FOR BHF USE

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2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

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

I. IDPH License ID Number: 0029975

Facility Name: Wilson Care

Address: 4544 North Hazel St (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: 9/1/1985

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 01/01/14 to 12/31/14 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

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/14 Ending: 12/31/14

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	40,732	576	18,062	59,370	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	40,732	576	18,062	59,370	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.15%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

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

I. On what date did you start providing long term care at this location?
Date started 09/01/1988

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 09/01/1988 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: 12/31/2014 Fiscal Year: 12/31/2014

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

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	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	216,300	29,539	33,238	279,077		279,077	(17,940)	261,137			1
2	Food Purchase		287,654		287,654		287,654	(28)	287,626			2
3	Housekeeping	219,333	38,373		257,706		257,706		257,706			3
4	Laundry		17,885	20,796	38,681		38,681		38,681			4
5	Heat and Other Utilities			173,111	173,111		173,111	(11,006)	162,105			5
6	Maintenance	48,402	33,255	100,650	182,307		182,307	(5,985)	176,322			6
7	Other (specify):*							4,669	4,669			7
8	TOTAL General Services	484,035	406,706	327,795	1,218,536		1,218,536	(30,290)	1,188,246			8
	B. Health Care and Programs											
9	Medical Director			3,200	3,200		3,200		3,200			9
10	Nursing and Medical Records	1,220,067	32,844	72,836	1,325,747		1,325,747	(14,382)	1,311,365			10
10a	Therapy			23,760	23,760		23,760	(12,205)	11,555			10a
11	Activities	110,538	2,506	2,627	115,671		115,671		115,671			11
12	Social Services	273,952	12,778		286,730		286,730		286,730			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							6,421	6,421			15
16	TOTAL Health Care and Programs	1,604,557	48,128	102,423	1,755,108		1,755,108	(20,166)	1,734,942			16
	C. General Administration											
17	Administrative	109,596		98,040	207,636		207,636	13,184	220,820			17
18	Directors Fees											18
19	Professional Services			168,298	168,298	(698)	167,600	(104,502)	63,098			19
20	Dues, Fees, Subscriptions & Promotions			71,251	71,251		71,251	(36,591)	34,660			20
21	Clerical & General Office Expenses	260,934	17,512	107,820	386,266		386,266	79,535	465,801			21
22	Employee Benefits & Payroll Taxes			434,939	434,939		434,939		434,939			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,949	2,949		2,949	819	3,768			24
25	Other Admin. Staff Transportation			4,073	4,073		4,073	10,151	14,224			25
26	Insurance-Prop.Liab.Malpractice			140,489	140,489		140,489	16,789	157,278			26
27	Other (specify):*							41,818	41,818			27
28	TOTAL General Administration	370,530	17,512	1,027,859	1,415,901	(698)	1,415,203	21,203	1,436,406			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,459,122	472,346	1,458,077	4,389,545	(698)	4,388,847	(29,253)	4,359,594			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Wilson Care #0029975 Report Period Beginning: 01/01/14 Ending: 12/31/14

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			46,571	46,571		46,571	183,060	229,631			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							641,257	641,257			32
33	Real Estate Taxes					698	698	200,627	201,325			33
34	Rent-Facility & Grounds			1,445,000	1,445,000		1,445,000	(1,445,000)				34
35	Rent-Equipment & Vehicles			4,013	4,013		4,013	6,472	10,485			35
36	Other (specify):*							46,918	46,918			36
37	**TOTAL Ownership**			1,495,584	1,495,584	698	1,496,282	(366,666)	1,129,616			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)**	2,459,122	472,346	2,953,661	5,885,129		5,885,129	(395,919)	5,489,210			45

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

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/14 Ending: 12/31/14

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(12,994)	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	67,167	30		9
10	Interest and Other Investment Income	(929)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(28)	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	(23,559)	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	(4,666)	21		24
25	Fund Raising, Advertising and Promotional	(5,893)	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	(55,357)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (36,259)		$	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)	(359,660)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (359,660)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (395,919)		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

