FOR BHF USE

LL1

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.

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

I. IDPH License ID Number: 0029975

Facility Name: Wilson Care Inc.

Address: 4544 N. Hazel Street (Number) Chicago (City) 60640 (Zip Code)

County: Cook

Telephone Number: (773) 561-7241 **Fax #** (773) 728-2606

HFS ID Number:

Date of Initial License for Current Owners: 09/01/85

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/11 to 12/31/11 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)
(Print Name and Title) Cary Drazner, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	198	Intermediate (ICF)	198	72,270	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	198	TOTALS	198	72,270	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	64,582	1,141		65,723	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	64,582	1,141		65,723	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.94%

D. How many bed-hold days during this year were paid by the Department?
2,195 (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 09/01/88

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 08/31/85 NO [ ]

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/11 Fiscal Year: 12/31/11

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	220,689	29,682	35,076	285,447		285,447	(16,587)	268,860			1
2	Food Purchase		279,910		279,910	(21,353)	258,558	(48)	258,509			2
3	Housekeeping	199,408	42,974		242,382		242,382	(1,534)	240,848			3
4	Laundry		16,981	8,114	25,095		25,095	10,936	36,031			4
5	Heat and Other Utilities			127,447	127,447		127,447	(1,945)	125,502			5
6	Maintenance	48,938	51,767	156,911	257,616		257,616	(773)	256,843			6
7	Other (specify):*							7,554	7,554			7
8	**TOTAL General Services**	469,035	421,314	327,548	1,217,897	(21,353)	1,196,545	(2,398)	1,194,146			8
	B. Health Care and Programs											
9	Medical Director			11,200	11,200		11,200		11,200			9
10	Nursing and Medical Records	1,224,118	36,705	76,906	1,337,729		1,337,729	(26,424)	1,311,305			10
10a	Therapy			23,760	23,760		23,760	(14,495)	9,265			10a
11	Activities	140,587	6,611	2,410	149,608		149,608		149,608			11
12	Social Services	364,905	13,441		378,346		378,346		378,346			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							5,482	5,482			15
16	**TOTAL Health Care and Programs**	1,729,610	56,757	114,276	1,900,643		1,900,643	(35,438)	1,865,205			16
	C. General Administration											
17	Administrative	137,309		311,040	448,349		448,349	(112,642)	335,707			17
18	Directors Fees											18
19	Professional Services			177,055	177,055	(1,122)	175,933	(120,974)	54,959			19
20	Dues, Fees, Subscriptions & Promotions			57,267	57,267		57,267	(40,148)	17,119			20
21	Clerical & General Office Expenses	202,043	20,285	158,616	380,944		380,944	20,975	401,919			21
22	Employee Benefits & Payroll Taxes			444,380	444,380	21,353	465,733		465,733			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,646	1,646		1,646	60	1,706			24
25	Other Admin. Staff Transportation			5,341	5,341		5,341	9,398	14,739			25
26	Insurance-Prop.Liab.Malpractice			130,250	130,250		130,250	13,257	143,507			26
27	Other (specify):*							41,874	41,874			27
28	**TOTAL General Administration**	339,352	20,285	1,285,595	1,645,232	20,231	1,665,463	(188,200)	1,477,263			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,537,997	498,356	1,727,419	4,763,772	(1,122)	4,762,650	(226,036)	4,536,614			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Wilson Care Inc. #0029975 Report Period Beginning: 01/01/11 Ending: 12/31/11

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			58,673	58,673		58,673	190,350	249,023			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			13,208	13,208		13,208	937,989	951,197			32
33	Real Estate Taxes					1,122	1,122	240,009	241,131			33
34	Rent-Facility & Grounds			1,558,000	1,558,000		1,558,000	(1,558,000)				34
35	Rent-Equipment & Vehicles			6,442	6,442		6,442	6,840	13,282			35
36	Other (specify):*							104,028	104,028			36
37	**TOTAL Ownership**			1,636,323	1,636,323	1,122	1,637,445	(78,784)	1,558,661			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			108,405	108,405		108,405		108,405			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			108,405	108,405		108,405		108,405			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,537,997	498,356	3,472,147	6,508,500		6,508,500	(304,820)	6,203,680			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 Reference	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	(4,486)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	85,784	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(48)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(9,950)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(54,236)	21		24
25	Fund Raising, Advertising and Promotional	(5,800)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(15,952)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(52,313)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (57,002)		$	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)	(247,819)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (247,819)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (304,820)		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

SEE ACCOUNTANTS' COMPILATION REPORT

Wilson Care Inc.

ID# 0029975

Report Period Beginning: 01/01/11

Ending: 12/31/11

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Office Expense - Bank Fees	$ (5,942)	21	1
2	Theft & Damage	(866)	21	2
3	Alliance for Living - PAC Dues	(15,290)	20	3
4	Annual Report	(250)	20	4
5	Collections	(2,595)	21	5
6	Capitalized R&M	(7,900)	06	6
7	Non-Allowable Legal	(1,615)	19	7
8	Filing Fees - Building Co.	(350)	20	8
9	Office Expense - Building Co.	(5)	21	9
10	Professional Expense - Building Co.	(7,500)	19	10
11	IDPH Fine	(10,000)	20	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(52,313)		49

Wilson Care Inc.

