FOR BHF USE

LL1

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

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

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: Steven N. Lavenda **Telephone Number:** (847) 282-6300
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 01/01/16 to 12/31/16 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer

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

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

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	198	Intermediate (ICF)	198	72,468	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	198	TOTALS	198	72,468	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	18,278	260	37,697	56,235	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,278	260	37,697	56,235	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.60%

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

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

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	238,132	27,200	33,264	298,596		298,596	(16,039)	282,557			1
2	Food Purchase		280,378		280,378		280,378	(1,213)	279,165			2
3	Housekeeping	233,980	41,983		275,963		275,963	(2,893)	273,070			3
4	Laundry		14,001	20,296	34,297		34,297		34,297			4
5	Heat and Other Utilities			167,373	167,373		167,373	(12,207)	155,166			5
6	Maintenance	50,518	34,398	96,376	181,292		181,292	(17,033)	164,259			6
7	Other (specify):*							2,127	2,127			7
8	**TOTAL General Services**	522,630	397,960	317,309	1,237,899		1,237,899	(47,258)	1,190,641			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600	1,184	4,784			9
10	Nursing and Medical Records	1,139,095	31,294	132,281	1,302,670		1,302,670	(14,306)	1,288,364			10
10a	Therapy			33,264	33,264		33,264	(16,093)	17,171			10a
11	Activities	116,549	15,375	2,455	134,379		134,379		134,379			11
12	Social Services	226,491		8,100	234,591		234,591		234,591			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							9,673	9,673			15
16	**TOTAL Health Care and Programs**	1,482,135	46,669	179,700	1,708,504		1,708,504	(19,543)	1,688,961			16
	C. General Administration											
17	Administrative	116,404		224,544	340,948		340,948	(99,967)	240,981			17
18	Directors Fees											18
19	Professional Services			278,310	278,310	(5,480)	272,830	(189,646)	83,184			19
20	Dues, Fees, Subscriptions & Promotions			94,047	94,047		94,047	(64,196)	29,851			20
21	Clerical & General Office Expenses	227,647	17,360	72,028	317,035		317,035	91,221	408,256			21
22	Employee Benefits & Payroll Taxes			390,033	390,033		390,033		390,033			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,945	4,945		4,945	180	5,125			24
25	Other Admin. Staff Transportation			6,925	6,925		6,925	8,177	15,102			25
26	Insurance-Prop.Liab.Malpractice			155,156	155,156		155,156	16,926	172,082			26
27	Other (specify):*							37,716	37,716			27
28	**TOTAL General Administration**	344,051	17,360	1,225,988	1,587,399	(5,480)	1,581,919	(199,589)	1,382,330			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,348,816	461,989	1,722,997	4,533,802	(5,480)	4,528,322	(266,390)	4,261,932			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: 01/01/16 Ending: 12/31/16

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			46,925	46,925		46,925	190,225	237,150			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			11,281	11,281		11,281	602,481	613,762			32
33	Real Estate Taxes					5,480	5,480	226,558	232,038			33
34	Rent-Facility & Grounds			1,440,000	1,440,000		1,440,000	(1,440,000)				34
35	Rent-Equipment & Vehicles			4,959	4,959		4,959	6,041	11,000			35
36	Other (specify):*							99,262	99,262			36
37	**TOTAL Ownership**			1,503,165	1,503,165	5,480	1,508,645	(315,433)	1,193,212			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)**	2,348,816	461,989	3,226,162	6,036,967		6,036,967	(581,823)	5,455,144			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: 01/01/16 Ending: 12/31/16

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(14,446)	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	71,288	30		9
10	Interest and Other Investment Income	(30,794)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(13)	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	(36,800)	20		18
19	Entertainment				19
20	Contributions	(12,507)	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	(28,193)	21		24
25	Fund Raising, Advertising and Promotional	(4,304)	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	14,783			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (40,986)		$	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)	(540,837)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (540,837)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (581,823)		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: 01/01/16

Ending: 12/31/16

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Bank Fees	$ (7,662)	21	1
2	Theft & Damage	(135)	21	2
3	Vending Income	(1,200)	02	3
4	Additional R&M	1,949	06	4
5	Alliance Contribution	(12,461)	20	5
6	Prior Year Pharm. Expense	(1,500)	10	6
7	Prior Year Seminar Expense	(375)	24	7
8	Building Co. - Amortization of HUD Fees	(2,770)	36	8
9	Building Co. - Filing Fees & Office Expense	(350)	21	9
10	Building Co. - Legal and Other Professional	(8,700)	19	10
11	Amortization of Bond Premium	58,174	36	11
12	Building Company - Capitalized R&M	(10,127)	06	12
13	Non-allowable Dues	(60)	20	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**	14,783		49

