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.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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 01/01/12 to 12/31/12 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: 01/01/12 Ending: 12/31/12

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	72,468	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	198	TOTALS	198	72,468	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	64,533	683	311	65,527	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	64,533	683	311	65,527	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.42%

D. How many bed-hold days during this year were paid by the Department?
568 (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 09/01/88 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: 12/31/12 Fiscal Year: 12/31/12

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

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	222,964	25,008	33,468	281,440		281,440	(16,863)	264,577			1
2	Food Purchase		310,366		310,366		310,366	(32)	310,334			2
3	Housekeeping	203,223	41,198		244,421		244,421		244,421			3
4	Laundry		20,514	17,985	38,499		38,499		38,499			4
5	Heat and Other Utilities			133,645	133,645		133,645	(6,191)	127,454			5
6	Maintenance	48,243	40,527	129,690	218,460		218,460	39,456	257,916			6
7	Other (specify):*							6,524	6,524			7
8	TOTAL General Services	474,430	437,613	314,788	1,226,831		1,226,831	22,894	1,249,725			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,270,606	29,295	87,072	1,386,973		1,386,973	(24,604)	1,362,369			10
10a	Therapy			23,760	23,760		23,760	(12,327)	11,433			10a
11	Activities	142,045	5,209	2,448	149,702		149,702		149,702			11
12	Social Services	341,599	14,216		355,815		355,815		355,815			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							5,738	5,738			15
16	TOTAL Health Care and Programs	1,754,250	48,720	119,280	1,922,250		1,922,250	(31,193)	1,891,057			16
	C. General Administration											
17	Administrative	108,531		313,740	422,271		422,271	(114,357)	307,914			17
18	Directors Fees											18
19	Professional Services			198,608	198,608	(19,050)	179,558	(123,356)	56,202			19
20	Dues, Fees, Subscriptions & Promotions			48,039	48,039		48,039	(35,248)	12,791			20
21	Clerical & General Office Expenses	264,983	19,499	127,395	411,877		411,877	65,275	477,152			21
22	Employee Benefits & Payroll Taxes			513,733	513,733		513,733		513,733			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,260	3,260		3,260	129	3,389			24
25	Other Admin. Staff Transportation			4,357	4,357		4,357	9,459	13,816			25
26	Insurance-Prop.Liab.Malpractice			131,114	131,114		131,114	14,361	145,475			26
27	Other (specify):*							46,406	46,406			27
28	TOTAL General Administration	373,514	19,499	1,340,246	1,733,259	(19,050)	1,714,209	(137,331)	1,576,878			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,602,194	505,832	1,774,314	4,882,340	(19,050)	4,863,290	(145,630)	4,717,660			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: 01/01/12 Ending: 12/31/12

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			54,797	54,797		54,797	191,303	246,100			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			24,086	24,086		24,086	905,436	929,522			32
33	Real Estate Taxes					19,050	19,050	225,083	244,133			33
34	Rent-Facility & Grounds			1,596,000	1,596,000		1,596,000	(1,596,000)				34
35	Rent-Equipment & Vehicles			6,575	6,575		6,575	6,035	12,610			35
36	Other (specify):*							102,816	102,816			36
37	TOTAL Ownership			1,681,458	1,681,458	19,050	1,700,508	(165,327)	1,535,181			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			504,409	504,409		504,409		504,409			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			504,409	504,409		504,409		504,409			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,602,194	505,832	3,960,181	7,068,207		7,068,207	(310,957)	6,757,250			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: 01/01/12 Ending: 12/31/12

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	(8,520)	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	73,945	30		9
10	Interest and Other Investment Income	(21,479)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(32)	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	(14,000)	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	(27,331)	21		24
25	Fund Raising, Advertising and Promotional	(3,792)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(53,861)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (55,070)		$	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)	(255,887)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (255,887)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (310,957)		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: 01/01/12

