		FOR BHF USE					

LL1

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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

I. IDPH License ID Number: 0039115

Facility Name: Wheaton Care Center

Address: 1325 Manchester Road (Number) Wheaton (City) 60187 (Zip Code)

County: Dupage

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

HFS ID Number:

Date of Initial License for Current Owners: 9/1/1993

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

PROPRIETARY: X

IRS Exemption Code

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/16 to 12/31/16 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) ______ (Date)
(Type or Print Name) ______
(Title) ______

Paid Preparer
(Signed) ______ * (Date)
** Subject to the attached Accountants Consulting Report*
(Print Name and Title) ______
(Firm Name & Address) Marcum, LLP
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

In the event there are further questions about this report, please contact:
Name: Steven N. Lavenda Telephone Number: (847) 282-6300
Email Address:

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

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/16 Ending: 12/31/16

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	82	Skilled (SNF)	82	30,012	1
2		Skilled Pediatric (SNF/PED)			2
3	41	Intermediate (ICF)	41	15,006	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	123	TOTALS	123	45,018	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	3,805	786	3,381	7,972	8
9	SNF/PED					9
10	ICF	34,236			34,236	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	38,041	786	3,381	42,208	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.76%

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 [X]

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

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 [X] Date 09/01/1993 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 81 and days of care provided 1,917

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number Wheaton Care Center # 0039115 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	292,409	41,943	4,983	339,335		339,335	8,465	347,800			1
2	Food Purchase		254,242		254,242		254,242	295	254,537			2
3	Housekeeping	160,068	53,803		213,871		213,871	975	214,846			3
4	Laundry	72,682	18,627		91,309		91,309		91,309			4
5	Heat and Other Utilities			139,098	139,098		139,098	1,350	140,448			5
6	Maintenance	101,703		166,769	268,472		268,472	12,803	281,275			6
7	Other (specify):*							2,468	2,468			7
8	**TOTAL General Services**	626,862	368,615	310,850	1,306,327		1,306,327	26,356	1,332,683			8
	B. Health Care and Programs											
9	Medical Director			20,000	20,000		20,000		20,000			9
10	Nursing and Medical Records	1,908,161	162,863	109,799	2,180,823		2,180,823	33,046	2,213,869			10
10a	Therapy	151,668			151,668		151,668		151,668			10a
11	Activities	115,269	23,843		139,112		139,112		139,112			11
12	Social Services	271,712	3,991		275,703		275,703	20,113	295,816			12
13	CNA Training											13
14	Program Transportation			2,472	2,472		2,472		2,472			14
15	Other (specify):*							7,553	7,553			15
16	**TOTAL Health Care and Programs**	2,446,810	190,697	132,271	2,769,778		2,769,778	60,712	2,830,490			16
	C. General Administration											
17	Administrative	96,548			96,548		96,548	84,483	181,031			17
18	Directors Fees											18
19	Professional Services			398,845	398,845	(872)	397,973	(300,489)	97,484			19
20	Dues, Fees, Subscriptions & Promotions			58,584	58,584		58,584	(13,352)	45,232			20
21	Clerical & General Office Expenses	109,121	22,511	182,196	313,828		313,828	(17,023)	296,805			21
22	Employee Benefits & Payroll Taxes			545,494	545,494		545,494	(9,696)	535,798			22
23	Inservice Training & Education											23
24	Travel and Seminar			498	498		498	762	1,260			24
25	Other Admin. Staff Transportation			7,604	7,604		7,604	888	8,492			25
26	Insurance-Prop.Liab.Malpractice			123,056	123,056		123,056	2,063	125,119			26
27	Other (specify):*							33,615	33,615			27
28	**TOTAL General Administration**	205,669	22,511	1,316,277	1,544,457	(872)	1,543,585	(218,749)	1,324,836			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,279,341	581,823	1,759,398	5,620,562	(872)	5,619,690	(131,680)	5,488,009			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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			75,276	75,276		75,276	50,392	125,668			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			398	398		398	(398)				32
33	Real Estate Taxes			72,168	72,168	872	73,040	1,212	74,252			33
34	Rent-Facility & Grounds			480,000	480,000		480,000	(480,000)				34
35	Rent-Equipment & Vehicles			3,127	3,127		3,127	839	3,966			35
36	Other (specify):*			123,349	123,349		123,349	(123,349)				36
37	**TOTAL Ownership**			754,318	754,318	872	755,190	(551,304)	203,886			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		106,425	378,001	484,426		484,426	(6,389)	478,037			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			310,411	310,411		310,411		310,411			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		106,425	688,412	794,837		794,837	(6,389)	788,448			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,279,341	688,248	3,202,128	7,169,717		7,169,717	(689,373)	6,480,344			45