Wilson Care

ID# 0029975

Report Period Beginning: 01/01/16

Ending: 12/31/16

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Wilson Care # 0029975 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary				(16,030)	(9)							(16,039)	1
2	Food Purchase	(1,213)											(1,213)	2
3	Housekeeping					(2,893)							(2,893)	3
4	Laundry													4
5	Heat and Other Utilities	(14,446)			2,239								(12,207)	5
6	Maintenance	(8,178)	11,487	(22,278)	1,967	(30)							(17,033)	6
7	Other (specify):*				2,127								2,127	7
8	**TOTAL General Services**	(23,837)	11,487	(22,278)	(9,698)	(2,933)							(47,258)	8
	B. Health Care and Programs													
9	Medical Director			1,184									1,184	9
10	Nursing and Medical Records	(1,500)		(17,998)	8,375	(1,339)	(1,844)						(14,306)	10
10a	Therapy				(16,093)								(16,093)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			5,177	4,496								9,673	15
16	**TOTAL Health Care and Programs**	(1,500)		(11,637)	(3,223)	(1,339)	(1,844)						(19,543)	16
	C. General Administration													
17	Administrative			(197,707)	97,740								(99,967)	17
18	Directors Fees													18
19	Professional Services	(8,700)	8,700	(205,995)	16,349								(189,646)	19
20	Fees, Subscriptions & Promotions	(66,132)		1,936									(64,196)	20
21	Clerical & General Office Expenses	(36,340)	362	127,188	143		(132)						91,221	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(375)		555									180	24
25	Other Admin. Staff Transportation			8,177									8,177	25
26	Insurance-Prop.Liab.Malpractice		14,742	1,986	198								16,926	26
27	Other (specify):*			13,786	23,930								37,716	27
28	**TOTAL General Administration**	(111,547)	23,804	(250,074)	138,360		(132)						(199,589)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(136,884)	35,291	(283,989)	125,439	(4,271)	(1,976)						(266,390)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Wilson Care **#** 0029975 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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

	Capital Expense	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	71,288	111,892		7,045								190,225	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(30,794)	631,105	(4,606)	6,776								602,481	32
33	Real Estate Taxes		218,152		8,406								226,558	33
34	Rent-Facility & Grounds		(1,440,000)										(1,440,000)	34
35	Rent-Equipment & Vehicles			6,041									6,041	35
36	Other (specify):*	55,404	43,858										99,262	36
37	TOTAL Ownership	95,898	(434,993)	1,435	22,227								(315,433)	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)	(40,986)	(399,702)	(282,554)	147,666	(4,271)	(1,976)						(581,823)	45

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See 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	$ 1,440,000	Wilson Care, LLC		$	$ (1,440,000)	1
2	V	21	Filing Fees		Wilson Care, LLC		350	350	2
3	V	32	Interest Income & Expense	613	Wilson Care, LLC		631,718	631,105	3
4	V	36	Mortgage Insurace		Wilson Care, LLC		99,262	99,262	4
5	V	21	Office Expense		Wilson Care, LLC		12	12	5
6	V	19	Professional Fees		Wilson Care, LLC		8,700	8,700	6
7	V	26	Property Insurace		Wilson Care, LLC		14,742	14,742	7
8	V	33	Real Estate Taxes		Wilson Care, LLC		218,152	218,152	8
9	V	06	Repairs & Maint. - Building		Wilson Care, LLC		11,487	11,487	9
10	V	36	Amort of Bond Premium	58,174	Wilson Care, LLC			(58,174)	10
11	V	36	Amort of HUD Fees		Wilson Care, LLC		2,770	2,770	11
12	V	30	Depreciation		Wilson Care, LLC		111,892	111,892	12
13	V								13
14	Total			$ 1,498,787			$ 1,099,085	$ * (399,702)	14