Ending: 12/31/12

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Collections	$ (933)	19	1
2	Bank Fees	(6,313)	21	2
3	Lobbying	(433)	19	3
4	Theft & Damage	(293)	21	4
5	State Replacement Tax	(1,571)	21	5
6	State Replacement Tax - Prior	(8,000)	21	6
7	Filing Fees - Building Co.	(400)	20	7
8	Office Expense- Building Co.	(10)	21	8
9	Professional fees - Building Co.	(7,500)	19	9
10	Capitailized R&M	(2,917)	06	10
11	Alliance Dues	(17,916)	20	11
12	Use Tax	(460)	21	12
13	P.P. Other Professional Expense	(152)	19	13
14	Non-allowable Legal Fees	(6,463)	19	14
15	2013 Seminar Expense	(500)	24	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**	(53,861)		49

Wilson Care Inc.

ID# 0029975

Report Period Beginning: 01/01/12

Ending: 12/31/12

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

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary				(16,863)								(16,863)	1
2	Food Purchase	(32)											(32)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(8,520)			2,329								(6,191)	5
6	Maintenance	(2,917)	55,396	(15,235)	2,212								39,456	6
7	Other (specify):*			667	5,857								6,524	7
8	**TOTAL General Services**	(11,469)	55,396	(14,568)	(6,465)								22,894	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			(32,227)	7,623								(24,604)	10
10a	Therapy				(12,327)								(12,327)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			2,572	3,166								5,738	15
16	**TOTAL Health Care and Programs**			(29,655)	(1,538)								(31,193)	16
	C. General Administration													
17	Administrative			(191,683)	77,326								(114,357)	17
18	Directors Fees													18
19	Professional Services	(15,481)	7,500	(130,214)	14,839								(123,356)	19
20	Fees, Subscriptions & Promotions	(36,108)	400	460									(35,248)	20
21	Clerical & General Office Expenses	(43,978)	10	109,172	71								65,275	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(500)		629									129	24
25	Other Admin. Staff Transportation			9,459									9,459	25
26	Insurance-Prop.Liab.Malpractice		12,798	1,440	123								14,361	26
27	Other (specify):*			29,545	16,861								46,406	27
28	**TOTAL General Administration**	(96,067)	20,708	(171,192)	109,220								(137,331)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(107,536)	76,104	(215,415)	101,217								(145,630)	29

STATE OF ILLINOIS

Summary B

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

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	73,945	108,465		8,893								191,303	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(21,479)	928,258	(7,912)	6,569								905,436	32
33	Real Estate Taxes		221,565		3,518								225,083	33
34	Rent-Facility & Grounds		(1,596,000)										(1,596,000)	34
35	Rent-Equipment & Vehicles			6,035									6,035	35
36	Other (specify):*		102,816										102,816	36
37	**TOTAL Ownership**	52,466	(234,896)	(1,877)	18,980								(165,327)	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)**	(55,070)	(158,792)	(217,292)	120,197								(310,957)	45

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

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		
				Wilson Care, LLC		Building Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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)	
1	V	34	Rental Income	$ 1,596,000	Wilson Care, LLC	100.00%	$	$ (1,596,000)	1
2	V	36	Amort. of HUD Fees		Wilson Care, LLC	100.00%	6,057	6,057	2
3	V	30	Depreciation		Wilson Care, LLC	100.00%	108,465	108,465	3
4	V	20	Filing Fees		Wilson Care, LLC	100.00%	400	400	4
5	V	32	Interest - Mortgage		Wilson Care, LLC	100.00%	928,885	928,885	5
6	V	36	Mortgage Insurance		Wilson Care, LLC	100.00%	96,759	96,759	6
7	V	21	Office Expense		Wilson Care, LLC	100.00%	10	10	7
8	V	19	Professional Fees		Wilson Care, LLC	100.00%	7,500	7,500	8
9	V	26	Property Insurance		Wilson Care, LLC	100.00%	12,798	12,798	9
10	V	33	Real Estate Taxes - Current		Wilson Care, LLC	100.00%	234,000	234,000	10
11	V	33	Real Estate Taxes - Prior	12,435	Wilson Care, LLC	100.00%		(12,435)	11
12	V	06	Repairs & Maint.		Wilson Care, LLC	100.00%	55,396	55,396	12
13	V	32	Interest Income	627	Wilson Care, LLC	100.00%		(627)	13
14	Total			$ 1,609,062			$ 1,450,270	$ * (158,792)	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: 01/01/12 Ending: 12/31/12