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

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/16 Ending: 12/31/16

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 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	(10,137)	30		9
10	Interest and Other Investment Income	(8,016)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(47)	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	(105)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(122,626)	21		24
25	Fund Raising, Advertising and Promotional	(9,757)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(186)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(185,358)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (336,232)		$	30

BHF USE ONLY

48		49		50		51		52	

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

		1 Amount	2 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)	(353,141)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (353,141)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (689,373)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Wheaton Care Center

ID# 0039115

Report Period Beginning: 01/01/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Patient Clothing	$ (108)	10	1
2	Collection Expense	(2,488)	21	2
3	Amortization	(123,349)	36	3
4	PAC Dues	(5,133)	20	4
5	Annual Report	(250)	20	5
6	Building Company - Amortization	(41,441)	36	6
7	Building Company - Management Fees	(6,150)	17	7
8	Building Company - Filing Fee	(250)	20	8
9	Building Company - Bank Service Charge	(277)	21	9
10	Non-Allowable Legal	(6,276)	19	10
11	Additional R&M	2,327	06	11
12	Other Income	(49)	21	12
13	Non-Allowable Expense	(1,914)	21	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(185,358)		49

STATE OF ILLINOIS

Wheaton Care Center

ID# 0039115

Report Period Beginning: 01/01/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	Total			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary			159		8,306							8,465	1
2	Food Purchase	(47)		342									295	2
3	Housekeeping			880		95							975	3
4	Laundry													4
5	Heat and Other Utilities			1,228		122							1,350	5
6	Maintenance	2,327		2,565	7,686	225							12,803	6
7	Other (specify):*				1,321	1,147							2,468	7
8	**TOTAL General Services**	2,280		5,174	9,007	9,895							26,356	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(108)				34,557	(1,252)		(150)				33,046	10
10a	Therapy													10a
11	Activities													11
12	Social Services					20,113							20,113	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					7,553							7,553	15
16	**TOTAL Health Care and Programs**	(108)				62,223	(1,252)		(150)				60,712	16
	C. General Administration													
17	Administrative	(6,150)	6,150	2,568	14,617	67,298							84,483	17
18	Directors Fees													18
19	Professional Services	(6,276)		(219,850)		(74,363)							(300,489)	19
20	Fees, Subscriptions & Promotions	(15,390)	250	833		955							(13,352)	20
21	Clerical & General Office Expenses	(127,645)	277	5,173	88,577	16,595							(17,023)	21
22	Employee Benefits & Payroll Taxes				(9,696)								(9,696)	22
23	Inservice Training & Education													23
24	Travel and Seminar			131		631							762	24
25	Other Admin. Staff Transportation			888									888	25
26	Insurance-Prop.Liab.Malpractice			1,537		526							2,063	26
27	Other (specify):*				22,368	11,247							33,615	27
28	**TOTAL General Administration**	(155,461)	6,677	(208,720)	115,866	22,889							(218,749)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(153,289)	6,677	(203,546)	124,873	95,007	(1,252)		(150)				(131,680)	29

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Capital Expense **D. Ownership**	**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)**	
30	Depreciation	**(10,137)**	**57,862**	**2,049**		**618**							**50,392**	**30**
31	Amortization of Pre-Op. & Org.													**31**
32	Interest	**(8,016)**		**7,440**		**178**							**(398)**	**32**
33	Real Estate Taxes		**(2,759)**	**3,584**		**387**							**1,212**	**33**
34	Rent-Facility & Grounds		**(480,000)**										**(480,000)**	**34**
35	Rent-Equipment & Vehicles			**839**									**839**	**35**
36	Other (specify):*	**(164,790)**	**41,441**										**(123,349)**	**36**
37	**TOTAL Ownership**	**(182,943)**	**(383,456)**	**13,912**		**1,183**							**(551,304)**	**37**
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													**38**
39	Ancillary Service Centers						**(6,389)**						**(6,389)**	**39**
40	Barber and Beauty Shops													**40**
41	Coffee and Gift Shops													**41**
42	Provider Participation Fee													**42**
43	Other (specify):*													**43**
44	**TOTAL Special Cost Centers**						**(6,389)**						**(6,389)**	**44**
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	**(336,232)**	**(376,779)**	**(189,634)**	**124,873**	**96,190**	**(7,641)**		**(150)**				**(689,373)**	**45**

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/16 Ending: 12/31/16

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. [X] 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		$	$ (480,000)	1
2	V	33	Rent - Property Tax	72,168	Wheaton HC Properties, LLC			(72,168)	2
3	V	32	Interest	150,383	Wheaton HC Properties, LLC		150,383		3
4	V	17	Management Fee		Wheaton HC Properties, LLC		6,150	6,150	4
5	V	21	Bank Charges		Wheaton HC Properties, LLC		277	277	5
6	V	20	Filing Fee		Wheaton HC Properties, LLC		250	250	6
7	V	30	Depreciation		Wheaton HC Properties, LLC		57,862	57,862	7
8	V	36	Amortization		Wheaton HC Properties, LLC		41,441	41,441	8
9	V	33	Real Estate Tax Expense		Wheaton HC Properties, LLC		69,409	69,409	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 702,551			$ 325,772	$ * (376,779)	14