Wilson Care

ID# 0029975

Report Period Beginning: 01/01/14

Ending: 12/31/14

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non Allowable Legal	$ (300)	19	1
2	PAC Dues	(10,057)	20	2
3	Jury Duty	(34)	21	3
4	Bank Fees	(6,878)	21	4
5	Theft & Damage	(200)	21	5
6	State Replacement Tax	(10,500)	21	6
7	Additional R & M	1,908	06	7
8	Capitalized R&M	(16,915)	06	8
9	Building Co. - Amortization of Bond & HUD Fees	(2,770)	36	9
10	Building Co. - Filing Fees & Office Exp	(362)	21	10
11	Building Co. - Legal and Other Professional	(6,389)	19	11
12	IDPH "B" violation	(2,860)	21	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(55,357)		49

Wilson Care

ID# 0029975

Report Period Beginning: 01/01/14

Ending: 12/31/14

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

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Wilson Care # 0029975 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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

	Operating Expenses	PAGES 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				(17,940)								(17,940)	1
2	Food Purchase	(28)											(28)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(12,994)			1,988								(11,006)	5
6	Maintenance	(15,007)	14,090	(12,657)	7,589								(5,985)	6
7	Other (specify):*			697	3,972								4,669	7
8	**TOTAL General Services**	(28,029)	14,090	(11,960)	(4,391)								(30,290)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			(22,435)	8,053								(14,382)	10
10a	Therapy				(12,205)								(12,205)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			3,547	2,874								6,421	15
16	**TOTAL Health Care and Programs**			(18,888)	(1,278)								(20,166)	16
	C. General Administration													
17	Administrative			(68,275)	81,459								13,184	17
18	Directors Fees													18
19	Professional Services	(6,689)	6,389	(120,533)	16,331								(104,502)	19
20	Fees, Subscriptions & Promotions	(39,509)		2,918									(36,591)	20
21	Clerical & General Office Expenses	(25,500)	362	104,601	72								79,535	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			819									819	24
25	Other Admin. Staff Transportation			10,151									10,151	25
26	Insurance-Prop.Liab.Malpractice		14,528	2,119	142								16,789	26
27	Other (specify):*			24,998	16,820								41,818	27
28	**TOTAL General Administration**	(71,698)	21,279	(43,202)	114,824								21,203	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(99,727)	35,369	(74,050)	109,155								(29,253)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Wilson Care # 0029975 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	67,167	110,104		5,789								183,060	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(929)	656,077	(20,187)	6,296								641,257	32
33	Real Estate Taxes		193,038		7,589								200,627	33
34	Rent-Facility & Grounds		(1,445,000)										(1,445,000)	34
35	Rent-Equipment & Vehicles			6,472									6,472	35
36	Other (specify):*	(2,770)	49,688										46,918	36
37	TOTAL Ownership	63,468	(436,093)	(13,715)	19,674								(366,666)	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)	(36,259)	(400,724)	(87,765)	128,829								(395,919)	45

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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	Rent	$ 1,445,000	Wilson Care, LLC	100.00%	$	$ (1,445,000)	1
2	V	32	Interest Income & Expense	677	Wilson Care, LLC	100.00%	656,754	656,077	2
3	V	36	Amort of Bond Premium	58,354	Wilson Care, LLC	100.00%		(58,354)	3
4	V	36	Amort of HUD Fees		Wilson Care, LLC	100.00%	2,770	2,770	4
5	V	06	Building Repairs & Mainten.		Wilson Care, LLC	100.00%	14,090	14,090	5
6	V	21	Filing Fees		Wilson Care, LLC	100.00%	350	350	6
7	V	21	Office Expense		Wilson Care, LLC	100.00%	12	12	7
8	V	36	Mortgage Insurance		Wilson Care, LLC	100.00%	105,272	105,272	8
9	V	26	Property Insurance		Wilson Care, LLC	100.00%	14,528	14,528	9
10	V	33	Real Estate	6,962	Wilson Care, LLC	100.00%	200,000	193,038	10
11	V	30	Depreciation		Wilson Care, LLC	100.00%	110,104	110,104	11
12	V	19	Legal, Audit, and Other Prof.		Wilson Care, LLC	100.00%	6,389	6,389	12
13	V								13
14	Total			$ 1,510,993			$ 1,110,269	$ * (400,724)	14