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%	$ 8,525	$ (15,235)	15
16	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	667	667	16
17	V	10	NURSING	47,520	S.I.R. MANAGEMENT, INC.	100.00%	15,293	(32,227)	17
18	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	2,572	2,572	18
19	V	19	PROFESSIONAL FEES	142,920	S.I.R. MANAGEMENT, INC.	100.00%	12,491	(130,429)	19
20	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	460	460	20
21	V	21	CLERICAL & GENERAL	47,520	S.I.R. MANAGEMENT, INC.	100.00%	58,330	10,810	21
22	V	24	EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	629	629	22
23	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	9,459	9,459	23
24	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	1,440	1,440	24
25	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	10,321	10,321	25
26	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(7,912)	(7,912)	26
27	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	6,035	6,035	27
28	V								28
29	V	17	ADMINISTRATIVE	217,740	S.I.R. MANAGEMENT, INC.	100.00%	26,057	(191,683)	29
30	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	215	215	30
31	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	98,362	98,362	31
32	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	19,224	19,224	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 479,460			$ 262,168	$ * (217,292)	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: 01/01/12 Ending: 12/31/12

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%	$ 6,897	$ (16,863)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	1,170	1,170	16
17	V	10	NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	7,623	7,623	17
18	V	15	EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	1,283	1,283	18
19	V	17	ADMIN./LEGAL SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	77,326	77,326	19
20	V	19	FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	14,784	14,784	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	16,861	16,861	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	23,760	S.I.R. MANAGEMENT, INC.	100.00%	11,433	(12,327)	24
25	V	15	EMPLOYEE BENFITS		S.I.R. MANAGEMENT, INC.	100.00%	1,883	1,883	25
26	V								26
27	V	6	MAINTENANCE SALARIES	24,104	S.I.R. MANAGEMENT, INC.	100.00%	25,775	1,671	27
28	V	7	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	4,687	4,687	28
29	V								29
30	V	5	UTILITIES		S.I.R. MANAGEMENT, INC.	100.00%	2,329	2,329	30
31	V	6	REPAIRS AND MAINT.		S.I.R. MANAGEMENT, INC.	100.00%	541	541	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%	123	123	34
35	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	8,893	8,893	35
36	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	6,569	6,569	36
37	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	3,518	3,518	37
38	V								38
39	Total			$ 71,624			$ 191,821	$ * 120,197	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: 01/01/12 Ending: 12/31/12

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%	$ 93,212	$ 93,212	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	93,212	CCS Employee Benefits Group	100.00%		(93,212)	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			$ 93,212			$ 93,212	$ *	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: 01/01/12 Ending: 12/31/12

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

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

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

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

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

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

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%	APPLEWOOD REHABILITATION CENTER,LLC	MATTESON	SIR MANAGEMENT	LINCOLNWOOD	MANAGEMENT CO.	2
3	B. BART BARRISH	0.278%	BRYN MAWR CARE INC.	CHICAGO	SIR PROPERTIES	LINCOLNWOOD	BUILDING CO.	3
4	BETH ALTER	5.556%	COLUMBUS PARK NURSING & REHABILITATION CENTER, INC.	CHICAGO	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	4
5	BRYAN BARRISH TRUST DTD 09/01/04	11.111%	DECATUR MANOR HEALTHCARE,LLC	DECATUR				5
6	CHERYL MAGENCE	4.722%	ELMWOOD CARE, INC.	ELMWOOD PARK				6
7	DANIEL ROTHNER	0.972%	FAIRVIEW NURSING PLAZA, INC.	ROCKFORD				7
8	DARCEY BARRISH	0.278%	GREENWOOD CARE, INC.	EVANSTON				8
9	ERIC ROTHNER	20.000%	MAPLEWOOD CARE, INC.	ELGIN				9
10	HOWARD GELLER	4.444%	NEIGHBORS REHABILITATION CENTER,LLC	BYRON				10
11	JESSE REYNOLDS DESCENDANTS TRUST	0.556%	REGENCY REHABILITATION CENTER,LLC	NILES				11
12	KIRSTEN BARRISH	0.278%	ROCK ISLAND NURSING & REHAB CENTER,LLC	ROCK ISLAND				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: 01/01/12 Ending: 12/31/12