ID# 0029975

Report Period Beginning: 01/01/11

Ending: 12/31/11

	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				49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Wilson Care Inc. # 0029975 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary				(16,587)								(16,587)	1
2	Food Purchase	(48)											(48)	2
3	Housekeeping					(1,534)							(1,534)	3
4	Laundry		10,946			(10)							10,936	4
5	Heat and Other Utilities	(4,486)			2,541								(1,945)	5
6	Maintenance	(7,900)	21,247	(13,323)	(797)								(773)	6
7	Other (specify):*			829	6,725								7,554	7
8	**TOTAL General Services**	(12,434)	32,193	(12,494)	(8,119)	(1,545)							(2,398)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			(32,240)	7,461	(1,645)							(26,424)	10
10a	Therapy				(14,495)								(14,495)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			2,625	2,857								5,482	15
16	**TOTAL Health Care and Programs**			(29,615)	(4,177)	(1,645)							(35,438)	16
	C. General Administration													
17	Administrative			(188,883)	76,241								(112,642)	17
18	Directors Fees													18
19	Professional Services	(9,115)	7,500	(135,167)	15,808								(120,974)	19
20	Fees, Subscriptions & Promotions	(41,640)	350	1,142									(40,148)	20
21	Clerical & General Office Expenses	(79,596)	5	100,495	71								20,975	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			60									60	24
25	Other Admin. Staff Transportation			9,398									9,398	25
26	Insurance-Prop.Liab.Malpractice		11,718	1,419	120								13,257	26
27	Other (specify):*			24,659	17,215								41,874	27
28	**TOTAL General Administration**	(130,351)	19,573	(186,877)	109,455								(188,200)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(142,785)	51,766	(228,986)	97,159	(3,190)							(226,036)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Wilson Care Inc. # 0029975 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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	85,784	96,450		8,116								190,350	30
31	Amortization of Pre-Op. & Org.													31
32	Interest		939,579	(8,588)	6,998								937,989	32
33	Real Estate Taxes		233,625		6,384								240,009	33
34	Rent-Facility & Grounds		(1,558,000)										(1,558,000)	34
35	Rent-Equipment & Vehicles			6,840									6,840	35
36	Other (specify):*		104,028										104,028	36
37	**TOTAL Ownership**	85,784	(184,318)	(1,748)	21,498								(78,784)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													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**													44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(57,002)	(132,552)	(230,734)	118,657	(3,190)							(304,820)	45

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 6-Supplemental		See 6-Supplemental		See 6-Supplemental		