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

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/14 Ending: 12/31/14

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%	$ 11,103	$ (12,657)	15
16	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	697	697	16
17	V	10	NURSING	47,520	S.I.R. MANAGEMENT, INC.	100.00%	25,085	(22,435)	17
18	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	3,547	3,547	18
19	V	19	PROFESSIONAL FEES	138,168	S.I.R. MANAGEMENT, INC.	100.00%	10,516	(127,652)	19
20	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	2,918	2,918	20
21	V	21	CLERICAL & GENERAL	47,520	S.I.R. MANAGEMENT, INC.	100.00%	46,725	(795)	21
22	V	24	EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	819	819	22
23	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	10,151	10,151	23
24	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	2,119	2,119	24
25	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	7,369	7,369	25
26	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(20,187)	(20,187)	26
27	V	35	AUTO RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	5,384	5,384	27
28	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	1,088	1,088	28
29	V								29
30	V	17	ADMINISTRATIVE	95,040	S.I.R. MANAGEMENT, INC.	100.00%	26,765	(68,275)	30
31	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	7,119	7,119	31
32	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	105,396	105,396	32
33	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	17,629	17,629	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 352,008			$ 264,243	$ * (87,765)	39

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

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/14 Ending: 12/31/14

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%	$ 5,820	$ (17,940)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	858	858	16
17	V	10	NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	8,053	8,053	17
18	V	15	EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	1,148	1,148	18
19	V	17	ADMIN./LEGAL SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	81,459	81,459	19
20	V	19	FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	15,559	15,559	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	16,820	16,820	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	23,760	S.I.R. MANAGEMENT, INC.	100.00%	11,555	(12,205)	24
25	V	15	EMPLOYEE BENFITS		S.I.R. MANAGEMENT, INC.	100.00%	1,726	1,726	25
26	V								26
27	V	6	MAINTENANCE SALARIES	13,881	S.I.R. MANAGEMENT, INC.	100.00%	19,908	6,027	27
28	V	7	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	3,114	3,114	28
29	V								29
30	V	5	UTILITIES		S.I.R. MANAGEMENT, INC.	100.00%	1,988	1,988	30
31	V	6	REPAIRS AND MAINT.		S.I.R. MANAGEMENT, INC.	100.00%	1,562	1,562	31
32	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	772	772	32
33	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	72	72	33
34	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	142	142	34
35	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	5,789	5,789	35
36	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	6,296	6,296	36
37	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	7,589	7,589	37
38	V								38
39	Total			$ 61,401			$ 190,230	$ * 128,829	39

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

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 # 0029975 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 # 0029975 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 # 0029975 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 # 0029975 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 # 0029975 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 # 0029975 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 # 0029975 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	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	OAKTON PAVILION	DESPLAINES	ASSISTED LIVING	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%	OAKTON ARMS	DES PLAINES				7
8	DARCEY BARRISH	0.278%	GREENWOOD CARE, INC.	EVANSTON				8
9	ERIC ROTHNER	20.000%	WESLEY REHABILITATION CENTER	AUBURN, IN				9
10	HOWARD GELLER TRUST	9.44%	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	WILLIAM ROTHNER	.972%						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 # 0029975 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES

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

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

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	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	Sarah Barrish	Owner	Administrative	0.56%	See Attached	3.55	7.80%	Alloc. Salary	$ 9,611	17-07	1
2	Kirsten Barrish	Owner	Clerical	0.28%	See Attached	3.95	7.90%	Alloc. Salary	7,287	21-07	2
3	Bryan Barrish	Relative	Administrative	0%	See Attached	3.16	7.00%	Alloc. Salary	15,800	17-07	3
4	Nenita Guzman	Relative	Dietary	0%	See Attached	3.95	7.90%	Alloc. Salary	5,820	01-07	4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 38,518		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 # 0029975 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [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 # 0029975 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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	751,530	16	$ 140,542	$ 58,090	59,370	$ 11,103	1
2	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	751,530	16	8,819		59,370	697	2
3	10	NURSING	PATIENT DAYS	751,530	16	317,539	317,539	59,370	25,085	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	751,530	16	44,898		59,370	3,547	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	751,530	16	133,120	89,849	59,370	10,516	5
6	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	751,530	16	36,940		59,370	2,918	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	751,530	16	591,459	531,411	59,370	46,725	7
8	24	EDUCATION & SEMINAR	PATIENT DAYS	751,530	16	10,362		59,370	819	8
9	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	751,530	16	128,491		59,370	10,151	9
10	26	INSURANCE	PATIENT DAYS	751,530	16	26,818		59,370	2,119	10
11	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	751,530	16	93,282		59,370	7,369	11
12	32	INTEREST	PATIENT DAYS	751,530	16	(255,531)		59,370	(20,187)	12
13	35	AUTO RENTAL	PATIENT DAYS	751,530	16	68,150		59,370	5,384	13
14	35	EQUIPMENT RENTAL	PATIENT DAYS	751,530	16	13,772		59,370	1,088	14
15										15
16	17	ADMINISTRATIVE	PATIENT DAYS	751,530	16	338,802	338,802	59,370	26,765	16
17	19	PROFESSIONAL FEES	PATIENT DAYS	751,530	16	90,119		59,370	7,119	17
18	21	CLERICAL & GENERAL	PATIENT DAYS	751,530	16	1,334,152	1,203,304	59,370	105,396	18
19	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	751,530	16	223,152		59,370	17,629	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,344,886	$ 2,538,995		$ 264,243	25