VII. RELATED PARTIES

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

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

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

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	Bryan Barrish	Relative	Administrative	N/A	See Attached	3.07	7.68%	Alloc. Salary	$ 15,364	17-7	1
2	Kirsten Barrish	Owner	Clerical	0.28	See Attached	3.07	7.68%	Alloc. Salary	3,579	21-7	2
3	Sarah Barrish	Owner	Administrative	0.56	See Attached	3.84	7.68%	Alloc. Salary	9,290	17-7	3
4	Howard Geller	Owner	Administrative	4.44	See Attached	8	16.00%	Consult. Fee	48,000	17-3	4
5	Nenita Guzman	Relative	Dietary	N/A	See Attached	3.84	7.68%	Alloc. Salary	6,897	1-7	5
6	Adam Vales	Relative	Clerical	N/A	See Attached	0.62	1.55%	Alloc. Salary	1,131	22-7	6
7	Noah Wolff	Owner	Administrative	5.56	See Attached	1	4.00%	Consult. Fee	48,000	17-3	7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 132,261		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: 01/01/12 Ending: 12/31/12

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

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	852,976	13	$ 110,978	$ 47,841	65,527	$ 8,525	1
2	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	852,976	13	8,688		65,527	667	2
3	10	NURSING	PATIENT DAYS	852,976	13	199,072	199,072	65,527	15,293	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	852,976	13	33,485		65,527	2,572	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	852,976	13	162,603	94,013	65,527	12,491	5
6	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	852,976	13	5,990		65,527	460	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	852,976	13	759,296	684,975	65,527	58,330	7
8	24	EDUCATION & SEMINAR	PATIENT DAYS	852,976	13	8,182		65,527	629	8
9	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	852,976	13	123,128		65,527	9,459	9
10	26	INSURANCE	PATIENT DAYS	852,976	13	18,740		65,527	1,440	10
11	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	852,976	13	134,350		65,527	10,321	11
12	32	INTEREST	PATIENT DAYS	852,976	13	(102,988)		65,527	(7,912)	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	852,976	13	78,558		65,527	6,035	13
14										14
15	17	ADMINISTRATIVE	PATIENT DAYS	852,976	13	339,187	339,187	65,527	26,057	15
16	19	PROFESSIONAL FEES	PATIENT DAYS	852,976	13	2,801		65,527	215	16
17	21	CLERICAL & GENERAL	PATIENT DAYS	852,976	13	1,280,400	1,178,532	65,527	98,362	17
18	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	852,976	13	250,244		65,527	19,224	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,412,714	$ 2,543,620		$ 262,168	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	852,976	13	$ 89,778	$ 89,778	65,527	$ 6,897	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	852,976	13	15,225		65,527	1,170	2
3	10	NURSING SALARIES	PATIENT DAYS	852,976	13	99,226	99,226	65,527	7,623	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	852,976	13	16,696		65,527	1,283	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	852,976	13	1,006,570	1,006,570	65,527	77,326	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	852,976	13	192,450		65,527	14,784	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	852,976	13	219,485		65,527	16,861	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	288,024	13	138,589	138,589	23,760	11,433	10
11	15	EMPLOYEE BENFITS	SPECIAL REHAB INC.	288,024	13	22,823		23,760	1,883	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	401,695	13	429,544	429,544	24,104	25,775	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	401,695	13	78,117		24,104	4,687	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,879	13	30,330		989	2,329	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,879	13	7,048		989	541	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,879	13	717		989	55	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,879	13	925		989	71	19
20	26	INSURANCE	ALLOCATED SQ FT	12,879	13	1,601		989	123	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,879	13	115,812		989	8,893	21
22	32	INTEREST	ALLOCATED SQ FT	12,879	13	85,544		989	6,569	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,879	13	45,809		989	3,518	23
24										24
25	TOTALS					$ 2,596,289	$ 1,763,707		$ 191,821	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