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent-Base	$ 1,558,000	Wilson Care, LLC	100.00%	$	$ (1,558,000)	1
2	V	36	Amortization		Wilson Care, LLC	100.00%	6,057	6,057	2
3	V	06	Building Repairs & Maint.		Wilson Care, LLC	100.00%	21,247	21,247	3
4	V	30	Depreciation		Wilson Care, LLC	100.00%	96,450	96,450	4
5	V	20	Filing Fees		Wilson Care, LLC	100.00%	350	350	5
6	V	32	Interest	941	Wilson Care, LLC	100.00%	940,520	939,579	6
7	V	04	Linen Replacement		Wilson Care, LLC	100.00%	10,946	10,946	7
8	V	36	Mortgage Insurance		Wilson Care, LLC	100.00%	97,971	97,971	8
9	V	21	Office Expense		Wilson Care, LLC	100.00%	5	5	9
10	V	19	Professional Fees		Wilson Care, LLC	100.00%	7,500	7,500	10
11	V	26	Property Insurance		Wilson Care, LLC	100.00%	11,718	11,718	11
12	V	33	Real Estate Taxes	1,375	Wilson Care, LLC	100.00%	235,000	233,625	12
13	V								13
14	Total			$ 1,560,316			$ 1,427,764	$ * (132,552)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	REPAIRS AND MAINT.	$ 23,760	S.I.R. MANAGEMENT, INC.	100.00%	$ 10,437	$ (13,323)	15
16	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	829	829	16
17	V	10	NURSING	47,520	S.I.R. MANAGEMENT, INC.	100.00%	15,280	(32,240)	17
18	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	2,625	2,625	18
19	V	19	PROFESSIONAL FEES	147,672	S.I.R. MANAGEMENT, INC.	100.00%	12,505	(135,167)	19
20	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	1,142	1,142	20
21	V	21	CLERICAL & GENERAL	47,520	S.I.R. MANAGEMENT, INC.	100.00%	51,414	3,894	21
22	V	24	EDUCATION & SEMINAR	622	S.I.R. MANAGEMENT, INC.	100.00%	682	60	22
23	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	9,398	9,398	23
24	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	1,419	1,419	24
25	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	4,508	4,508	25
26	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(8,588)	(8,588)	26
27	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	6,840	6,840	27
28	V								28
29	V	17	ADMINISTRATIVE	215,040	S.I.R. MANAGEMENT, INC.	100.00%	26,157	(188,883)	29
30	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	1,879		30
31	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	96,601	96,601	31
32	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	20,151	20,151	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 482,134			$ 253,279	$ * (230,734)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SALARIES	$ 23,760	S.I.R. MANAGEMENT, INC.	100.00%	$ 7,173	$ (16,587)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	1,247	1,247	16
17	V	10	NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	7,461	7,461	17
18	V	15	EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	1,292	1,292	18
19	V	17	ADMIN./LEGAL SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	76,241	76,241	19
20	V	19	FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	14,831	14,831	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	17,215	17,215	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	23,760	S.I.R. MANAGEMENT, INC.	100.00%	9,265	(14,495)	24
25	V	15	EMPLOYEE BENFITS		S.I.R. MANAGEMENT, INC.	100.00%	1,565	1,565	25
26	V								26
27	V	6	MAINTENANCE SALARIES	29,164	S.I.R. MANAGEMENT, INC.	100.00%	27,327	(1,837)	27
28	V	7	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	5,478	5,478	28
29	V								29
30	V	5	UTILITIES		S.I.R. MANAGEMENT, INC.	100.00%	2,541	2,541	30
31	V	6	REPAIRS AND MAINT.		S.I.R. MANAGEMENT, INC.	100.00%	1,040	1,040	31
32	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	55	55	32
33	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	71	71	33
34	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	120	120	34
35	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	8,116	8,116	35
36	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	6,998	6,998	36
37	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	6,384	6,384	37
38	V	19	PROFESSIONAL FEES (RE TAX)		S.I.R. MANAGEMENT, INC.	100.00%	922	922	38
39	Total			$ 76,684			$ 195,341	$ * 118,657	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Xcel Supply, LLC	100.00%	$	$	15
16	V	3	Housekeeping	25,305	Xcel Supply, LLC	100.00%	23,771	(1,534)	16
17	V	4	Laundry	172	Xcel Supply, LLC	100.00%	162	(10)	17
18	V	6	Repairs & Maintenance		Xcel Supply, LLC	100.00%			18
19	V	10	Nursing	27,138	Xcel Supply, LLC	100.00%	25,493	(1,645)	19
20	V	11	Activities		Xcel Supply, LLC	100.00%			20
21	V	21	Office And Clerical		Xcel Supply, LLC	100.00%			21
22	V	22	Employee Benefits		Xcel Supply, LLC	100.00%			22
23	V	30	Fixed Assets-Depreciation		Xcel Supply, LLC	100.00%			23
24	V	39	Ancillary		Xcel Supply, LLC	100.00%			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			$ 52,615			$ 49,426	$ * (3,190)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Health Insurance	$	CCS Employee Benefits Group	100.00%	$ 119,820	$ 119,820	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	119,820	CCS Employee Benefits Group	100.00%		(119,820)	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			$ 119,820			$ 119,820	$ *	39

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

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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 Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	ARI WOLFF	2.222%	ALBANY CARE INC	EVANSTON	WILSON CARE, LLC	LINCOLNWOOD	BUILDING CO.	1
2	ASHLEY BARRISH	0.278%	BRYN MAWR CARE INC.	CHICAGO	SIR MANAGEMENT	LINCOLNWOOD	MANAGEMENT CO.	2
3	B. BART BARRISH	0.278%	COLUMBUS PARK NURSING & REHABILITATION CENTER, INC.	CHICAGO	SIR PROPERTIES	LINCOLNWOOD	BUILDING CO.	3
4	BETH ALTER	5.556%	DECATUR MANOR HEALTHCARE,LLC	DECATUR	XCEL MEDICAL SUPPLY, LLC	EVANSTON	SUPPLIES	4
5	BRYAN BARRISH TRUST DTD 09/01/04	11.111%	ELMWOOD CARE, INC.	ELMWOOD PARK	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	5
6	CHERYL MAGENCE	4.722%	FAIRVIEW NURSING PLAZA, INC.	ROCKFORD				6
7	DANIEL ROTHNER	0.972%	GREENWOOD CARE, INC.	EVANSTON				7
8	DARCEY BARRISH	0.278%	MAPLEWOOD CARE, INC.	ELGIN				8
9	ERIC ROTHNER	20.000%	NEIGHBORS REHABILITATION CENTER,LLC	BYRON				9
10	HOWARD GELLER	4.444%	REGENCY REHABILITATION CENTER,LLC	NILES				10
11	JESSE REYNOLDS DESCENDANTS TRUST	0.556%	ROCK ISLAND NURSING & REHAB CENTER,LLC	ROCK ISLAND				11
12	KIRSTEN BARRISH	0.278%	APPLEWOOD REHABILITATION CENTER	MATTESON				12
13	LAURI WOLFF POLEN	2.222%						13
14	LINDA VARDI	1.111%						14
15	MARC GELLER	5.556%						15
16	MARILYN WOLFF	5.556%						16
17	MARK STEINBERG	2.500%						17
18	MAYER MAGENCE	4.722%						18
19	MELISSA ROTHNER	0.972%						19
20	NOAH WOLFF	5.556%						20
21	RACHEL ROTHNER	0.972%						21
22	RANAN WOLFF	2.222%						22
23	RITA GELLER	5.000%						23
24	SANDRA KLIERS	1.111%						24
25	SARAH BARRISH	0.556%						25
26	SHIRLEY DRELICH	2.500%						26
27	STEVEN GELLER	5.556%						27
28	TZIONA ZEFFREN	2.222%						28
29	WILLIAM ROTHNER	0.972%						29
30								30