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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	751,530	16	$ 73,669	$ 73,669	59,370	$ 5,820	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	751,530	16	10,866		59,370	858	2
3	10	NURSING SALARIES	PATIENT DAYS	751,530	16	101,941	101,941	59,370	8,053	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	751,530	16	14,528		59,370	1,148	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	751,530	16	1,031,137	1,031,137	59,370	81,459	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	751,530	16	196,950		59,370	15,559	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	751,530	16	212,914		59,370	16,820	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	274,680	15	133,582	133,582	23,760	11,555	10
11	15	EMPLOYEE BENFITS	SPECIAL REHAB INC.	274,680	15	19,951		23,760	1,726	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	395,144	15	566,698	566,698	13,881	19,908	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	395,144	15	88,633		13,881	3,114	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,880	15	25,179		1,017	1,988	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,880	15	19,781		1,017	1,562	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,880	15	9,777		1,017	772	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,880	15	907		1,017	72	19
20	26	INSURANCE	ALLOCATED SQ FT	12,880	15	1,804		1,017	142	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,880	15	73,312		1,017	5,789	21
22	32	INTEREST	ALLOCATED SQ FT	12,880	15	79,739		1,017	6,296	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,880	15	96,114		1,017	7,589	23
24										24
25	TOTALS					$ 2,757,482	$ 1,907,027		$ 190,230	25

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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 # 0029975 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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 # 0029975 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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 # 0029975 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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 # 0029975 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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 # 0029975 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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 # 0029975 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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 # 0029975 Report Period Beginning: 01/01/14 Ending: 12/31/14

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Private Bank		X	Mortgage Payable			$	$ 18,605,343			$ 656,754	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Lake Forest Bank & Trust		X	Line of Credit				125,000				6
7	Alloc. From S.I.R. Mngmnt	X									6,296	7
8												8
9	TOTAL Facility Related						$	$ 18,730,343			$ 663,050	9
	B. Non-Facility Related*											
10	Interst Income		X								(929)	10
11	Interest Income - Bldg Co.		X								(677)	11
12	Alloc. From S.I.R. Mngmnt	X									(20,187)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (21,793)	14
15	TOTALS (line 9+line14)						$	$ 18,730,343			$ 641,257	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$ 105,272** **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.)**

**** 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 # 0029975 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

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

	1	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 # 0029975 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 197,000	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.)		$ 197,627	2
3. Under or (over) accrual (line 2 minus line 1).		$ 627	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 200,000	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.)**		$ 698	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.		$ 201,325	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	214,301	8
	2010	223,625	9
	2011	222,565	10
	2012	187,952	11
	2013	190,038	12

2014 Accrual - $190,038 x 1.05 = $200,000 (Rounded)
Allocated from S.I.R. Management - $7,589.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Wilson Care COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0029975

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2013 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2013.

	(A) 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	$ 190,038.18	$ 190,038.18
2.	See Attached	Home Office	$ 116,016.54	$ 7,174.20
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 306,054.72	$ 197,212.38

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

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 COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0029975

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 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 # 0029975 Report Period Beginning: 01/01/14 Ending: 12/31/14

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. [X] (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