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

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

1 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.	$ 28,512	SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	$ 6,234	$ (22,278)	15
16	V	9	MEDICAL DIRECTOR CONSULTS		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	1,184	1,184	16
17	V	10	NURSING	57,024	SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	39,026	(17,998)	17
18	V	15	EMP. BEN.-H.C.		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	5,177	5,177	18
19	V	17	ADMINISTRATIVE	224,544	SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	26,837	(197,707)	19
20	V	19	PROFESSIONAL FEES	210,696	SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	4,701	(205,995)	20
21	V	20	FEES,SUBSCRIPTIONS		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	1,936	1,936	21
22	V	21	CLERICAL & GENERAL	9,504	SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	136,692	127,188	22
23	V	24	EDUCATION & SEMINAR		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	555	555	23
24	V	25	OTHER ADMIN. STAFF TRANS.		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	8,177	8,177	24
25	V	26	INSURANCE		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	1,986	1,986	25
26	V	27	EMP. BEN.-GEN. ADMIN.		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	13,786	13,786	26
27	V	32	INTEREST		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	(4,606)	(4,606)	27
28	V	35	AUTO RENTAL		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	5,106	5,106	28
29	V	35	EQUIPMENT RENTAL		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	935	935	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			$ 530,280			$ 247,726	$ * (282,554)	39

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

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

1 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	SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	$ 7,730	$ (16,030)	15
16	V	7	EMP. BEN.-DIETARY		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	1,353	1,353	16
17	V	10	NURSING SALARIES		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	8,375	8,375	17
18	V	15	EMP. BEN.-NURSING		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	1,460	1,460	18
19	V	17	ADMIN./LEGAL SALARIES		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	97,740	97,740	19
20	V	19	FIN. CONSULT./REGL. DIR.		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	15,793	15,793	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	23,930	23,930	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	33,264	SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	17,171	(16,093)	24
25	V	15	EMPLOYEE BENFITS		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	3,036	3,036	25
26	V								26
27	V	6	MAINTENANCE SALARIES	3,267	SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	4,355	1,088	27
28	V	7	EMPLOYEE BENEFITS		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	774	774	28
29	V								29
30	V	5	UTILITIES		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	2,239	2,239	30
31	V	6	REPAIRS AND MAINT.		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	879	879	31
32	V	19	PROFESSIONAL FEES		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	556	556	32
33	V	21	CLERICAL & GENERAL		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	143	143	33
34	V	26	INSURANCE		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	198	198	34
35	V	30	DEPRECIATION		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	7,045	7,045	35
36	V	32	INTEREST		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	6,776	6,776	36
37	V	33	REAL ESTATE TAXES		SIR MGMT.INC & GENERATIONS HC NETWORK, LLC	100.00%	8,406	8,406	37
38	V								38
39	Total			$ 60,291			$ 207,957	$ * 147,666	39

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

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

1 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	$ 123	Big Ten Supply, LLC	100.00%	$ 114	$ (9)	15
16	V	3	Housekeeping	39,488	Big Ten Supply, LLC	100.00%	36,595	(2,893)	16
17	V	4	Laundry		Big Ten Supply, LLC	100.00%			17
18	V	6	Repairs & Maintenance	415	Big Ten Supply, LLC	100.00%	384	(30)	18
19	V	10	Nursing And Medical Records	18,272	Big Ten Supply, LLC	100.00%	16,934	(1,339)	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			$ 58,298			$ 54,026	$ * (4,271)	39

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

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

1 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	10	Nursing and Medical Records	$ 25,603	MAC Rx, LLC	100.00%	$ 23,759	$ (1,844)	15
16	V	21	Clerical & General Office Expenses	1,834	MAC Rx, LLC	100.00%	1,702	(132)	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			$ 27,436			$ 25,460	$ * (1,976)	39

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

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

1 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: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

1 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: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

1 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: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

1 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: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

1 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: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	ARI WOLFF	2.222%	ALBANY CARE INC	EVANSTON	WILSON CARE, LLC	LINCOLNWOOD	BUILDING CO.	1
2	ASHLEY BARRISH	0.278%	GENERATIONS AT APPLEWOOD, 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%	GENERATIONS AT COLUMBUS PARK, INC	CHICAGO	OAKTON ARMS	DES PLAINES	ASSISTED LIVING	4
5	BRYAN BARRISH TRUST DTD 09/01/04	11.111%	DECATUR MANOR HEALTHCARE,LLC	DECATUR	MAC Rx LLC	DES PLAINES	PHARMACY CONSULT	5
6	CHERYL MAGENCE	4.722%	GENERATIONS AT ELMWOOD PARK, INC	ELMWOOD PARK	GENERATIONS HEALTH NETW	LINCOLNWOOD	MANAGEMENT CO.	6
7	DANIEL ROTHNER	0.972%	GREENWOOD CARE, INC.	EVANSTON	BIG TEN SUPPLY, LLC	LIBERTYVILLE	SUPPLY CO.	7
8	DARCEY BARRISH	0.278%	GENERATIONS AT NEIGHBORS, LLC	BYRON				8
9	ERIC ROTHNER	20.000%	GENERATIONS AT ROCK ISLAND, LLC	ROCK ISLAND				9
10	HOWARD GELLER TRUST	9.44%	GENERATIONS AT REGENCY, LLC	NILES				10
11	JESSE REYNOLDS DESCENDANTS TRUST	0.556%	AUBURN VILLAGE	AUBURN, IN				11
12	KIRSTEN BARRISH	0.278%	GENERATIONS AT OAKTON, LLC	DES PLAINES				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: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES

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

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

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Bryan Barrish	Relative	Administrative	0%	See Attached	3.16	7.02%	Alloc. Salary	$ 15,793	17-07	1
2	Kirsten Schloss	Owner	Maintenance	0.278%	See Attached	3.95	7.90%	Alloc. Salary	7,542	06-07	2
3	Sarah Barrish	Owner	Administrative	0.556%	See Attached	3.95	7.90%	Alloc. Salary	9,737	17-07	3
4	Nenita Guzman	Relative	Dietary	0%	See Attached	3.95	7.90%	Alloc. Salary	7,730	01-07	4
5	Clark Collins	Relative	Administrative	0%	See Attached	0.95	2.38%	Alloc. Salary	1,188	Var.	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	$ 41,990		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: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: SIR MGMT.INC & GENERATIONS HC NETW
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	712,171	14	$ 78,945	$	56,235	$ 6,234	1
2	9	MEDICAL DIRECTOR CONSUL	PATIENT DAYS	712,171	14	15,000		56,235	1,184	2
3	10	NURSING	PATIENT DAYS	712,171	14	494,227		56,235	39,026	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	712,171	14	65,558	494,227	56,235	5,177	4
5	17	ADMINISTRATIVE	PATIENT DAYS	712,171	14	339,874	339,874	56,235	26,837	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	712,171	14	59,533		56,235	4,701	6
7	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	712,171	14	24,522		56,235	1,936	7
8	21	CLERICAL & GENERAL	PATIENT DAYS	712,171	14	1,731,089	1,318,665	56,235	136,692	8
9	24	EDUCATION & SEMINAR	PATIENT DAYS	712,171	14	7,033		56,235	555	9
10	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	712,171	14	103,561		56,235	8,177	10
11	26	INSURANCE	PATIENT DAYS	712,171	14	25,150		56,235	1,986	11
12	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	712,171	14	174,591		56,235	13,786	12
13	32	INTEREST	PATIENT DAYS	712,171	14	(58,326)		56,235	(4,606)	13
14	35	AUTO RENTAL	PATIENT DAYS	712,171	14	64,663		56,235	5,106	14
15	35	EQUIPMENT RENTAL	PATIENT DAYS	712,171	14	11,842		56,235	935	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,137,262	$ 2,152,767		$ 247,726	25

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: SIR MGMT.INC & GENERATIONS HC NETW
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	712,171	14	$ 97,898	$ 97,898	56,235	$ 7,730	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	712,171	14	17,139		56,235	1,353	2
3	10	NURSING SALARIES	PATIENT DAYS	712,171	14	106,059	106,059	56,235	8,375	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	712,171	14	18,488		56,235	1,460	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	712,171	14	1,237,797	1,115,138	56,235	97,740	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	712,171	14	200,000		56,235	15,793	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	712,171	14	303,056		56,235	23,930	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	322,920	13	166,688	166,688	33,264	17,171	10
11	15	EMPLOYEE BENFITS	SPECIAL REHAB INC.	322,920	13	29,469		33,264	3,036	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	335,151	14	446,742	446,742	3,267	4,355	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	335,151	14	79,358		3,267	774	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,878	14	28,358		1,017	2,239	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,878	14	11,129		1,017	879	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,878	14	7,038		1,017	556	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,878	14	1,812		1,017	143	19
20	26	INSURANCE	ALLOCATED SQ FT	12,878	14	2,507		1,017	198	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,878	14	89,214		1,017	7,045	21
22	32	INTEREST	ALLOCATED SQ FT	12,878	14	85,804		1,017	6,776	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,878	14	106,445		1,017	8,406	23
24										24
25	TOTALS					$ 3,035,001	$ 1,932,526		$ 207,959	25

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Big Ten Supply, LLC
Street Address: 15632 West Sprucewood Lane
City / State / Zip Code: Libertyville, IL 60048
Phone Number: (312)502-5882
Fax Number: (847)816-3425