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	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 Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Owner	Administrative	20.00	See Attached	0.47	1.01%	Alloc. Salary	$ 10,695	17-7	1
2	Bryan Barrish	Owner	Administrative	11.11	See Attached	3.14	6.98%	Alloc. Salary	15,694	17-7	2
3	Nenita Guzman	Relative	Dietary	N/A	See Attached	3.92	7.84%	Alloc. Salary	7,173	1-7	3
4	Sarah Barrish	Owner	Administrative	0.56	See Attached	3.92	7.84%	Alloc. Salary	9,396	17-7	4
5	Kirsten Barrish	Owner	Clerical	0.28	See Attached	3.14	7.85%	Alloc. Salary	3,533	21-7	5
6	Adam Vales	Relative	Clerical	N/A	See Attached	0.71	1.78%	Alloc. Salary	1,267	22-7	6
7	G. Matt Silvers	Relative	Administrative	N/A	See Attached	0.17	0.43%	Alloc. Salary	660	17-7	7
8	Howard Geller	Owner	Administrative	4.44	See Attached	8.00	16.00%	Consult. Fee	48,000	17-3	8
9	Noah Wolff	Owner	Administrative	5.56	See Attached	3.00	15.00%	Consult. Fee	48,000	17-3	9
10	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only amounts										10
11	anticipated to be considered allowable by the Il. Dept of HFS.										11
12											12
13								TOTAL	$ 144,418		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 Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/11 Ending: 12/31/11

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]

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 Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/11 Ending: 12/31/11

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: S.I.R. MANAGEMENT, INC.
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 675 -7979
Fax Number: (847) 675 -0555

	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	6	REPAIRS AND MAINT.	PATIENT DAYS	837,569	13	$ 133,007	$ 59,965	65,723	$ 10,437	1
2	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	837,569	13	10,563		65,723	829	2
3	10	NURSING	PATIENT DAYS	837,569	13	194,733	194,733	65,723	15,280	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	837,569	13	33,459		65,723	2,625	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	837,569	13	159,360	132,109	65,723	12,505	5
6	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	837,569	13	14,549		65,723	1,142	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	837,569	13	655,215	586,698	65,723	51,414	7
8	24	EDUCATION & SEMINAR	PATIENT DAYS	837,569	13	8,688		65,723	682	8
9	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	837,569	13	119,765		65,723	9,398	9
10	26	INSURANCE	PATIENT DAYS	837,569	13	18,080		65,723	1,419	10
11	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	837,569	13	57,453		65,723	4,508	11
12	32	INTEREST	PATIENT DAYS	837,569	13	(109,444)		65,723	(8,588)	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	837,569	13	87,163		65,723	6,840	13
14										14
15	17	ADMINISTRATIVE	PATIENT DAYS	837,569	13	333,346	333,346	65,723	26,157	15
16	19	PROFESSIONAL FEES	PATIENT DAYS	837,569	13	23,941		65,723	1,879	16
17	21	CLERICAL & GENERAL	PATIENT DAYS	837,569	13	1,231,079	1,128,775	65,723	96,601	17
18	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	837,569	13	256,807		65,723	20,151	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,227,764	$ 2,435,627		$ 253,279	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/11 Ending: 12/31/11

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: S.I.R. MANAGEMENT, INC.
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 675 -7979
Fax Number: (847) 675 -0555

	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	DIETARY SALARIES	PATIENT DAYS	837,569	13	$ 91,408	$ 91,408	65,723	$ 7,173	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	837,569	13	15,892		65,723	1,247	2
3	10	NURSING SALARIES	PATIENT DAYS	837,569	13	95,082	95,082	65,723	7,461	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	837,569	13	16,460		65,723	1,292	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	837,569	13	971,606	971,606	65,723	76,241	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	837,569	13	189,000		65,723	14,831	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	837,569	13	219,385		65,723	17,215	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	315,820	13	123,146	123,146	23,760	9,265	10
11	15	EMPLOYEE BENFITS	SPECIAL REHAB INC.	315,820	13	20,802		23,760	1,565	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	367,402	13	344,256	344,256	29,164	27,327	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	367,402	13	69,007		29,164	5,478	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,880	13	32,378		1,011	2,541	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,880	13	13,246		1,011	1,040	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,880	13	705		1,011	55	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,880	13	899		1,011	71	19
20	26	INSURANCE	ALLOCATED SQ FT	12,880	13	1,527		1,011	120	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,880	13	103,394		1,011	8,116	21
22	32	INTEREST	ALLOCATED SQ FT	12,880	13	89,152		1,011	6,998	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,880	13	81,334		1,011	6,384	23
24	19	PROFESSIONAL FEES (RE TAX	ALLOCATED SQ FT	12,880	13	11,747		1,011	922	24
25	TOTALS					$ 2,490,426	$ 1,625,498		$ 195,341	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