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 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	$ 110,104	35	$ 43,994	$ (66,110)	$ 1,583,794	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1985	65,366		20			65,366	9
10	Various			1986	161,365		20			161,365	10
11	Various			1987	49,380		20			49,380	11
12	Various			1989	49,210		20			49,210	12
13	Various			1990	105,470		20			105,470	13
14	Various			1991	29,903		20			29,903	14
15	Various			1992	69,669		20			69,669	15
16	Various			1993	61,688		20			61,688	16
17	Various			1994	55,691		20	1,537	1,537	55,687	17
18	Various			1995	87,144		20	4,357	4,357	84,983	18
19	Various			1996	303,393		20	15,170	15,170	279,700	19
20	Various			1997	145,411		20	7,347	7,347	123,223	20
21	Various			1998	34,959		20	1,748	1,748	28,925	21
22	Various			1999	53,478		20	2,674	2,674	41,645	22
23	Various			2000	221,871		20	11,094	11,094	158,525	23
24	Various			2001	102,633		20	5,132	5,132	70,118	24
25	Various			2002	67,986		20			67,986	25
26	Various			2003	97,187		20	3,693	3,693	65,692	26
27	Various			2004	62,333		20	3,071	3,071	44,263	27
28	Various			2005	214,966		20	13,469	13,469	128,561	28
29	Various			2006	56,219		20	2,958	2,958	24,859	29
30	Various			2007	362,270		20	19,637	19,637	145,954	30
31	Various			2008	29,574		20	1,479	1,479	9,798	31
32	Various			2009	22,564		20	1,361	1,361	7,991	32
33	Various			2010	11,969		20	1,044	1,044	5,181	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 # 0029975 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
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)		1,334,252			68,154	68,154	244,948	67
68	Related Party Allocations (Pages 12H & 12I)		154,491	3,873		5,493	1,620	81,193	68
69	Financial Statement Depreciation			46,571			(46,571)		69
70	TOTAL (lines 4 thru 69)		$ 5,550,241	$ 160,548		$ 213,411	$ 52,863	$ 3,845,077	70

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

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 5,550,241	$ 160,548		$ 213,411	$ 52,863	$ 3,845,077	1
2	Security Camera System	2011	9,084		20	908	908	2,952	2
3	Concrete & Sewer Work	2011	2,650		20	133	133	464	3
4	Sprinkler System Repair	2011	5,250		20	263	263	809	4
5	Sprinkler Heads	2012	2,917		20	146	146	340	5
6	Supply & Install 4 Fire Steel Doors With Heavy Duty Frame	2014	7,350		20	368	368	368	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)		$ 5,577,492	$ 160,548		$ 215,228	$ 54,680	$ 3,850,011	34

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

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 5,577,492	$ 160,548		$ 215,228	$ 54,680	$ 3,850,011	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
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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)		$ 5,577,492	$ 160,548		$ 215,228	$ 54,680	$ 3,850,011	34

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

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 5,577,492	$ 160,548		$ 215,228	$ 54,680	$ 3,850,011	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)		$ 5,577,492	$ 160,548		$ 215,228	$ 54,680	$ 3,850,011	34

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

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 5,577,492	$ 160,548		$ 215,228	$ 54,680	$ 3,850,011	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)		$ 5,577,492	$ 160,548		$ 215,228	$ 54,680	$ 3,850,011	34

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

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements								8
9	Bathroom Remodel	2007	35,100		20	1,755	1,755	10,530	9
10	Flooring (4th)	2008	29,171		20	1,459	1,459	7,295	10
11	Flooring (5th)	2008	29,171		20	1,459	1,459	7,295	11
12	Bathroom Remodel	2008	135,720		20	6,786	6,786	33,930	12
13	Bathroom Remodel	2008	23,400		20	1,170	1,170	5,850	13
14	Painting	2008	146,700		20	7,335	7,335	36,675	14
15	Bathtub Liner	2008	16,250		20	813	813	4,064	15
16	Elevator Controller	2008	35,150		20	1,758	1,758	8,789	16
17	Handrails	2008	9,794		20	490	490	2,449	17
18	Phone System	2008	5,828		20	583	583	2,915	18
19	Hot Water Boilers	2008	29,247		20	1,462	1,462	7,311	19
20	Gas Line Piping	2008	4,979		20	249	249	1,245	20
21	Bathtub Liners	2009	12,200		20	610	610	2,440	21
22	Painting	2008	16,300		20	1,630	1,630	6,520	22
23	Terra Cotta Work	2010	154,950		20	7,748	7,748	23,244	23
24	HVAC Unit	2010	15,992		20	800	800	2,400	24
25	Dining Room Flooring	2010	47,092		20	2,355	2,355	5,510	25
26	Laundry Vent- Drain	2010	6,100		20	305	305	915	26
27	HVAC Electrical	2010	8,997		20	450	450	1,350	27
28	Flooring	2010	4,034		20	202	202	606	28
29	Concrete and Beams	2010	70,000		20	3,515	3,515	10,545	29
30	Oxygen Room Work- Installation of Exhaust Fan	2010	8,000		20	400	400	1,200	30
31	Fire Doors	2010	8,500		20	425	425	1,275	31
32	Nurse Station- Built in Custom Cabinets	2010	7,000		20	350	350	1,050	32
33	Fire Doors	2010	2,700		20	135	135	290	33
34	TOTAL (lines 1 thru 33)		$ 862,375	$		$ 44,244	$ 44,244	$ 185,693	34

