5
6	17	Administrative	Patient Days	1,251,572	31	84,000	41,981	2,818	6
7	19	Professional Fees	Patient Days	1,251,572	31	239,560	41,981	8,035	7
8	20	Dues and Subscriptions	Patient Days	1,251,572	31	44,626	41,981	1,497	8
9	21	Office and Clerical	Patient Days	1,251,572	31	305,586	41,981	10,250	9
10	24	Seminar and Travel	Patient Days	1,251,572	31	6,989	41,981	234	10
11	25	Other Staff Admin. Trans.	Patient Days	1,251,572	31	34,307	41,981	1,151	11
12	26	Insurance	Patient Days	1,251,572	31	36,877	41,981	1,237	12
13	30	Depreciation	Patient Days	1,251,572	31	113,642	41,981	3,812	13
14	32	Interest	Patient Days	1,251,572	31	26,010	41,981	872	14
15	33	Real Estate Taxes	Patient Days	1,251,572	31	66,240	41,981	2,222	15
16	35	Rent - Equipment & Auto	Patient Days	1,251,572	31	20,168	41,981	676	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,170,816	\$	\$ 39,271	25

Facility Name & ID Number Wheaton Care Center

# 0039115 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	06	Maintenance (Pooled)	Patient Days	1,251,572	31	217,811	217,811	41,981	7,306	1
2	06	Maintenance (Direct)	Direct		31	252,781	252,781		15,599	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,251,572	31	20,665		41,981	693	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		31	33,212			2,360	4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,251,572	31	454,189	454,189	41,981	15,235	7
8	21	Office and Clerical (Pooled)	Patient Days	1,251,572	31	2,664,951	2,664,951	41,981	89,389	8
9	21	Office and Clerical (Direct)	Direct		31	385,321	385,321		24,728	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,251,572	31	574,509		41,981	19,271	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		31	59,282			2,832	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					\$ 4,662,721	\$ 3,975,053		\$ 177,413	25

Facility Name & ID Number Wheaton Care Center

# 0039115

Report Period Beginning:

01/01/14

Ending: 12/31/14

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	758,409	19	\$ 1,549	\$ 41,981	\$ 86	1
2	05	Utilities	Patient Days	758,409	19	2,849	41,981	158	2
3	06	Maintenance	Patient Days	758,409	19	2,348	41,981	130	3
4	19	Professional Fees	Patient Days	758,409	19	15,090	41,981	835	4
5	20	Dues and Subscriptions	Patient Days	758,409	19	4,042	41,981	224	5
6	21	Office & Clerical	Patient Days	758,409	19	23,285	41,981	1,289	6
7	24	Travel and Seminar	Patient Days	758,409	19	21,158	41,981	1,171	7
8	26	Insurance	Patient Days	758,409	19	8,431	41,981	467	8
9	30	Depreciation	Patient Days	758,409	19	19,889	41,981	1,101	9
10	32	Interest	Patient Days	758,409	19	563,670	41,981	31,201	10
11	33	Real Estate Taxes	Patient Days	758,409	19	7,558	41,981	418	11
12	01	Dietary Salary	Patient Days	758,409	19	75,731	75,731	4,192	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	758,409	19	8,645	41,981	479	13
14	10	Nursing Salary	Patient Days	758,409	19	697,742	697,742	38,623	14
15	12	Social Service Salary	Patient Days	758,409	19	316,078	316,078	17,496	15
16	15	Emp. Ben. - Healthcare	Patient Days	758,409	19	115,731	41,981	6,406	16
17	17	Administration Salary	Patient Days	758,409	19	1,104,097	1,104,097	61,116	17
18	21	Office Salary	Patient Days	758,409	19	427,044	427,044	23,639	18
19	27	Emp. Ben. - Gen. Admin.	Patient Days	758,409	19	174,785	41,981	9,675	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 3,589,719	\$ 2,620,691	\$ 198,706	25

Facility Name & ID Number Wheaton Care Center

# 0039115 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 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

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	<b>39</b>	<b>Various Equipment</b>	<b>Direct Allocation</b>					<b>4,928</b>	<b>1</b>
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	<b>TOTALS</b>				\$	\$		\$ <b>4,928</b>	<b>25</b>

Facility Name & ID Number Wheaton Care Center

# 0039115

Report Period Beginning:

01/01/14

Ending: 12/31/14

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		\$	\$		\$ 257,223	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				\$	\$		\$ 257,223	25

Facility Name & ID Number Wheaton Care Center

# 0039115

Report Period Beginning:

01/01/14

Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	22	Employee Health Insurance	Direct Allocation		\$	\$		\$ 148,717	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				\$	\$		\$ 148,717	25

Facility Name & ID Number Wheaton Care Center

# 0039115

Report Period Beginning:

01/01/14

Ending: 12/31/14

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	<u>1</u>	<u>Dietary Supplies, Supplements</u>	<u>Direct Allocation</u>					\$ 5,780	1
2	<u>39</u>	<u>Ancillary Expense</u>	<u>Direct Allocation</u>					1,373	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	<b>TOTALS</b>				\$	\$		\$ 7,153	25

Facility Name & ID Number Wheaton Care Center

# 0039115 Report Period Beginning: 01/01/14 Ending: 12/31/14

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									1
2	39	Ancillary Expense						6,880	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				\$	\$		\$ 6,880	25

Facility Name & ID Number Wheaton Care Center

# 0039115 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number

Wheaton Care Center

# 0039115

Report Period Beginning:

01/01/14

Ending:

12/31/14

**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		7	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			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	CIB		X	Mortgage			\$	\$ 122,381			\$	12,218	1					
2													2					
3													3					
4													4					
5													5					
<b>Working Capital</b>																		
6	Manchester Manor		X	Loan				48,028				23,368	6					
7	ECC - Dell		X	Note Payable				10,112					7					
8	See Supplemental Schedule											32,073	8					
9	<b>TOTAL Facility Related</b>						\$	\$ 180,521			\$	67,659	9					
<b>B. Non-Facility Related*</b>																		
10	Interest Income		X									(14,876)	10					
11													11					
12													12					
13													13					
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	(14,876)	14					
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 180,521			\$	52,783	15					

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

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

\*\* 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:

01/01/14

Ending:

12/31/14

**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			
	<b>A. Directly Facility Related</b>															
	<b>Long-Term</b>															
1							\$	\$			\$					
2																
3																
4																
5																
6																
7	<b>TOTAL Long-Term</b>															
	<b>Working Capital</b>															
8	Alloc from Extended Care Consulting	X					\$	\$			\$ 872					
9	Alloc from Extended Care Clinical	X									31,201					
10																
11																
12																
13																
14	<b>TOTAL Working Capital</b>										32,073					
	<b>B. Non-Facility Related*</b>															
15							\$	\$			\$					
16																
17																
18																
19																
20	<b>TOTAL Non-Facility Related</b>															

\* 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

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
1. Real Estate Tax accrual used on 2013 report.		\$	<u>66,554</u>	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.)		\$	<u>67,694</u>	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>1,140</u>	3	
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>68,307</u>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<u>69,447</u>	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2009	<u>54,933</u>	8	<b>FOR BHF USE ONLY</b>	
	2010	<u>56,589</u>	9	13	FROM R. E. TAX STATEMENT FOR 2013 \$ 13
	2011	<u>57,597</u>	10	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2012	<u>63,385</u>	11	15	LESS REFUND FROM LINE 6 \$ 15
	2013	<u>65,054</u>	12	16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
<b>2014 Accrual = \$65,054 x 1.05 = \$68,307</b>					
<b>Allocated from Extended Care Consulting LLC \$2,222</b>					
<b>Allocated from Extended Care Clinical LLC \$418</b>					

## NOTES:

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

## 2013 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 2013 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 2013.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>05-17-114-010</u>	<u>Long Term Care Property</u>	\$ <u>65,054.48</u>	\$ <u>65,054.48</u>
2. <u>See Attached</u>	<u>Alloc from Extended Care Consult</u>	\$ <u>162,082.08</u>	\$ <u>2,514.56</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>227,136.56</u></u>	\$ <u><u>67,569.04</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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

**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.	_____	_____	\$ _____	\$ _____
		<b>TOTALS</b>	\$ <u>_____</u>	\$ <u>_____</u>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

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

Facility Name & ID Number Wheaton Care Center

# 0039115 Report Period Beginning:

01/01/14 Ending:

12/31/14

**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>12,721</u>	<u>2</u>
3	<b>TOTALS</b>			<b>\$ 840,902</b>	<b>3</b>

Facility Name & ID Number Wheaton Care Center

# 0039115

Report Period Beginning:

01/01/14

Ending:

12/31/14

**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)	\$ 378,725	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Various		1993	41,331		20			41,331	9
10	Various		1994	104,965		20	1,663	1,663	104,935	10
11	Various		1995	16,968		20	848	848	16,772	11
12	Various		1996	158,287		20	7,914	7,914	146,584	12
13	Various		1997	103,690		20	5,185	5,185	91,185	13
14	Various		1998	56,873		20	2,844	2,844	46,564	14
15	Various		1999	21,286		20	1,064	1,064	16,537	15
16	Various		2000	57,068		20	2,292	2,292	40,575	16
17	Various		2001	48,282		20	2,297	2,297	34,250	17
18	Various		2002	15,745		20	242	242	15,315	18
19	Various		2003	18,300		20	248	248	17,030	19
20	Various		2004	134,063		20	4,947	4,947	128,562	20
21	Various		2005	38,153		20	3,282	3,282	32,197	21
22	Various		2006	95,583		20	8,639	8,639	73,887	22
23	Various		2007	76,180		20	5,728	5,728	64,450	23
24	Various		2008	31,780		20	3,051	3,051	19,955	24
25	Various		2009	9,024		20	272	272	7,686	25
26	Various		2010	6,642		20	664	664	2,712	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

Facility Name & ID Number Wheaton Care Center

# 0039115

Report Period Beginning:

01/01/14

Ending:

12/31/14

**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			55,595	3,510	3,510		38,469	68
69				65,732		(65,732)		69
70		\$	2,637,893	\$ 111,060		\$ 94,385	\$ (16,675)	\$ 1,317,720 70

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

Facility Name &amp; ID Number Wheaton Care Center

# 0039115

Report Period Beginning:

01/01/14

Ending:

12/31/14

## 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		\$ 2,637,893	\$ 111,060		\$ 94,385	\$ (16,675)	\$ 1,317,720	1
2	3 Ductless Mini Splits Cooling	2011	25,500		20	2,550	2,550	9,563	2
3	New Soffit-Dry Wall, Cover Holes	2011	4,550		20	455	455	1,706	3
4	Roof Repairs	2011	3,000		20	300	300	1,075	4
5	Fire Alarm Repair	2011	6,624		20	662	662	2,319	5
6	Attach Ac Units To Em Panel	2011	4,600		20	460	460	1,610	6
7	New 5 Ton Ac Unit	2011	6,175		20	618	618	2,058	7
8	Dry Wall, Cover Pipes	2011	3,400		20	87	87	287	8
9	Install Of New Double Doors	2011	2,570		20	66	66	211	9
10	Roof Work	2011	3,585		20	92	92	295	10
11	Generator Work	2011	2,896		20	74	74	238	11
12	Painting	2011	2,512		20	126	126	429	12
13	Painting	2011	2,940		20	147	147	453	13
14	Duct Installation	2012	5,600		20	560	560	1,680	14
15	Supply Duct Distribution System	2012	33,000		20	3,300	3,300	9,900	15
16	Exhaust Fan & Duct Work	2012	7,300		20	730	730	1,947	16
17	Elevator Renovation - Install 6 Inch Cylinder For 2 Stop Hydraulic	2012	35,183		20	3,518	3,518	9,382	17
18	Elevator Renovation - Replace Passenger Elevator Hydraulic Cylind	2012	28,575		20	2,858	2,858	8,334	18
19	Installation Of A 24 Channel Cable System	2012	14,328		20	1,433	1,433	3,343	19
20	Running Conduit	2012	5,848		20	585	585	1,365	20
21	Complete Remodel Of Basement Bathroom-New Walls, Tile, Toilet	2012	3,471		20	347	347	752	21
22	New Grease Trap	2013	7,800		20	780	780	1,560	22
23	Flooring Installation	2013	3,890		20	389	389	778	23
24	Water Heater Code Violation Fix	2013	2,557		20	511	511	767	24
25	New Compressor	2013	13,954		20	1,395	1,395	1,861	25
26	Re-Do Parking Lot	2013	53,518		20	3,568	3,568	4,460	26
27	Door Repairs	2014	14,500		20	604	604	604	27
28	Sewer Work	2014	14,800		20	432	432	432	28
29	Compressor	2014	7,140		20	179	179	179	29
30	Sprinkler System	2014	9,293		20	155	155	155	30
31	Rooftop A/C Unit	2014	5,950		20	99	99	99	31
32	Elevator Work	2014	7,608		20	32	32	32	32
33	Passenger Elevator Repair	2014	5,711		20	286	286	286	33
34	TOTAL (lines 1 thru 33)		\$ 2,986,272	\$ 111,060		\$ 121,781	\$ 10,721	\$ 1,385,879	34