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			$	$		$ 93,212	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					$	$		$ 93,212	25

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

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

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

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

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

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

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

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			$	$ 19,237,232			$ 928,885	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Lake Forest Bank & Trust		X	Line of Credit				350,000			24,086	6
7	Alloc. S.I.R. Management	X									6,569	7
8	See Supplemental Schedule											8
9	TOTAL Facility Related						$	$ 19,587,232			$ 959,540	9
	B. Non-Facility Related*											
10	Interest Income		X								(21,479)	10
11	Interest Income - Bldg. Co.		X								(627)	11
12	Alloc. S.I.R. Management	X									(7,912)	12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (30,018)	14
15	TOTALS (line 9+line14)						$	$ 19,587,232			$ 929,523	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 96,759 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: 01/01/12 Ending: 12/31/12

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 235,000	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.)		$ 226,083	2
3. Under or (over) accrual (line 2 minus line 1).		$ (8,917)	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 234,000	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.**		$ 19,050	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.		$ 244,133	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	169,130	8
	2008	171,205	9
	2009	214,301	10
	2010	223,625	11
	2011	222,565	12

Accrual = $222,565 x 1.05 = $234,000 (Rounded)

Allocated S.I.R. Management = $6,084

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

2011 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 2011 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 2011.

	(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	$ 222,565.17	$ 222,565.17
2.	Home Office Allocation	See Attached	$ 101,165.17	$ 6,084.06
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 323,730.34	$ 228,649.23

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

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

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

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		1985	1967	$ 1,539,800	$ 96,450	35	$ 43,994	$ (52,456)	$ 1,539,800	4
5											5
6											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			29,891	14
15	Various			1992	69,669		20	1,539	1,539	69,666	15
16	Various			1993	61,688		20	3,084	3,084	60,122	16
17	Various			1994	55,691		20	2,653	2,653	51,498	17
18	Various			1995	87,144		20	4,357	4,357	76,268	18
19	Various			1996	303,393		20	15,170	15,170	249,361	19
20	Various			1997	145,411		20	7,347	7,347	108,529	20
21	Various			1998	34,959		20	1,748	1,748	25,429	21
22	Various			1999	53,478		20	2,674	2,674	36,297	22
23	Various			2000	221,871		20	11,094	11,094	136,338	23
24	Various			2001	102,633		20	5,132	5,132	59,855	24
25	Various			2002	67,986		20	2,999	2,999	67,986	25
26	Various			2003	97,187		20	6,025	6,025	56,609	26
27	Various			2004	62,333		20	4,333	4,333	36,859	27
28	Various			2005	214,966		20	13,469	13,469	101,622	28
29	Various			2006	56,219		20	2,958	2,958	18,942	29
30	Various			2007	362,270		20	19,637	19,637	106,680	30
31	Various			2008	29,574		20	1,479	1,479	6,840	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: 01/01/12 Ending: 12/31/12

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		$ 5,502,464	$ 155,928		$ 223,139	$ 67,211	$ 3,515,946	1
2	Boiler Work	2009	4,297		20	215	215	806	2
3	Water Pump	2009	2,717		20	136	136	532	3
4	Plumbing Work	2009	2,840		20	142	142	568	4
5	Plumbing Work	2009	2,580		20	129	129	484	5
6	Fire Pump Check Valve	2009	2,860		20	143	143	572	6
7	Smoke Detector	2009	2,620		20	131	131	448	7
8	Water Pump	2009	4,650		20	465	465	1,395	8
9	Exhaust Fan	2010	4,997		20	500	500	1,499	9
10	Boiler Dampers	2010	3,912		20	391	391	1,174	10
11	Boiler Repair	2010	3,060		20	153	153	421	11
12	Security Camera System	2011	9,084		20	908	908	1,136	12
13	Concrete & Sewer Work	2011	2,650		20	133	133	199	13
14	Sprinkler System Repair	2011	5,250		20	263	263	284	14
15	Sprinkler Heads	2012	2,917		20	146	146	146	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)		$ 5,556,897	$ 155,928		$ 226,993	$ 71,065	$ 3,525,608	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: 01/01/12 Ending: 12/31/12