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

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 862,375	$		$ 44,244	$ 44,244	$ 185,693	1
2	Fire Doors	2010	27,610		1,381	1,381	1,381	4,143	2
3	Satellite- Cableing and Installation	2010	11,362		881	881	881	2,643	3
4	Fire Doors	2010	3,650		183	183	183	549	4
5	Fire Rated Doors	2011	18,500		925	925	925	1,850	5
6	Ceiling Grid and Lighting	2011	5,685		284	284	284	568	6
7	Lintels and Tuckpointing	2011	47,745		2,387	2,387	2,387	4,774	7
8	Fired Rated Doors	2011	13,600		680	680	680	1,360	8
9	Fire Rated Doors	2011	2,200		110	110	110	220	9
10	Fire Rated Doors	2011	2,425		121	121	121	242	10
11	Gate Work	2011	2,925		146	146	146	292	11
12	Stair Treads	2011	3,771		189	189	189	378	12
13	Doors, Frames, Closets	2011	7,171		359	359	359	718	13
14	Installed Surface Mount Wiremold Raceways	2012	28,600		1,430	1,430	1,430	2,860	14
15	Installed Freezer Evaporator Coil and Expansion Valve	2012	3,640		182	182	182	364	15
16	Replaces Defective Cloth Covered Wires	2012	21,456		1,073	1,073	1,073	2,146	16
17	Replaced 496 Sprinklers	2012	21,990		1,100	1,100	1,100	2,200	17
18	Removed Non-working Doors, Replaced Existing Locks	2012	6,950		348	348	348	696	18
19	Replaced Pipe From 2nd to 3rd Floor, Plastered Drywall	2012	3,500		175	175	175	350	19
20	Installed New Window Screens	2012	2,524		126	126	126	252	20
21	Repaired walls & flooring for smoke room, office, & kitchen	2012	7,336		367	367	367	734	21
22	Replaced 51 exit signs & fuses & installed electric heaters	2012	17,075		854	854	854	1,708	22
23	Replaced A/C Units	2012	6,837		342	342	342	684	23
24	Repaired and Installed Railing With Round Pipe, Primed & Finish Colc	2012	3,935		197	197	197	394	24
25	Replaced Fire Exit Door Hardware	2012	3,598		180	180	180	360	25
26	Modernization of Two Traction Elevators	2011	185,400		9,270	9,270	9,270	27,810	26
27	Penthouse Elevator Project	2011	3,392		170	170	170	510	27
28	Conference Room Cabinetry	2013	6,500		325	325	325	325	28
29	Doctor's Office Cabinetry	2013	2,500		125	125	125	125	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,334,252	$		$ 68,154	$ 68,154	$ 244,948	34