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

**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	Totals from Page 12B, Carried Forward		\$ 2,986,272	\$ 111,060		\$ 121,781	\$ 10,721	\$ 1,385,879	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)		\$ 2,986,272	\$ 111,060		\$ 121,781	\$ 10,721	\$ 1,385,879	34

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

Facility Name & ID Number Wheaton Care Center

# 0039115

Report Period Beginning:

01/01/14

Ending:

12/31/14

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		\$ 2,986,272	\$ 111,060		\$ 121,781	\$ 10,721	\$ 1,385,879	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		\$ 2,986,272	\$ 111,060		\$ 121,781	\$ 10,721	\$ 1,385,879	34

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

Facility Name & ID Number Wheaton Care Center

# 0039115

Report Period Beginning:

01/01/14

Ending:

12/31/14

**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		\$ 2,986,272	\$ 111,060		\$ 121,781	\$ 10,721	\$ 1,385,879	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)	\$ 2,986,272	\$ 111,060		\$ 121,781	\$ 10,721	\$ 1,385,879	34

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

Facility Name & ID Number Wheaton Care Center

# 0039115

Report Period Beginning:

01/01/14

Ending:

12/31/14

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$	\$		\$	\$	\$	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	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

Facility Name & ID Number Wheaton Care Center

# 0039115

Report Period Beginning:

01/01/14

Ending:

12/31/14

**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	<b>Totals from Page 12F, Carried Forward</b>								
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34	<b>TOTAL (lines 1 thru 33)</b>		\$	\$		\$	\$	\$	34

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

Facility Name &amp; ID Number Wheaton Care Center

# 0039115

Report Period Beginning:

01/01/14

Ending:

12/31/14

## 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	<b>Totals from Page 12G, Carried Forward</b>		\$	\$		\$	\$	\$	1
2	<b>Buildings:</b>								2
3	Allocated from 2201 Main/Care Center Building LLC	2002	14,753	378	20	378		4,650	3
4	Allocated from Extended Care Clinical LLC	2002	2,778	71	20	71		876	4
5									5
6									6
7									7
8	<b>Leasehold Information</b>								8
9	Allocated from Extended Care Consulting LLC	2007	154	8	20	8		62	9
10	Allocated from Extended Care Consulting LLC	2009	92	5	20	5		28	10
11	Allocated from Extended Care Consulting LLC	2010	905	45	20	45		226	11
12	Allocated from Extended Care Consulting LLC	2011	326	16	20	16		65	12
13	Allocated from Extended Care Consulting LLC	2012	107	5	20	5		16	13
14	Allocated from Extended Care Consulting LLC	2014	1,488	74	20	74		74	14
15									15
16	Allocated from 2201 Main/Care Center Building LLC	2002	12,187	1,039	20	1,039		12,187	16
17	Allocated from 2201 Main/Care Center Building LLC	2003	14,362	1,224	20	1,224		14,362	17
18	Allocated from 2201 Main/Care Center Building LLC	2005	714	76	20	76		636	18
19	Allocated from 2201 Main/Care Center Building LLC	2009	129	6	20	6		39	19
20	Allocated from 2201 Main/Care Center Building LLC	2014	2,056	103	20	103		103	20
21									21
22	Allocated from Extended Care Clinical LLC	2002	2,295	196	20	196		2,295	22
23	Allocated from Extended Care Clinical LLC	2003	2,704	230	20	230		2,704	23
24	Allocated from Extended Care Clinical LLC	2005	134	14	20	14		120	24
25	Allocated from Extended Care Clinical LLC	2009	24	1	20	1		7	25
26	Allocated from Extended Care Clinical LLC	2014	387	19	20	19		19	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 55,595	\$ 3,510		\$ 3,510	\$	\$ 38,469	34