	1 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	Dietary	Direct Allocation			$	$		$	1
2	3	Housekeeping	Direct Allocation						23,771	2
3	4	Laundry	Direct Allocation						162	3
4	6	Repairs & Maintenance	Direct Allocation							4
5	10	Nursing	Direct Allocation						25,493	5
6	11	Activities	Direct Allocation							6
7	21	Office And Clerical	Direct Allocation							7
8	22	Employee Benefits	Direct Allocation							8
9	30	Fixed Assets-Depreciation	Direct Allocation							9
10	39	Ancillary	Direct Allocation							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					$	$		$ 49,426	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/11 Ending: 12/31/11

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			$	$		$ 119,820	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					$	$		$ 119,820	25

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/11 Ending: 12/31/11

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Private Bank		X	Mortgage Payable			$	$ 19,484,996			$ 940,520	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Lake Forest Bank & Trust		X	Line of Credit				700,000			13,208	6
7	Alloc. - SIR Management										6,998	7
8	See Supplemental Schedule											8
9	TOTAL Facility Related						$	$ 20,184,996			$ 960,726	9
	B. Non-Facility Related*											
10	Interest Income - Bldg Co.		X								(941)	10
11	Alloc. - SIR Management										(8,588)	11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (9,529)	14
15	TOTALS (line 9+line14)						$	$ 20,184,996			$ 951,197	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$ 97,971** **Line # 36**

*** 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 Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/11 Ending: 12/31/11

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	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 Wilson Care Inc. # 0029975 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 225,000	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.)		$ 230,009	2
3. Under or (over) accrual (line 2 minus line 1).		$ 5,009	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 235,000	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.**		$ 1,122	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.		$ 241,131	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	169,658	8
	2007	169,130	9
	2008	171,205	10
	2009	214,301	11
	2010	223,625	12

Accrual = $223,625 x 1.05 = $235000

Alloc. - SIR Management = $6,384

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Wilson Care Inc. COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0029975

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-17-220-009-0000	Long Term Care Property	$ 223,625.32	$ 223,625.32
2.	See Attached	See Attached	$ 98,193.53	$ 6,036.24
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 321,818.85	$ 229,661.56

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Wilson Care Inc. COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0029975

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

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

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) 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 & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

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

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/11 Ending: 12/31/11

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 42,020 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 5

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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1985	$ 25,200	1
2					2
3	TOTALS			$ 25,200	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	198			1967	$ 1,539,800	$ 96,450	35	$ 43,994	$ (52,456)	$ 1,723,228	4
5				2011	185,400		35	9,270	9,270	9,270	5
6				2011	3,392		35	170	170	170	6
7											7
8											8
	Improvement Type**										
9	Various			1985	65,366		20			65,340	9
10	Various			1986	161,365		20			161,346	10
11	Various			1987	49,380		20			49,349	11
12	Various			1989	49,210		20			49,196	12
13	Various			1990	105,470		20			105,271	13
14	Various			1991	29,903		20	647	647	29,891	14
15	Various			1992	69,669		20	3,483	3,483	68,128	15
16	Various			1993	61,688		20	3,084	3,084	57,038	16
17	Various			1994	55,691		20	2,653	2,653	48,845	17
18	Various			1995	87,144		20	4,357	4,357	71,911	18
19	Various			1996	303,393		20	15,170	15,170	234,192	19
20	Various			1997	145,411		20	7,347	7,347	101,182	20
21	Various			1998	34,959		20	1,748	1,748	23,682	21
22	Various			1999	53,478		20	2,674	2,674	33,623	22
23	Various			2000	342,218		20	17,111	17,111	193,375	23
24	Various			2001	102,633		20	5,132	5,132	54,724	24
25	Various			2002	67,986		20	4,957	4,957	64,987	25
26	Various			2003	97,187		20	6,025	6,025	50,583	26
27	Various			2004	62,333		20	4,333	4,333	32,527	27
28	Various			2005	214,966		20	13,469	13,469	88,153	28
29	Various			2006	56,219		20	2,958	2,958	15,984	29
30	Various			2007	362,270		20	19,637	19,637	87,043	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 Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/11 Ending: 12/31/11