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)		1,325,252			67,702	67,702	178,349	67
68	Related Party Allocations (Pages 12H & 12I)		150,246	4,681		5,745	1,064	68,501	68
69	Financial Statement Depreciation			54,797			(54,797)		69
70	TOTAL (lines 4 thru 69)		$ 5,502,464	$ 155,928		$ 223,139	$ 67,211	$ 3,515,946	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: 01/01/12 Ending: 12/31/12

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		$ 5,556,897	$ 155,928		$ 226,993	$ 71,065	$ 3,525,608	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)		$ 5,556,897	$ 155,928		$ 226,993	$ 71,065	$ 3,525,608	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: 01/01/12 Ending: 12/31/12

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		$ 5,556,897	$ 155,928		$ 226,993	$ 71,065	$ 3,525,608	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)		$ 5,556,897	$ 155,928		$ 226,993	$ 71,065	$ 3,525,608	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: 01/01/12 Ending: 12/31/12

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		$ 5,556,897	$ 155,928		$ 226,993	$ 71,065	$ 3,525,608	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)		$ 5,556,897	$ 155,928		$ 226,993	$ 71,065	$ 3,525,608	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: 01/01/12 Ending: 12/31/12

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

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	11,362		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	Installed Surface Mount Wiremold Raceways	2012	28,600		20	1,430	1,430	1,430	14
15	Installed Freezer Evaporator Coil and Expansion Valve	2012	3,640		20	182	182	182	15
16	Replaces Defective Cloth Covered Wires	2012	21,456		20	1,073	1,073	1,073	16
17	Replaced 496 Sprinklers	2012	21,990		20	1,100	1,100	1,100	17
18	Removed Non-working Doors, Replaced Existing Locks	2012	6,950		20	348	348	348	18
19	Replaced Pipe From 2nd to 3rd Floor, Plastered Drywall	2012	3,500		20	175	175	175	19
20	Installed New Window Screens	2012	2,524		20	126	126	126	20
21	Repaired walls & flooring for smoke room, office, & kitchen	2012	7,336		20	367	367	367	21
22	Replaced 51 exit signs & fuses & installed electric heaters	2012	17,075		20	854	854	854	22
23	Replaced A/C Units	2012	6,837		20	342	342	342	23
24	Repaired and Installed Railing With Round Pipe, Primed & Finish Col	2012	3,935		20	197	197	197	24
25	Replaced Fire Exit Door Hardware	2012	3,598		20	180	180	180	25
26	Modernization of Two Traction Elevators	2011	185,400		20	9,270	9,270	18,540	26
27	Penthouse Elevator Project	2011	3,392		20	170	170	340	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		$ 1,325,252	$		$ 67,702	$ 67,702	$ 178,349	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: 01/01/12 Ending: 12/31/12