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

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/16 Ending: 12/31/16

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. [X] 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%	$ 159	$ 159	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	342	342	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	880	880	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	1,228	1,228	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	2,565	2,565	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	2,568	2,568	20
21	V	19	Professional Fees	224,976	Extended Care Consulting, LLC	100.00%	5,126	(219,850)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	833	833	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	5,173	5,173	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	131	131	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	888	888	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	1,537	1,537	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	2,049	2,049	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	7,440	7,440	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	3,584	3,584	29
30	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	839	839	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			$ 35,342	$ * (189,634)	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: 01/01/16 Ending: 12/31/16

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. [X] 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%	7,686	$ 7,686	15
16	V	06	Maintenance (Direct)	6,957	Extended Care Consulting, LLC	100.00%	6,957		16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	720	720	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	601	601	18
19	V								19
20	V								20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	14,617	14,617	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	88,577	88,577	22
23	V	21	Office and Clerical (Direct)	25,363	Extended Care Consulting, LLC	100.00%	25,363		23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	18,874	18,874	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	3,494	3,494	25
26	V	22	Employee Benefits	9,696	Extended Care Consulting, LLC	100.00%		(9,696)	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			$ 42,016			$ 166,889	$ * 124,873	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: 01/01/16 Ending: 12/31/16

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. [X] 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%	$ 95	$ 95	15
16	V	05	Utilities		Extended Care Clinical, LLC	100.00%	122	122	16
17	V	06	Maintenance		Extended Care Clinical, LLC	100.00%	225	225	17
18	V	19	Professional Fees	74,988	Extended Care Clinical, LLC	100.00%	625	(74,363)	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	955	955	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC	100.00%	2,483	2,483	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC	100.00%	631	631	21
22	V	26	Insurance		Extended Care Clinical, LLC	100.00%	526	526	22
23	V	30	Depreciation		Extended Care Clinical, LLC	100.00%	618	618	23
24	V	32	Interest		Extended Care Clinical, LLC	100.00%	178	178	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC	100.00%	387	387	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC	100.00%	8,306	8,306	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	1,147	1,147	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC	100.00%	34,557	34,557	28
29	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%	20,113	20,113	29
30	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	7,553	7,553	30
31	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%	67,298	67,298	31
32	V	21	Office Salary		Extended Care Clinical, LLC	100.00%	14,112	14,112	32
33	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	11,247	11,247	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 74,988			$ 171,178	$ * 96,190	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: 01/01/16 Ending: 12/31/16

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. [X] 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	10	Nursing and Medical Records	$ 17,390	MAC Rx, LLC	100.00%	$ 16,137	$ (1,252)	15
16	V	21	Clerical & General Office Expenses		MAC Rx, LLC	100.00%			16
17	V	22	Employee Benefits		MAC Rx, LLC	100.00%			17
18	V	39	Ancillary	88,704	MAC Rx, LLC	100.00%	82,315	(6,389)	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			$ 106,094			$ 98,453	$ * (7,641)	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: 01/01/16 Ending: 12/31/16

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. [X] 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%	$ 244,709	$ 244,709	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	244,709	CCS Employee Benefits Group	100.00%		(244,709)	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			$ 244,709			$ 244,709	$ *	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: 01/01/16 Ending: 12/31/16