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)		1,015,269			51,885	51,885	153,095	67
68	Related Party Allocations (Pages 12H & 12I)		129,291	3,695		4,279	584	61,844	68
69	Financial Statement Depreciation			58,673			(58,673)		69
70	TOTAL (lines 4 thru 69)		$ 5,451,091	$ 158,818		$ 224,385	$ 65,567	$ 3,633,974	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 12A, Carried Forward		$ 5,451,091	$ 158,818		$ 224,385	$ 65,567	$ 3,633,974	1
2	Landscaping - Trees. Bush	2008	5,185		20	259	259	864	2
3	Elevator Cables	2008	3,925		20	196	196	720	3
4	Heat Repair	2008	3,069		20	153	153	601	4
5	Chiller Repair	2008	3,196		20	160	160	586	5
6	Electrical Work	2008	3,013		20	151	151	527	6
7	Mixing Valves	2008	3,050		20	153	153	470	7
8	Heating System	2008	8,136		20	407	407	1,593	8
9	Sir Management	2009			20				9
10	Boiler Work	2009	4,297		20	215	215	591	10
11	Water Pump	2009	2,717		20	136	136	396	11
12	Plumbing Work	2009	2,840		20	142	142	426	12
13	Plumbing Work	2009	2,580		20	129	129	355	13
14	Fire Pump Check Valve	2009	2,860		20	143	143	429	14
15	Smoke Detector	2009	2,620		20	131	131	317	15
16	Exhaust Fan	2010	4,997		20	500	500	999	16
17	Boiler Dampers	2010	3,912		20	391	391	782	17
18	Water Pump	2010	4,650		20	465	465	930	18
19	Boiler Repair	2010	3,060		20	153	153	268	19
20	Security Camera System	2011	9,084		20	227	227	227	20
21	Security Camera System	2011	9,084		20	454	454	454	21
22	Concrete & Sewer Work	2011	2,650		20	133	133	133	22
23	Sprinkler System Repair	2011	5,250		20	263	263	263	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)		$ 5,541,265	$ 158,818		$ 229,345	$ 70,527	$ 3,645,904	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/11 Ending: 12/31/11

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		$ 5,541,265	$ 158,818		$ 229,345	$ 70,527	$ 3,645,904	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)		$ 5,541,265	$ 158,818		$ 229,345	$ 70,527	$ 3,645,904	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/11 Ending: 12/31/11

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		$ 5,541,265	$ 158,818		$ 229,345	$ 70,527	$ 3,645,904	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)		$ 5,541,265	$ 158,818		$ 229,345	$ 70,527	$ 3,645,904	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/11 Ending: 12/31/11