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	Allocated - S.I.R. Management	2009	19,198		39	492	492	1,497	3
4	Allocated - S.I.R. Properties - S.I.R. Management	1993	34,761	1,104	35	993	(111)	19,366	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated - S.I.R. Management	1993	8,813	245	20	437	192	8,738	9
10	Allocated - S.I.R. Management	1994	27		20			27	10
11	Allocated - S.I.R. Management	1995	201		20	10	10	175	11
12	Allocated - S.I.R. Management	1997	13,542	303	20	664	361	10,678	12
13	Allocated - S.I.R. Management	1999	1,065		20	53	53	705	13
14	Allocated - S.I.R. Management	1999	11,079		20			11,079	14
15	Allocated - S.I.R. Management	2000	1,257		20	63	63	788	15
16	Allocated - S.I.R. Management	2007	4,039	276	20	202	(74)	1,049	16
17	Allocated - S.I.R. Management	2008	11,132	1,063	20	702	(361)	3,399	17
18	Allocated - S.I.R. Management	2009	27,661	253	20	1,383	1,130	4,487	18
19	Allocated - S.I.R. Management	2011	684	68	20	68		97	19
20	Allocated - S.I.R. Management	2012	2,190	46	20	46		46	20
21									21
22	Allocated - S.I.R. Properties - S.I.R. Management	2012	2,129	1,133	20	9	(1,124)	9	22
23	Allocated - S.I.R. Properties - S.I.R. Management	2010	2,098		20	105	105	245	23
24	Allocated - S.I.R. Properties - S.I.R. Management	2009	2,087	130	20	104	(26)	397	24
25	Allocated - S.I.R. Properties - S.I.R. Management	2007	609	49	20	30	(19)	183	25
26	Allocated - S.I.R. Properties - S.I.R. Management	2002	138		20	7	7	73	26
27	Allocated - S.I.R. Properties - S.I.R. Management	1999	4,405		20	220	220	2,973	27
28	Allocated - S.I.R. Properties - S.I.R. Management	1998	2,105		20	105	105	1,526	28
29	Allocated - S.I.R. Properties - S.I.R. Management	1997	131		20	7	7	108	29
30	Allocated - S.I.R. Properties - S.I.R. Management	1994	331	8	20	17	9	306	30
31	Allocated - S.I.R. Properties - S.I.R. Management	1993	564	3	20	28	25	550	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: 01/01/12 Ending: 12/31/12

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)		$ 150,246	$ 4,681		$ 5,745	$ 1,064	$ 68,501	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: 01/01/12 Ending: 12/31/12

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	$ 706,524	$ 15,690	$ 18,359	$ 2,669	10	$ 427,054	71
72	Current Year Purchases	28,387	155	340	185	10	2,298	72
73	Fully Depreciated Assets	597,625				10	597,625	73
74								74
75	TOTALS	$ 1,332,536	$ 15,845	$ 18,699	$ 2,854		$ 1,026,977	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 Managemnet	2011	$ 2,699	$ 382	$ 409	$ 27	5	$ 944	76
77										77
78										78
79										79
80	TOTALS			$ 2,699	$ 382	$ 409	$ 27		$ 944	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)	$ 6,917,332	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 172,155	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 246,100	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 73,945	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,553,529	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	HUD-Cambridge Realty	$ 72,941	92
93			93
94			94
95		$ 72,941	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: 01/01/12 Ending: 12/31/12

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.	/2013	$
13.	/2014	$
14.	/2015	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ 12,610 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: 01/01/12 Ending: 12/31/12

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

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

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/12 **(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	$ 36,754	$ 42,655	1
2	Cash-Patient Deposits	30,359	30,359	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,365,890	1,365,890	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	24,961	26,036	6
7	Other Prepaid Expenses	4,370	4,370	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule		936,020	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,462,334	$ 2,405,330	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	2,674,749	15
16	Equipment, at Historical Cost	1,413,139	2,150,222	16
17	Accumulated Depreciation (book methods)	(2,152,639)	(4,046,210)	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	72,941	265,749	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,048,743	$ 2,609,510	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,511,077	$ 5,014,840	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 133,869	$ 133,866	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	30,442	30,442	28
29	Short-Term Notes Payable	350,000	350,000	29
30	Accrued Salaries Payable	235,209	235,209	30
31	Accrued Taxes Payable (excluding real estate taxes)	16,415	16,415	31
32	Accrued Real Estate Taxes(Sch.IX-B)		234,000	32
33	Accrued Interest Payable		76,949	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	212,016	221,119	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 977,951	$ 1,298,000	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		19,237,232	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)**	$	$ 19,237,232	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 977,951	$ 20,535,232	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,533,126	$ (15,520,392)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,511,077	$ 5,014,840	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