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. [X] 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	10	Various Equipment	2,580	Vent Lease LLC	100.00%	2,430	$ (150)	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			$ 2,580			$ 2,430	$ * (150)	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: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Wheaton Care Center # 0039115 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	4.07%	BEECHER MANOR NURSING AND REHABILITATION CENTER, LLC	BEECHER	Wheaton HC Properties, LLC		BUILDING COMPANY	1
2	DANIEL ROTHNER ACCUMULATION TRUST	4.07%	BRIAR PLACE LTD.	INDIAN HEAD PARK	EXTENDED CARE CONSULTING	EVANSTON	MGMT/BOOKKEEPING	2
3	ERIC ROTHNER	38.21%	CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	EXTENDED CARE CLINICAL	EVANSTON	CLINICAL	3
4	ILANA KLEIN REICH	0.81%	COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	CARE CENTERS BUILDING	EVANSTON	BUILDING COMPANY	4
5	JUDITH FREEMAN	1.63%	GRASMERE PLACE, LLC	CHICAGO	VENT LEASE LLC	EVANSTON	NURSING EQUIPMENT	5
6	KATHRYN VALES ACCUMULATION TRUST	4.07%	LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	6
7	KIMBERLY RICHMOND ACCUMULATION TRUST	4.07%	LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT	MAC RX	DES PLAINES	PHARMACY	7
8	MELISSA ROTHNER ACCUMULATION TRUST	4.07%	MAJOR HOSPITAL DYER	DYER, IN	RELIABLE MEDICAL SUPPLY	DES PLAINES	MEDICAL SUPPLIES	8
9	COOPER KLEIN	0.81%	MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN				9
10	NATHAN & SHIRLEY ROTHNER FAMILY TRUST	26.83%	MAJOR HOSPITAL LINCOLNSHIRE	MERRIVILLE, IN				10
11	NEAL ROTHNER	1.63%	MAJOR HOSPITAL MUNSTER	MUNSTER, IN				11
12	NWOS, INC.	1.63%	MAJOR HOSPITAL SEBOS	HOBART, IN				12
13	RACHEL ROTHNER ACCUMULATION TRUST	4.07%	MCKINLEY HEALTH CARE CENTER	CANTON, OH				13
14	WILLIAM ROTHNER ACCUMULATION TRUST	4.07%	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			SPRING CREEK NURSING & REHAB CENTER	JOLIET				21
22			ST. JAMES WELLNESS REHAB VILLAS	CRETE				22
23			THE ESTATES OF HYDE PARK	CHICAGO				23
24			THE PARC AT JOLIET	JOLIET				24
25			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				25
26			TRI-STATE NURSING & REHABILITATION CENTER, INC.	LANSING				26
27								27
28								28
29								29
30								30

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/16 Ending: 12/31/16

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: 01/01/16 Ending: 12/31/16

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	2	3	4	5	6		7		8	
					Compensation Received From Other	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	Adam Vales	Relative	Clerical	N/A	See Attached	1.24	3.10%	Alloc. Sal.	$ 2,280	22-07	1
2	Mark Steinberg	Relative	Administrative	N/A	See Attached	2.44	4.44%	Alloc Fee/Sal	8,825	17-07	2
3	Kimberly Rudolph	Relative	Clerical	N/A	See Attached	0.23	3.03%	Alloc. Sal.	71	21-07	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	$ 11,176		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: 01/01/16 Ending: 12/31/16

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 [X]

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

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

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

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 X 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,380,761	34	$ 5,206	$	42,208	$ 159	1
2	02	Food	Patient Days	1,380,761	34	11,203		42,208	342	2
3	03	Housekeeping	Patient Days	1,380,761	34	28,798		42,208	880	3
4	05	Utilities	Patient Days	1,380,761	34	40,168		42,208	1,228	4
5	06	Maintenance	Patient Days	1,380,761	34	83,922		42,208	2,565	5
6	17	Administrative	Patient Days	1,380,761	34	84,000		42,208	2,568	6
7	19	Professional Fees	Patient Days	1,380,761	34	167,697		42,208	5,126	7
8	20	Dues and Subscriptions	Patient Days	1,380,761	34	27,266		42,208	833	8
9	21	Office and Clerical	Patient Days	1,380,761	34	169,235		42,208	5,173	9
10	24	Seminar and Travel	Patient Days	1,380,761	34	4,279		42,208	131	10
11	25	Other Staff Admin. Trans.	Patient Days	1,380,761	34	29,053		42,208	888	11
12	26	Insurance	Patient Days	1,380,761	34	50,289		42,208	1,537	12
13	30	Depreciation	Patient Days	1,380,761	34	67,038		42,208	2,049	13
14	32	Interest	Patient Days	1,380,761	34	243,379		42,208	7,440	14
15	33	Real Estate Taxes	Patient Days	1,380,761	34	117,233		42,208	3,584	15
16	35	Rent - Equipment & Auto	Patient Days	1,380,761	34	27,451		42,208	839	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,156,218	$		$ 35,342	25

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	06	Maintenance (Pooled)	Patient Days	1,380,761	34	251,431	251,431	42,208	7,686	1
2	06	Maintenance (Direct)	Direct		20	373,682	373,682		6,957	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,380,761	34	23,565		42,208	720	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		20	46,748			601	4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,380,761	34	478,172	478,172	42,208	14,617	7
8	21	Office and Clerical (Pooled)	Patient Days	1,380,761	34	2,897,656	2,897,656	42,208	88,577	8
9	21	Office and Clerical (Direct)	Direct		24	460,382	460,382		25,363	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,380,761	34	617,434		42,208	18,874	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		24	73,413			3,494	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,222,483	$ 4,461,323		$ 166,889	25