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		$ 5,541,265	$ 158,818		$ 229,345	$ 70,527	$ 3,645,904	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)		$ 5,541,265	$ 158,818		$ 229,345	$ 70,527	$ 3,645,904	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 Information								1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Bathroom Remodel	2007	35,100		20	1,755	1,755	8,775	9
10	Flooring (4th)	2008	29,171		20	1,459	1,459	5,836	10
11	Flooring (5th)	2008	29,171		20	1,459	1,459	5,836	11
12	Bathroom Remodel	2008	135,720		20	6,786	6,786	27,144	12
13	Bathroom Remodel	2008	23,400		20	1,170	1,170	4,680	13
14	Painting	2008	146,700		20	7,335	7,335	29,340	14
15	Bathtub Liner	2008	16,250		20	813	813	3,251	15
16	Elevator Controller	2008	35,150		20	1,758	1,758	7,031	16
17	Handrails	2008	9,794		20	490	490	1,959	17
18	Phone System	2008	5,828		20	583	583	2,332	18
19	Hot Water Boilers	2008	29,247		20	1,462	1,462	5,849	19
20	Gas Line Piping	2008	4,979		20	249	249	996	20
21	Bathtub Liners	2009	12,200		20	610	610	1,830	21
22	Painting	2008	16,300		10	1,630	1,630	4,890	22
23	Terra Cotta Work	2010	154,950		20	7,748	7,748	15,496	23
24	HVAC Unit	2010	15,992		20	800	800	1,600	24
25	Dining Room Flooring	2010	47,092		20	2,355	2,355	4,710	25
26	Laundry Vent- Drain	2010	6,100		20	305	305	610	26
27	HVAC Electrical	2010	8,997		20	450	450	900	27
28	Flooring	2010	4,034		20	202	202	404	28
29	Concrete and Beams	2010	70,000		20	3,515	3,515	7,030	29
30	Oxygen Room Work- Installation of Exhaust Fan	2010	8,000		20	400	400	800	30
31	Fire Doors	2010	8,500		20	425	425	850	31
32	Nurse Station- Built in Custom Cabinets	2010	7,000		20	350	350	700	32
33	Fire Doors	2010	2,700		20	135	135	155	33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 Information Continued		$	$		$	$	$	1
2	Fire Doors	2010	27,610		20	1,381	1,381	2,762	2
3	Satellite- Cableing and Installation	2010	17,612		20	881	881	1,762	3
4	Fire Doors	2010	3,650		20	183	183	366	4
5	Fire Rated Doors	2011	18,500		20	925	925	925	5
6	Ceiling Grid and Lighting	2011	5,685		20	284	284	284	6
7	Lintels and Tuckpointing	2011	47,745		20	2,387	2,387	2,387	7
8	Fired Rated Doors	2011	13,600		20	680	680	680	8
9	Fire Rated Doors	2011	2,200		20	110	110	110	9
10	Fire Rated Doors	2011	2,425		20	121	121	121	10
11	Gate Work	2011	2,925		20	146	146	146	11
12	Stair Treads	2011	3,771		20	189	189	189	12
13	Doors, Frames, Closets	2011	7,171		20	359	359	359	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		$ 1,015,269	$		$ 51,885	$ 51,885	$ 153,095	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 Information		$	$		$	$	$	1
2	Buildings:								2
3									3
4	S.I.R. Properties- S.I.R. Management- Allocation	1993	35,531	1,128	1015	35	(1,093)	17,765	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10	SIR Management - Allocation	1993	9,008	251	20	447	196	8,485	10
11	SIR Management - Allocation	1994	28		20			28	11
12	SIR Management - Allocation	1995	206		20	10	10	169	12
13	SIR Management - Allocation	1997	13,842	310	20	679	369	10,236	13
14	SIR Management - Allocation	1999	1,088		20	54	54	666	14
15	SIR Management - Allocation	1999	11,079		20			11,079	15
16	SIR Management - Allocation	2000	1,285		20	64	64	741	16
17	SIR Management - Allocation	2007	4,129	381	20	206	(175)	866	17
18	SIR Management - Allocation	2008	11,379	1,087	20	717	(370)	2,757	18
19	SIR Management - Allocation	2009	28,274	259	20	1,414	1,155	3,173	19
20	SIR Management - Allocation	2011	700	29	20	15	(14)	15	20
21									21
22	S.I.R. Properties- S.I.R. Management- Allocation	2010	2,144		20	107	107	143	22
23	S.I.R. Properties- S.I.R. Management- Allocation	2009	2,133	187	20	107	(80)	299	23
24	S.I.R. Properties- S.I.R. Management- Allocation	2007	622	51	20	31	(20)	156	24
25	S.I.R. Properties- S.I.R. Management- Allocation	2002	141		20	7	7	67	25
26	S.I.R. Properties- S.I.R. Management- Allocation	1999	4,502		20	225	225	2,814	26
27	S.I.R. Properties- S.I.R. Management- Allocation	1998	2,152		20	108	108	1,452	27
28	S.I.R. Properties- S.I.R. Management- Allocation	1997	134		20	7	7	104	28
29	S.I.R. Properties- S.I.R. Management- Allocation	1994	338	9	20	17	8	296	29
30	S.I.R. Properties- S.I.R. Management- Allocation	1993	576	3	20	29	26	533	30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 Information Continued								1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		$ 129,291	$ 3,695		$ 4,279	$ 584	$ 61,844	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	$ 403,628	$ 4,073	$ 19,262	$ 15,189	10	$ 322,171	71
72	Current Year Purchases	308,789	9	9		10	57,124	72
73	Fully Depreciated Assets	587,530		17	17	10	587,530	73
74								74
75	TOTALS	$ 1,299,947	$ 4,082	$ 19,288	$ 15,206		$ 966,825	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		Alloc - SIR Management	2011	$ 2,759	$ 340	$ 391	$ 51	5	$ 546	76
77										77
78										78
79										79
80	TOTALS			$ 2,759	$ 340	$ 391	$ 51		$ 546	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)	$ 6,869,172	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 163,240	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 249,024	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 85,784	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,613,276	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.

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/11 Ending: 12/31/11

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.	/2012	$
13.	/2013	$
14.	/2014	$

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: $ 13,282 Description: See Attached Schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/11 Ending: 12/31/11

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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	N/A	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							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									13
14	TOTAL			$		$	$		$	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/11 Ending: 12/31/11

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/11 (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	$ 50,743	$ 58,277	1
2	Cash-Patient Deposits	31,633	31,633	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,545,301	1,545,301	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	25,292	26,267	6
7	Other Prepaid Expenses	3,482	3,482	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	11,153	1,004,608	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,667,604	$ 2,669,568	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		25,200	13
14	Buildings, at Historical Cost		1,539,800	14
15	Leasehold Improvements, at Historical Cost	1,715,302	2,608,953	15
16	Equipment, at Historical Cost	1,406,487	2,069,593	16
17	Accumulated Depreciation (book methods)	(2,097,842)	(4,015,499)	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	14,300	261,312	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,038,247	$ 2,489,359	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,705,851	$ 5,158,927	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 108,626	$ 108,628	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	31,654	31,654	28
29	Short-Term Notes Payable	700,000	700,000	29
30	Accrued Salaries Payable	216,560	216,560	30
31	Accrued Taxes Payable (excluding real estate taxes)	14,859	14,859	31
32	Accrued Real Estate Taxes(Sch.IX-B)		235,000	32
33	Accrued Interest Payable		77,940	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	18,500	18,500	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,090,199	$ 1,403,141	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		19,484,996	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 19,484,996	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,090,199	$ 20,888,137	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,615,652	$ (15,729,210)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,705,851	$ 5,158,927	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Wilson Care Inc. # 0029975 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,869,503	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,869,503	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	970,149	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	(1,224,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (253,851)	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)**	$ 1,615,652	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/11 Ending: 12/31/11