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

Facility Name & ID Number Wheaton Care Center

# 0039115

Report Period Beginning:

01/01/14

Ending:

12/31/14

**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	Totals from Page 12H, Carried Forward		\$ 55,595	\$ 3,510		\$ 3,510	\$	\$ 38,469	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)		\$ 55,595	\$ 3,510		\$ 3,510	\$	\$ 38,469	34

\*\*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	\$ 150,778	\$ 413	\$ 7,288	\$ 6,875	10	\$ 125,948	71
72	Current Year Purchases	26,834	248	2,307	2,059	10	2,307	72
73	Fully Depreciated Assets	695,416				10	695,416	73
74								74
75	TOTALS	\$ 873,028	\$ 661	\$ 9,595	\$ 8,934		\$ 823,671	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	2014	6,053	171	171		5	5,369	77
78		Allocated from Extended Care C	2014	2,844	569	569		5	1,409	78
79										79
80	TOTALS			\$ 28,891	\$ 740	\$ 740	\$		\$ 26,772	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)	\$ 4,729,092	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 112,461	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 132,116	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 19,655	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,236,322	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: 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. \_\_\_\_\_ /2015                      \$ \_\_\_\_\_

13. \_\_\_\_\_ /2016                      \$ \_\_\_\_\_

14. \_\_\_\_\_ /2017                      \$ \_\_\_\_\_

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: \$ 2,483

Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

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

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

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

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

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/14 Ending: 12/31/14  
**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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
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**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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**

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

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

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

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	\$			\$ 70,935	\$		\$ 70,935	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				7,324			7,324	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39 - 03	hrs				199,321			199,321	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39 - 02	# of prescripts					173,209		173,209	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>						6,342	61,069		67,411	13
14	TOTAL			\$			\$ 283,922	\$ 234,278		\$ 518,200	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.

Facility Name & ID Number Wheaton Care Center# 0039115Report Period Beginning: 01/01/14

Ending:

12/31/14

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 6,740	\$ 71,292	1
2	Cash-Patient Deposits	26,970	26,970	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	806,853	806,853	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	163,868	163,868	6
7	Other Prepaid Expenses	40,306	45,056	7
8	Accounts Receivable (owners or related parties)		1,232,894	8
9	Other(specify):	979,954	995,954	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,024,691	\$ 3,342,887	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		828,181	13
14	Buildings, at Historical Cost		1,496,317	14
15	Leasehold Improvements, at Historical Cost	1,288,683	1,340,444	15
16	Equipment, at Historical Cost	506,870	838,142	16
17	Accumulated Depreciation (book methods)	(1,456,064)	(2,178,803)	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):	1,228,469	1,248,306	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,567,958	\$ 3,572,587	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,592,649	\$ 6,915,474	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 1,310,076	\$ 1,310,076	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	22,524	22,524	28
29	Short-Term Notes Payable	10,112	10,112	29
30	Accrued Salaries Payable	127,933	127,933	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	68,307	68,307	32
33	Accrued Interest Payable		877	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	See Attached Schedule	1,230,114	1,259,026	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,769,066	\$ 2,798,855	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable		48,028	39
40	Mortgage Payable		122,381	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 170,409	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,769,066	\$ 2,969,264	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 823,583	\$ 3,946,210	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,592,649	\$ 6,915,474	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>335,433</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Prior Year Bad Debt Adjustment</b>	(31,741)	<b>3</b>
<b>4</b>	<b>Prior Year Distribution Adjustment</b>	200,000	<b>4</b>
<b>5</b>	<b>Office Expense</b>	(9)	<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>503,683</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(1,680,100)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants	2,000,000	<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>319,900</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>823,583</b>	<b>24</b> *

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

Facility Name & ID Number Wheaton Care Center# 0039115Report Period Beginning: 01/01/14Ending: 12/31/14