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	03	Housekeeping	Patient Days	818,091	19	$ 1,844	$	42,208	$ 95	1
2	05	Utilities	Patient Days	818,091	19	2,355		42,208	122	2
3	06	Maintenance	Patient Days	818,091	19	4,352		42,208	225	3
4	19	Professional Fees	Patient Days	818,091	19	12,122		42,208	625	4
5	20	Dues and Subscriptions	Patient Days	818,091	19	18,512		42,208	955	5
6	21	Office & Clerical	Patient Days	818,091	19	48,124		42,208	2,483	6
7	24	Travel and Seminar	Patient Days	818,091	19	12,239		42,208	631	7
8	26	Insurance	Patient Days	818,091	19	10,196		42,208	526	8
9	30	Depreciation	Patient Days	818,091	19	11,978		42,208	618	9
10	32	Interest	Patient Days	818,091	19	3,446		42,208	178	10
11	33	Real Estate Taxes	Patient Days	818,091	19	7,506		42,208	387	11
12	01	Dietary Salary	Patient Days	818,091	19	160,997	160,997	42,208	8,306	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	818,091	19	22,241		42,208	1,147	13
14	10	Nursing Salary	Patient Days	818,091	19	669,803	669,803	42,208	34,557	14
15	12	Social Service Salary	Patient Days	818,091	19	389,842	389,842	42,208	20,113	15
16	15	Emp. Ben. - Healthcare	Patient Days	818,091	19	146,386		42,208	7,553	16
17	17	Administration Salary	Patient Days	818,091	19	1,304,395	1,304,395	42,208	67,298	17
18	21	Office Salary	Patient Days	818,091	19	273,525	273,525	42,208	14,112	18
19	27	Emp. Ben. - Gen. Admin.	Patient Days	818,091	19	217,984		42,208	11,247	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,317,844	$ 2,798,561		$ 171,178	25

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization: MAC Rx, LLC
Street Address: 2307 S. Mount Prospect Road
City / State / Zip Code: Des Plaines, IL 60018
Phone Number: (224)220-2700
Fax Number: (224)220-2730

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Nursing And Medical Records	Direct Allocation			$	$		$ 16,137	1
2	21	Clerical & General Office Expense	Direct Allocation							2
3	22	Employee Benefits	Direct Allocation							3
4	39	Ancillary	Direct Allocation						82,315	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					$	$		$ 98,453	25

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Employee Health Insurance	Direct Allocation			$	$		$ 244,709	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					$	$		$ 244,709	25

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 X NO

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Various Equipment	Direct Allocation						2,430	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					$	$		$ 2,430	25

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number: Wheaton Care Center # 0039115 Report Period Beginning: 01/01/16 Ending: 12/31/16

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Private Bank		X	Mortgage			$	$ 3,880,000			$ 150,383	1
2												2
3												3
4												4
5					-							5
	Working Capital											
6	Alloc from Extended Care Consulting		X								7,440	6
7	Alloc from Extended Care Clinical		X								178	7
8					-							8
9	TOTAL Facility Related						$	$ 3,880,000			$ 158,001	9
	B. Non-Facility Related*											
10	Interest Income		X								(8,016)	10
11	Interest		X								398	11
12	Interest Income - Bldg Co		X								(150,383)	12
13					-							13
14	TOTAL Non-Facility Related						$	$			$ (158,001)	14
15	TOTALS (line 9+line14)						$	$ 3,880,000			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ ____________ 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: 01/01/16 Ending: 12/31/16

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Item		Amount	Line
1. Real Estate Tax accrual used on 2015 report.	$	72,880	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.)	$	73,380	2
3. Under or (over) accrual (line 2 minus line 1).	$	500	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)	$	72,880	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	872	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ ____ For ____ Tax Year. **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	74,252	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Year	Amount	Line
	2011	57,597	8
	2012	63,385	9
	2013	65,054	10
	2014	66,782	11
	2015	69,409	12

2016 Accrual = $69,409 x 1.05= $72,880
Allocated from Extended Care Consulting LLC: $3,584
Allocated from Extended Care Clinical LLC: $387
*Beginning accrual adjusted

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

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.**

2015 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) 236-6300 FAX #: (847) 236-6301

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	05-17-114-010	Long Term Care Property	$ 69,409.22	$ 69,409.22
2.	See Attached	Alloc from Extended Care Consult	$ 167,518.13	$ 3,583.67
3.	See Attached	Alloc from Extended Care Clinical	$ 167,518.13	$ 387.27
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 404,445.48	$ 73,380.16

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2015 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2015 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) 236-6300 FAX #: (847) 236-6301

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

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

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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.