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

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$	$		$	$	$	1
2	Buildings:								2
3	Allocated - S.I.R. Management	2009	19,740		39	506	506	2,552	3
4	Allocated - S.I.R. Properties - S.I.R. Management	1993	35,742	1,135	20	1,021	(114)	21,956	4
5									5
6									6
7									7
8	Leasehold Information								8
9	Allocated - S.I.R. Management	1993	9,062	252	20		(252)	9,062	9
10	Allocated - S.I.R. Management	1994	28		20			28	10
11	Allocated - S.I.R. Management	1995	207		20	10	10	201	11
12	Allocated - S.I.R. Management	1997	13,924	312	20	679	367	12,333	12
13	Allocated - S.I.R. Management	1999	1,095		20	55	55	834	13
14	Allocated - S.I.R. Management	1999	11,079		20			11,079	14
15	Allocated - S.I.R. Management	2000	1,293		20	65	65	940	15
16	Allocated - S.I.R. Management	2007	4,153	283	20	208	(75)	1,494	16
17	Allocated - S.I.R. Management	2008	11,446	1,094	20	721	(373)	4,938	17
18	Allocated - S.I.R. Management	2009	28,442	260	20	1,422	1,162	7,458	18
19	Allocated - S.I.R. Management	2011	704	70	20	70		240	19
20	Allocated - S.I.R. Management	2012	2,252	113	20	113		272	20
21	Allocated - S.I.R. Management	2014	316		20	9	9	9	21
22	Allocated - S.I.R. Properties - S.I.R. Management	2012	2,189	215	20	11	(204)	28	22
23	Allocated - S.I.R. Properties - S.I.R. Management	2010	2,157		20	108	108	467	23
24	Allocated - S.I.R. Properties - S.I.R. Management	2009	2,146	96	20	107	11	622	24
25	Allocated - S.I.R. Properties - S.I.R. Management	2007	626	31	20	31		250	25
26	Allocated - S.I.R. Properties - S.I.R. Management	2002	142		20	7	7	89	26
27	Allocated - S.I.R. Properties - S.I.R. Management	1999	4,529		20	226	226	3,510	27
28	Allocated - S.I.R. Properties - S.I.R. Management	1998	2,164		20	108	108	1,786	28
29	Allocated - S.I.R. Properties - S.I.R. Management	1997	135		20	7	7	125	29
30	Allocated - S.I.R. Properties - S.I.R. Management	1994	340	9	20	9		340	30
31	Allocated - S.I.R. Properties - S.I.R. Management	1993	580	3	20		(3)	580	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 154,491	$ 3,873		$ 5,493	$ 1,620	$ 81,193	34

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

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 154,491	$ 3,873		$ 5,493	$ 1,620	$ 81,193	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
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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)		$ 154,491	$ 3,873		$ 5,493	$ 1,620	$ 81,193	34

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

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 713,514	$ 1,519	$ 13,134	$ 11,615	10	$ 320,652	71
72	Current Year Purchases	380,529	146	973	827	10	770	72
73	Fully Depreciated Assets	637,607				10	637,607	73
74								74
75	TOTALS	$ 1,731,650	$ 1,665	$ 14,106	$ 12,441		$ 959,029	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		Allocated from S.I.R. Manageme	2014	$ 2,776	$ 251	$ 297	$ 46	5	$ 1,599	76
77										77
78										78
79										79
80	TOTALS			$ 2,776	$ 251	$ 297	$ 46		$ 1,599	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)	$ 7,337,119	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 162,464	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 229,631	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 67,167	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,810,639	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	Fire Alarm System	$ 11,238	92
93			93
94			94
95		$ 11,238	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 # 0029975 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.	/2015	$
13.	/2016	$
14.	/2017	$

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: $ 5,101 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	Allocated from S.I.R. Management		$	$ 5,384	17
18					18
19					19
20					20
21	TOTAL		$	$ 5,384	21

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

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

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

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

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.

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

STATE OF ILLINOIS

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/14 Ending: 12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 34,735	$ 151,526	1
2	Cash-Patient Deposits	26,397	26,397	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	932,396	932,396	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	23,228	50,085	6
7	Other Prepaid Expenses	1,824	1,824	7
8	Accounts Receivable (owners or related parties)	200,000	200,000	8
9	Other(specify):		963,553	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,218,580	$ 2,325,781	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	2,693,099	15
16	Equipment, at Historical Cost	1,415,047	2,161,253	16
17	Accumulated Depreciation (book methods)	(2,247,147)	(4,360,692)	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):	11,238	94,113	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 894,440	$ 2,152,773	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,113,020	$ 4,478,554	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 173,888	$ 173,889	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	26,415	26,415	28
29	Short-Term Notes Payable	125,000	125,000	29
30	Accrued Salaries Payable	249,901	249,901	30
31	Accrued Taxes Payable (excluding real estate taxes)	17,675	17,675	31
32	Accrued Real Estate Taxes(Sch.IX-B)		200,000	32
33	Accrued Interest Payable		54,266	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	25,500	25,500	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 618,379	$ 872,646	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		18,605,343	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43			1,244,882	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 19,850,225	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 618,379	$ 20,722,871	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,494,641	$ (16,244,317)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,113,020	$ 4,478,554	48

*(See instructions.)