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

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,615,652	1
2	Restatements (describe):		2
3	Rounding	(4)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,615,648	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	484,478	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	(567,000)	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)**	$ (82,522)	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)**	$ 1,533,126	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,530,006	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,530,006	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***	21,479	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 21,479	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	1,200	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,200	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,552,685	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,226,831	31
32	Health Care	1,922,250	32
33	General Administration	1,733,259	33
	B. Capital Expense		
34	Ownership	1,681,458	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	504,409	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,068,207	40
41	**Income before Income Taxes (line 30 minus line 40)****	484,478	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 484,478	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 7,444,426	44
45	Private Pay - Net Inpatient Revenue	85,580	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,530,006	49

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	2,010	2,091	$ 100,981	$ 48.29	1
2	Assistant Director of Nursing	1,802	2,091	75,735	36.22	2
3	Registered Nurses	4,492	4,771	135,537	28.41	3
4	Licensed Practical Nurses	9,301	10,071	236,513	23.48	4
5	CNAs & Orderlies	60,496	64,136	638,939	9.96	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,912	2,091	43,073	20.60	9
10	Activity Assistants	7,999	8,748	87,083	9.95	10
11	Social Service Workers	17,921	19,913	341,599	17.15	11
12	Dietician					12
13	Food Service Supervisor	1,842	2,091	36,833	17.62	13
14	Head Cook	5,767	6,043	59,822	9.90	14
15	Cook Helpers/Assistants	12,202	13,220	126,309	9.55	15
16	Dishwashers					16
17	Maintenance Workers	3,787	4,043	48,243	11.93	17
18	Housekeepers	18,566	20,147	203,223	10.09	18
19	Laundry					19
20	Administrator	1,880	2,091	108,531	51.90	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	20,276	21,986	264,983	12.05	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	3,886	4,097	82,901	20.23	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	2,822	2,882	11,889	4.13	33
34	TOTAL (lines 1 - 33)	176,961	190,512	$ 2,602,194 *	$ 13.66	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	$ 33,468	01-03	35
36	Medical Director	Monthly	6,000	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	11,756	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	2,448	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Specialized Rehab Consultant	Monthly	23,760	10a-03	47
48	Psychiatric Director Consultant	Monthly	8,100	10-03	48
49	TOTAL (lines 35 - 48)		$ 137,564		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	437	15,184	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	437	$ 15,184		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: 01/01/12 Ending: 12/31/12

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Augusto Beley	Administrator	0.00%	$ 108,531
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 108,531

B. Administrative - Other

Description	Amount
Consulting Fees - SIR Management	$ 120,000
SIR- Direcotr of Admin. Services	47,520
SIR Management - Admin Charges	50,220
See Supplemetal Schedule	96,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 313,740
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
SIR Management	Dir. Of Regulatory Service	$ 23,760
SIR Management	Accounting	36,000
SIR Management	Bookkeeping	83,160
FR&R	Accounting	16,037
Plante Moran	Consulting	1,081
Personnel Planners	Unemployement Consulting	2,171
Lobbying	ADJ PG5A	433
Collections	ADJ PG5A	933
Pinnacle Consulting	Customer Satisifaction	996
HK Payroll Services	WOTC Consulting	430
Legat Architects	Consulting	7,333
See Supplemetal Schedule		26,275
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 198,609

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 38,825
Unemployment Compensation Insurance	54,200
FICA Taxes	192,851
Employee Health Insurance	103,488
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
City Head Tax	2,782
Union Pension	26,128
Union Health & Welfare	84,920
401K Contributions	2,190
Other Employee Benefits	8,349
TOTAL (agree to Schedule V, line 22, col.8)	$ 513,733

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	$ 1,988
Advertising: Employee Recruitment	660
Health Care Worker Background Check	7,179
(Indicate # of checks performed 718)	
Patient Background Checks	
Advertising & Promotions	3,792
Licenses & Permits	2,138
Dues & Subscriptions	366
Allocated from S.I.R. Management	460
Less: Public Relations Expense	( )
Non-allowable advertising	(3,792)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,791

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,760
	629
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,389

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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 $18,282**

(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. $ **8,981** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **504,409**
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. $ **None** 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? **No**
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? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.