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,477,521	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,477,521	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	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		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	1,128	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,128	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,478,649	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,217,897	31
32	Health Care	1,900,643	32
33	General Administration	1,645,232	33
	B. Capital Expense		
34	Ownership	1,636,323	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	108,405	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,508,500	40
41	**Income before Income Taxes (line 30 minus line 40)****	970,149	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 970,149	43

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

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

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

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

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	1,972	2,086	$ 97,433	$ 46.71	1
2	Assistant Director of Nursing	1,917	2,086	73,396	35.19	2
3	Registered Nurses	2,464	2,640	76,996	29.17	3
4	Licensed Practical Nurses	11,455	12,006	290,862	24.23	4
5	CNAs & Orderlies	56,364	59,528	604,877	10.16	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,940	2,086	41,523	19.91	9
10	Activity Assistants	8,379	8,878	87,764	9.89	10
11	Social Service Workers	19,869	21,448	364,905	17.01	11
12	Dietician					12
13	Food Service Supervisor	1,933	2,086	35,377	16.96	13
14	Head Cook	6,088	6,480	61,364	9.47	14
15	Cook Helpers/Assistants	12,074	13,064	123,948	9.49	15
16	Dishwashers					16
17	Maintenance Workers	3,986	4,170	48,938	11.74	17
18	Housekeepers	18,531	20,030	199,408	9.96	18
19	Laundry					19
20	Administrator	2,089	2,275	111,114	48.84	20
21	Assistant Administrator	1,192	1,448	26,195	18.09	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,408	15,551	202,043	12.99	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,552	4,103	80,554	19.63	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	2,677	2,677	11,300	4.22	33
34	TOTAL (lines 1 - 33)	170,890	182,642	$ 2,537,997 *	$ 13.90	34

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	Monthly	$ 35,076	01-03	35
36	Medical Director	Monthly	11,200	09-03	36
37	Medical Records Consultant	Monthly	4,512	10-03	37
38	Nurse Consultant	Monthly	47,520	10-03	38
39	Pharmacist Consultant	Monthly	12,067	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	Monthly	2,410	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Psychiatric Consultant	Monthly	8,100	10-03	47
48	Specialized Rehab Consultant	Monthly	23,760	10a-03	48
49	TOTAL (lines 35 - 48)		$ 144,645		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	8	$ 367	10-03	50
51	Licensed Practical Nurses	127	4,340	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	135	$ 4,707		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/11 Ending: 12/31/11

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Augusto Beley	Administrator	0.00%	$ 111,114
Elizabeth Webster	Asst. Admin	0.00%	26,195
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 137,309

B. Administrative - Other

Description	Amount
Consulting Fees -SIR Management	$ 120,000
SIR -Director of Admin. Services	47,520
SIR Management - Admin Charges	47,520
See Supplemetal Schedule	96,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 311,040
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
S.I.R. Management	Dir. Of Regulatory Service	$ 23,760
S.I.R. Management	Accounting	36,000
Frost, Ruttenberg, & Rothblatt	Accounting	15,208
S.I.R. Management	Bookkeeping Services	87,912
Pinnacle Consulting	Customer Satisfaction Prg.	541
LTC Solutions	Data Processing	1,500
Rieff Schramm & Kanter	Valuation Services	200
SAS Architects & Planners	Architectural Services	1,658
Health Data Systems, Inc.	Consulting	80
Honkamp Krueger & Co., P.C.	Accounting	150
Olympic Engineering	Engineering Services	1,000
See Supplemetal Schedule		9,046
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 177,055

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 42,519
Unemployment Compensation Insurance	34,411
FICA Taxes	188,352
Employee Health Insurance	141,631
Employee Meals	21,353
Illinois Municipal Retirement Fund (IMRF)*	
City Head Tax	3,984
Union Pension Expense	25,490
Employee Benefits - Other	5,804
401k Contributions	2,190
TOTAL (agree to Schedule V, line 22, col.8)	$ 465,734

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	477
Health Care Worker Background Check	
(Indicate # of checks performed 94)	10,378
Patient Background Checks 11	110
Licenses and Permits	2,623
Advertising and Promotion	5,800
Dues and Subscriptions	399
Alloc.- SIR Management	1,142
Less: Public Relations Expense	( )
Non-allowable advertising	(5,800)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,119

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,024
Alloc. - SIR Management	682
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,706

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/11 Ending: 12/31/11

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. **Alliance for Living - $15,290**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **8,872** 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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **108,405**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(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. $ **21,353** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
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? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **No**
Attach invoices and a summary of services for all architect and appraisal fees.