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/14 Ending: 12/31/14

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,399,828	1
2	Restatements (describe):		2
3			3
4	**Rounding**	(3)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,399,825	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	634,816	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	(540,000)	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)**	$ 94,816	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)**	$ 1,494,641	24 *

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

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,517,882	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,517,882	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***	929	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 929	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	1,134	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,134	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,519,945	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,218,536	31
32	Health Care	1,755,108	32
33	General Administration	1,415,901	33
	B. Capital Expense		
34	Ownership	1,495,584	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,885,129	40
41	**Income before Income Taxes (line 30 minus line 40)****	634,816	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 634,816	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,505,471	44
45	Private Pay - Net Inpatient Revenue	77,648	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) Managed Care	1,934,763	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,517,882	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.**

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/14 Ending: 12/31/14

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,011	2,038	$ 85,160	$ 41.79	1
2	Assistant Director of Nursing	1,780	2,086	77,606	37.20	2
3	Registered Nurses	2,537	2,727	74,893	27.46	3
4	Licensed Practical Nurses	11,240	12,113	302,989	25.01	4
5	CNAs & Orderlies	55,413	59,758	601,024	10.06	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,861	2,086	44,249	21.21	9
10	Activity Assistants	5,177	5,835	54,368	9.32	10
11	Social Service Workers	13,343	14,572	273,952	18.80	11
12	Dietician					12
13	Food Service Supervisor	2,034	2,203	39,437	17.90	13
14	Head Cook	5,139	5,481	60,856	11.10	14
15	Cook Helpers/Assistants	11,093	12,034	116,007	9.64	15
16	Dishwashers					16
17	Maintenance Workers	3,651	4,062	48,402	11.92	17
18	Housekeepers	18,933	21,183	219,333	10.35	18
19	Laundry					19
20	Administrator	1,857	2,086	109,596	52.54	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	20,023	21,783	260,934	11.98	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	3,220	3,484	78,395	22.50	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	2,830	2,830	11,921	4.21	33
34	TOTAL (lines 1 - 33)	162,142	176,361	$ 2,459,122 *	$ 13.94	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 33,238	01-03	35
36	Medical Director	Monthly	3,200	09-03	36
37	Medical Records Consultant	Monthly	4,516	10-03	37
38	Nurse Consultant	Monthly	47,520	10-03	38
39	Pharmacist Consultant	Monthly	11,920	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	2,627	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Specialized Rehab Consultant	Monthly	23,760	10a-03	47
48	Psychiatric Consultant	Monthly	8,100	10-03	48
49	TOTAL (lines 35 - 48)		$ 134,881		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	23	780	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	23	$ 780		53

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/14 Ending: 12/31/14

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Augusto Beleg	Administrator	0.00%	$ 109,596
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 109,596

B. Administrative - Other

Description	Amount
Bonus	$ 3,000
SIR - Director of Admin Services	47,520
SIR - Ancillary Admin Charges	47,520
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 98,040

C. Professional Services

Vendor/Payee	Type	Amount
SIR Management	Dir. Of Regulatory Service	$ 23,760
SIR Management	Accounting	4,950
SIR Management	Bookkeeping	78,408
FROST	Accounting	13,170
See Attached	Legal Fees	6,696
Allscripts	Computer Services	1,912
SIR Management	Director of Finanacial Services	36,000
Personnel Planners	Unemployment Consulting	1,162
Pinnacle	Customer Satisfaction	1,071
Legat Architects	Consulting	1,170
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 168,299

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 22,642
Unemployment Compensation Insurance	46,090
FICA Taxes	183,665
Employee Health Insurance	68,202
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Chicago Head Tax	
Union Pension Expense	19,007
Union Health & Welfare	90,502
401K Contributions	1,675
Other Employee Benefits	3,157
TOTAL (agree to Schedule V, line 22, col.8)	$ 434,940

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	$ 1,992
Advertising: Employee Recruitment	2,235
Health Care Worker Background Check (Indicate # of checks performed)	7,728
Patient Background Checks 179	1,790
Dues & Subscriptions	14,377
Licenses & Permits	3,620
Alloced from S.I.R. Management	2,918
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 34,660

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,949
Allocated from S.I.R. Management	819
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,768

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/14 Ending: 12/31/14

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													
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19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/14 Ending: 12/31/14

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Alliance for Living - $24,434.00**

(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. $ **38** Line **10-02**

(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. $
This amount is to be recorded on line 42 of Schedule V.

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

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.