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 7,019,982	1
2	Discounts and Allowances for all Levels	(1,264,640)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 5,755,342</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,091,946	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 1,091,946</b>	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	177,388	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,734	19
20	Radiology and X-Ray	4,150	20
21	Other Medical Services	16,022	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 207,294</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	14,876	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 14,876</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	30	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 30</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 7,069,488</b>	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,306,240	31
32	Health Care	2,514,159	32
33	General Administration	3,497,074	33
<b>B. Capital Expense</b>			
34	Ownership	614,345	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	518,386	35
36	Provider Participation Fee	299,384	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 8,749,588</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(1,680,100)</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (1,680,100)</b>	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 5,273,370	44
45	Private Pay - Net Inpatient Revenue	202,854	45
46	Medicare - Net Inpatient Revenue	196,342	46
47	Other-(specify) <u>Hospice</u>	92,626	47
48	Other-(specify) <u>Insurance</u>	(9,850)	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$ 5,755,342</b>	49

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

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

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

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

Facility Name & ID Number Wheaton Care Center

# 0039115

Report Period Beginning:

01/01/14

Ending:

12/31/14

**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	2,009	2,194	\$ 92,790	\$ 42.29	1
2	Assistant Director of Nursing	1,643	1,807	60,841	33.67	2
3	Registered Nurses	12,053	13,125	400,899	30.54	3
4	Licensed Practical Nurses	17,812	19,175	483,329	25.21	4
5	CNAs & Orderlies	49,963	54,145	703,330	12.99	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,946	7,606	164,694	21.65	8
9	Activity Director	1,964	2,155	35,713	16.57	9
10	Activity Assistants	8,454	9,185	96,897	10.55	10
11	Social Service Workers	10,586	11,807	239,765	20.31	11
12	Dietician	878	886	18,926	21.36	12
13	Food Service Supervisor	1,847	2,124	48,713	22.93	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,506	7,239	98,516	13.61	15
16	Dishwashers	11,718	12,897	121,548	9.42	16
17	Maintenance Workers	3,784	4,155	72,611	17.48	17
18	Housekeepers	12,086	13,726	150,573	10.97	18
19	Laundry	6,923	7,791	79,017	10.14	19
20	Administrator	1,980	2,120	95,048	44.83	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,468	5,955	68,109	11.44	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	1,994	2,223	35,425	15.94	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	2,386	2,498	42,230	16.90	33
34	TOTAL (lines 1 - 33)	167,000	182,813	\$ 3,108,974 *	\$ 17.01	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	80	\$ 3,971	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	8,141	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)	80	\$ 31,312		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	76	3,388	10-03	51
52	Certified Nurse Assistants/Aides	7	156	10-03	52
53	TOTAL (lines 50 - 52)	83	\$ 3,544		53

**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	
David Taylor	Administrator	0	\$ 95,048	Workers' Compensation Insurance	\$ 80,802	IDPH License Fee	\$	
				Unemployment Compensation Insurance	49,919	Advertising: Employee Recruitment	5,048	
				FICA Taxes	234,126	Health Care Worker Background Check		
				Employee Health Insurance	90,408	(Indicate # of checks performed <u>54</u> )	1,335	
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues and Subscriptions	11,053	
				Employee Physicals	5,262	License and Permits	6,090	
				Other Employee Welfare	9,024	Alloc from Extended Care Consulting	1,497	
				Holiday Expense	2,462	Alloc from Extended Care Clinical	224	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 95,048					
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		\$ 27,505			\$	Out-of-State Travel	\$
See Attached	Legal		7,973					
Personnel Planners	Unemployment Consultant		1,888					
Extended Care Consulting LLC	Home Office Allocation		224,976				In-State Travel	
Extended Care Clinical LLC	Home Office Allocation		74,988					
Pro Payroll Solutions	Data Processing		17,625					
E-Health Data Solutions	Data Processing		2,385					
AIS Assessment & Intelligence	Data Processing		1,329				Seminar Expense	2,872
Ability Network	Medicare Billing		1,854				Alloc from Extended Care Consulting	234
National Datacare Corporation	Resident Fund Processing		1,959				Alloc from Extended Care Clinical	1,171
Plante & Moran	Accounting		703					
See Supplemental Schedule			17,677				Entertainment Expense	( )
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			(agree to Sch. V, line 24, col. 8)	
(For legal fee disclosure, see page 39 of instructions)			\$ 380,862				TOTAL \$ 4,277	

\* Attach copy of IMRF notifications

\*\*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												
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14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Wheaton Care Center# 0039115

Report Period Beginning:

01/01/14

Ending:

12/31/14**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 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 33,247 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. \$ 299,384  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ No Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 100% 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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes  
Attach invoices and a summary of services for all architect and appraisal fees.