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/16 Ending: 12/31/16

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 33,417 B. General Construction Type: Exterior Brick Frame Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (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 [X] 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	Facility		2005	$ 828,181	1
2	Allocated from 2201 Main/Extended Care Clinical			19,438	2
3	TOTALS			$ 847,619	3

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	$ 57,862	39	$ 39,694	$ (18,168)	$ 458,113	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	41,331		20			41,331	9
10	Various			1994	104,965		20			104,935	10
11	Various			1995	16,968		20			16,961	11
12	Various			1996	158,287		20	3,777	3,777	158,274	12
13	Various			1997	103,690		20	5,184	5,184	101,553	13
14	Various			1998	56,873		20	2,844	2,844	52,252	14
15	Various			1999	21,286		20	1,064	1,064	18,666	15
16	Various			2000	57,068		20	2,292	2,292	45,159	16
17	Various			2001	48,282		20	2,297	2,297	38,844	17
18	Various			2002	15,745		20	198	198	15,712	18
19	Various			2003	18,300		20	169	169	17,401	19
20	Various			2004	134,063		20	1,161	1,161	130,884	20
21	Various			2005	38,153		20	533	533	33,595	21
22	Various			2006	95,583		20	3,944	3,944	86,470	22
23	Various			2007	76,180		20	4,801	4,801	74,053	23
24	Various			2008	31,780		20	3,051	3,051	26,056	24
25	Various			2009	9,024		20	272	272	8,230	25
26	Various			2010	6,642		20	664	664	4,041	26
27	Various			2011	68,352		20	5,637	5,637	31,518	27
28	Various			2012	133,305		20	13,331	13,331	63,364	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: 01/01/16 Ending: 12/31/16

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	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		92,280	1,286		1,286		92,177	68
69	Financial Statement Depreciation			75,276			(75,276)		69
70	TOTAL (lines 4 thru 69)		$ 2,876,236	$ 134,424		$ 92,198	$ (42,226)	$ 1,619,587	70

**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: 01/01/16 Ending: 12/31/16

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 12A, Carried Forward		$ 2,876,236	$ 134,424		$ 92,198	$ (42,226)	$ 1,619,587	1
2	New Grease Trap	2013	7,800		20	780	780	3,120	2
3	Flooring Installation	2013	3,890		20	389	389	1,556	3
4	Water Heater Code Violation Fix	2013	2,557		20	511	511	1,790	4
5	New Compressor	2013	13,954		20	1,395	1,395	4,651	5
6	Re-Do Parking Lot	2013	53,518		20	3,568	3,568	11,596	6
7	Door Repairs	2014	14,500		20	725	725	2,054	7
8	Sewer Work	2014	14,800		20	740	740	1,912	8
9	Compressor	2014	7,140		20	357	357	893	9
10	Sprinkler System	2014	9,293		20	465	465	1,084	10
11	Rooftop A/C Unit	2014	5,950		20	298	298	694	11
12	Elevator Work	2014	7,608		20	380	380	793	12
13	Passenger Elevator Repair	2014	5,711		20	286	286	714	13
14	Asphalt Repairs To Parking Lot	2014	13,336		20	667	667	1,611	14
15	Tear Off & Install 25 Sq Flat Roof	2015	9,050		20	453	453	830	15
16	Roofing And Flashing	2015	54,450		20	2,723	2,723	4,991	16
17	Reinsulate 2 Attic Areas	2015	13,500		20	675	675	1,069	17
18	Remote Air Cooled Chiller (30 Ton)	2015	36,000		20	1,800	1,800	2,850	18
19	Chimney Repair	2015	4,200		20	210	210	333	19
20	Replace 1200 Sf Vinyl Siding, All Soffit & All Fascia	2015	19,404		20	970	970	1,455	20
21	Gutters	2015	8,740		20	437	437	656	21
22	Emergency Generator System	2015	11,000		20	550	550	779	22
23	New Storm Sewer Line	2015	32,000		20	1,600	1,600	2,267	23
24	Plumbing And Sewers	2015	6,500		20	325	325	406	24
25	Radiator And Boiler	2015	7,053		20	353	353	382	25
26	Fiberglass Insulation	2016	4,218		20	211	211	211	26
27	Draft Vent System For Hot Water Tank	2016	2,600		20	33	33	33	27
28	Repairs To 78 Hvac Units	2016	2,920		20	12	12	12	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,247,928	$ 134,424		$ 113,109	$ (21,315)	$ 1,668,327	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: 01/01/16 Ending: 12/31/16

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 12B, Carried Forward		$ 3,247,928	$ 134,424		$ 113,109	$ (21,315)	$ 1,668,327	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)		$ 3,247,928	$ 134,424		$ 113,109	$ (21,315)	$ 1,668,327	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: 01/01/16 Ending: 12/31/16

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 12C, Carried Forward		$ 3,247,928	$ 134,424		$ 113,109	$ (21,315)	$ 1,668,327	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)		$ 3,247,928	$ 134,424		$ 113,109	$ (21,315)	$ 1,668,327	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: 01/01/16 Ending: 12/31/16

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 12D, Carried Forward		$ 3,247,928	$ 134,424		$ 113,109	$ (21,315)	$ 1,668,327	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)		$ 3,247,928	$ 134,424		$ 113,109	$ (21,315)	$ 1,668,327	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: 01/01/16 Ending: 12/31/16

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	Building Company		$	$		$	$	$	1
2									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: 01/01/16 Ending: 12/31/16

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 12F, Carried Forward		$	$		$	$	$	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)		$	$		$	$	$	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: 01/01/16 Ending: 12/31/16

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	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from Extended Care Clinical LLC	2002	2,612	67	20	67		957	3
4	Allocated from 2201 Main/Care Center Building LLC	2002	24,174	620	20	620		8,859	4
5	Allocated from Extended Care Consulting LLC	2007	7,336	163	20	163		1,544	5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Extended Care Consulting LLC	2007	141	7	20	7		70	9
10	Allocated from Extended Care Consulting LLC	2009	84	4	20	4		34	10
11	Allocated from Extended Care Consulting LLC	2010	825	41	20	41		289	11
12	Allocated from Extended Care Consulting LLC	2011	297	15	20	15		89	12
13	Allocated from Extended Care Consulting LLC	2012	98	5	20	5		24	13
14	Allocated from Extended Care Consulting LLC	2014	1,356	68	20	68		203	14
15	Allocated from Extended Care Consulting LLC	2016	1,626	81	20	81		81	15
16									16
17	Allocated from Extended Care Clinical LLC	2002	2,158		20			2,158	17
18	Allocated from Extended Care Clinical LLC	2003	2,543		20			2,543	18
19	Allocated from Extended Care Clinical LLC	2005	126		20			126	19
20	Allocated from Extended Care Clinical LLC	2009	23	1	20	1		9	20
21	Allocated from Extended Care Clinical LLC	2014	212	11	20	11		32	21
22	Allocated from Extended Care Clinical LLC	2015	36	2	20	2		4	22
23	Allocated from Extended Care Clinical LLC	2016	142	7	20	7		7	23
24									24
25	Allocated from 2201 Main/Care Center Building LLC	2002	19,969		20			19,969	25
26	Allocated from 2201 Main/Care Center Building LLC	2003	23,533		20			53,533	26
27	Allocated from 2201 Main/Care Center Building LLC	2005	1,169	2	20	2		1,169	27
28	Allocated from 2201 Main/Care Center Building LLC	2009	211	11	20	11		84	28
29	Allocated from 2201 Main/Care Center Building LLC	2014	1,962	98	20	98		294	29
30	Allocated from 2201 Main/Care Center Building LLC	2015	333	17	20	17		33	30
31	Allocated from 2201 Main/Care Center Building LLC	2016	1,314	66	20	66		66	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 92,280	$ 1,286		$ 1,286	$	$ 92,177	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: 01/01/16 Ending: 12/31/16

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 12H, Carried Forward		$ 92,280	$ 1,286		$ 1,286	$	$ 92,177	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)		$ 92,280	$ 1,286		$ 1,286	$	$ 92,177	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: 01/01/16 Ending: 12/31/16

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	$ 174,455	$ 697	$ 11,875	$ 11,178	10	$ 145,025	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	696,067				10	696,067	73
74								74
75	TOTALS	$ 870,522	$ 697	$ 11,875	$ 11,178		$ 841,092	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(	2015	5,517	156	156		5	5,205	77
78		Allocated from Extended Care Cl	2012	2,651	530	530		5	2,374	78
79										79
80	TOTALS			$ 28,162	$ 686	$ 686	$		$ 27,573	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)	$ 4,994,231	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 135,807	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 125,670	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (10,137)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,536,992	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

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: *

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.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 3,966 Description: See Attached Schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

XIII. EXPENSES RELATING TO 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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 126,293	$		$ 126,293	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			47,392			47,392	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			201,279			201,279	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				90,804		90,804	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					3,037	15,621		18,658	13
14	TOTAL			$		$ 378,001	$ 106,425		$ 484,426	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 # 0039115 Report Period Beginning: 01/01/16 Ending: 12/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/16 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 4,410	$ 155,603	1
2	Cash-Patient Deposits	27,848	27,848	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	404,835	404,835	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	39,068	39,068	6
7	Other Prepaid Expenses	5,674	5,674	7
8	Accounts Receivable (owners or related parties)		3,880,000	8
9	Other(specify): See Attached Schedule	1,220,233	1,221,233	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,702,068	$ 5,734,261	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,464,135	13
14	Buildings, at Historical Cost		1,496,317	14
15	Leasehold Improvements, at Historical Cost	1,511,778	1,563,539	15
16	Equipment, at Historical Cost	509,874	841,146	16
17	Accumulated Depreciation (book methods)	(1,604,412)	(2,593,292)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	984,856	1,007,200	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,402,096	$ 3,779,045	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,104,164	$ 9,513,306	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,801,524	$ 568,630	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	23,718	23,718	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	146,858	146,858	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,110	5,110	31
32	Accrued Real Estate Taxes(Sch.IX-B)	72,880	72,880	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	1,993	24,112	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,052,083	$ 841,308	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,880,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 3,880,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,052,083	$ 4,721,308	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,052,081	$ 4,791,998	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,104,164	$ 9,513,306	48

*(See instructions.)

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/16 Ending: 12/31/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 758,587	1
2	Restatements (describe):		2
3	Repairs & Maintenance	(2,404)	3
4	Goodwill Amortization	(122,847)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 633,336	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	418,745	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 418,745	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,052,081	24 *

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

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,442,106	1
2	Discounts and Allowances for all Levels	(1,305,996)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,136,110	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,276,455	6
7	Oxygen	326	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,276,781	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	93,482	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	26,536	19
20	Radiology and X-Ray	1,410	20
21	Other Medical Services	36,821	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 158,249	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	17,273	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 17,273	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Supplemental Schedule	49	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 49	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,588,462	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,306,327	31
32	Health Care	2,769,778	32
33	General Administration	1,544,457	33
	B. Capital Expense		
34	Ownership	754,318	34
	C. Ancillary Expense		
35	Special Cost Centers	484,426	35
36	Provider Participation Fee	310,411	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,169,717	40
41	**Income before Income Taxes (line 30 minus line 40)****	418,745	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 418,745	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,719,975	44
45	Private Pay - Net Inpatient Revenue	178,360	45
46	Medicare - Net Inpatient Revenue	150,232	46
47	Other-(specify) Hospice	87,603	47
48	Other-(specify) Insurance	(60)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,136,110	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: 01/01/16 Ending: 12/31/16

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,958	2,392	$ 106,650	$ 44.58	1
2	Assistant Director of Nursing	1,826	2,149	75,561	35.16	2
3	Registered Nurses	8,890	9,660	331,577	34.32	3
4	Licensed Practical Nurses	23,148	25,120	652,118	25.96	4
5	CNAs & Orderlies	48,550	52,136	706,084	13.54	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,960	7,241	151,668	20.95	8
9	Activity Director	1,834	2,104	36,308	17.26	9
10	Activity Assistants	7,131	7,600	78,961	10.39	10
11	Social Service Workers	11,780	12,760	271,712	21.29	11
12	Dietician					12
13	Food Service Supervisor	2,973	3,206	75,778	23.64	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,473	20,058	216,631	10.80	15
16	Dishwashers					16
17	Maintenance Workers	5,021	5,294	101,703	19.21	17
18	Housekeepers	13,389	14,487	160,068	11.05	18
19	Laundry	6,114	6,957	72,682	10.45	19
20	Administrator	1,918	2,065	96,548	46.76	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,784	8,375	109,121	13.03	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	1,801	2,034	36,171	17.78	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	169,550	183,637	$ 3,279,341 *	$ 17.86	34

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

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	103	$ 4,983	01-03	35
36	Medical Director	Monthly	20,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	10,234	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	Dental	9	871	10-03	47
48					48
49	TOTAL (lines 35 - 48)	112	$ 36,088		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	28	$ 911	10-03	50
51	Licensed Practical Nurses	95	4,641	10-03	51
52	Certified Nurse Assistants/Aides	3,866	93,142	10-03	52
53	TOTAL (lines 50 - 52)	3,989	$ 98,694		53

Facility Name & ID Number: Wheaton Care Center # 0039115 Report Period Beginning: 01/01/16 Ending: 12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
David Taylor	Administrator		$ 96,548
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 96,548

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Paycor Payroll Services	Data Processing	$ 18,588
E-Health Data Solutions	MDS Software/Data Processing	1,590
Reimb Achieve	Data Processing	15,038
Ability Network	Medicare Billing	1,275
National Datacare Corporation	Resident Fund Processing	2,555
ECC Consulting	Home Office Expenses	224,976
ECC Clinical	Home Office Expenses	74,988
Marcum LLP	Accounting	27,026
Personnel Planners, Inc	Unemployment Tax	660
Pinnacle Quality Insight	Customer Satisfaction	2,813
See Supplemental Schedule		29,336
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 398,843

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 98,007
Unemployment Compensation Insurance	28,782
FICA Taxes	240,256
Employee Health Insurance	161,100
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	442
Other Employee Welfare	6,738
Union Dues	473
TOTAL (agree to Schedule V, line 22, col.8)	$ 535,798

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	20,149
Health Care Worker Background Check (Indicate # of checks performed 226.5)	2,265
Patient Background Checks	
License and Permits	1,703
Dues and Subscriptions	17,337
Alloc from Extended Care Consulting	833
Alloc from Extended Care Clinical	955
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 45,233

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	498
Alloc from Extended Care Consulting	131
Alloc from Extended Care Clinical	631
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,260

**See instructions.

Facility Name & ID Number **Wheaton Care Center** **#** **0039115** **Report Period Beginning:** **01/01/16** **Ending:** **12/31/16**

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. **ICLTC $15,553.40**

(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. $ **47,850** 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. $ **310,411**
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. $ ____ 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 1**
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