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Direct Allocation			$	$		$ 114	1
2	3	Housekeeping	Direct Allocation						36,595	2
3	4	Laundry	Direct Allocation							3
4	6	Repairs & Maintenance	Direct Allocation						384	4
5	10	Nursing And Medical Records	Direct Allocation						16,934	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					$	$		$ 54,026	25

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Nursing And Medical Records	Direct Allocation			$	$		$ 23,759	1
2	21	Clerical & General Office Expense	Direct Allocation						1,702	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					$	$		$ 25,460	25

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/16 Ending: 12/31/16

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Private Bank		X	Mortgage Payable			$	$ 17,878,411			$ 631,718	1
2												2
3												3
4												4
5					-							5
	Working Capital											
6	Lake Forest Bank		X	Line of Credit							11,281	6
7	Alloc. From SIR/Generations H	X									6,776	7
8					-							8
9	TOTAL Facility Related						$	$ 17,878,411			$ 649,775	9
	B. Non-Facility Related*											
10	Interest Income		X								(30,793)	10
11	Interest Income - Bldg Co.		X								(613)	11
12	Alloc. From SIR/Generations H	X									(4,606)	12
13					-							13
14	TOTAL Non-Facility Related						$	$			$ (36,012)	14
15	TOTALS (line 9+line14)						$	$ 17,878,411			$ 613,763	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 99,262 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: 01/01/16 Ending: 12/31/16

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

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** 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: 01/01/16 Ending: 12/31/16

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 202,400	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.)		$ 213,558	2
3. Under or (over) accrual (line 2 minus line 1).		$ 11,158	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 215,400	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.)		$ 5,480	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.		$ 232,038	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	222,565	8
	2012	187,952	9
	2013	190,038	10
	2014	192,737	11
	2015	205,152	12

2016 Accrual - $205,152 x 1.05 = $215,410 (Rounded)
Allocated from SIR/Generations HN = $8,406

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

NOTES:

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Wilson Care COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0029975

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-17-220-009-0000	Long Term Care Property	$ 205,151.64	$ 205,151.64
2.	10-31-401-046-0000	Allocated from Regency Property	$ 890,957.88	$ 854.88
3.	See Attached	Allocated from SIR/Generations HN	$ 123,678.12	$ 7,649.16
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 1,219,787.64	$ 213,655.68

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

IMPORTANT NOTICE

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

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

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

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Wilson Care COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0029975

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

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

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/16 Ending: 12/31/16

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 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	$ 111,892	35	$	$ (111,892)	$ 1,539,800	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1985	65,366		20			65,340	9
10	Various			1986	161,365		20			161,346	10
11	Various			1987	49,380		20			49,349	11
12	Various			1989	49,210		20			49,196	12
13	Various			1990	105,470		20			105,271	13
14	Various			1991	29,903		20			29,891	14
15	Various			1992	69,669		20			69,666	15
16	Various			1993	61,688		20			61,682	16
17	Various			1994	55,691		20			55,687	17
18	Various			1995	87,144		20			86,566	18
19	Various			1996	303,393		20	7,655	7,655	302,525	19
20	Various			1997	145,411		20	6,583	6,583	137,152	20
21	Various			1998	34,959		20	1,748	1,748	32,421	21
22	Various			1999	53,478		20	2,674	2,674	46,993	22
23	Various			2000	221,871		20	11,094	11,094	180,712	23
24	Various			2001	102,633		20	5,132	5,132	80,382	24
25	Various			2002	67,986		20			67,986	25
26	Various			2003	97,187		20	3,693	3,693	73,079	26
27	Various			2004	62,333		20	1,900	1,900	48,064	27
28	Various			2005	214,966		20	8,027	8,027	146,741	28
29	Various			2006	56,219		20	2,762	2,762	30,580	29
30	Various			2007	362,270		20	19,637	19,637	185,228	30
31	Various			2008	29,574		20	1,479	1,479	12,755	31
32	Various			2009	22,564		20	1,361	1,361	10,712	32
33	Various			2010	11,969		20	1,044	1,044	7,269	33
34	Various			2011	16,984		20	1,303	1,303	6,832	34
35	Various			2012	2,917		20	146	146	632	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: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		1,393,651			70,013	70,013	385,576	67
68	Related Party Allocations (Pages 12H & 12I)		174,667	4,210		6,094	1,884	96,133	68
69	Financial Statement Depreciation			46,925			(46,925)		69
70	TOTAL (lines 4 thru 69)		$ 5,649,717	$ 163,027		$ 152,344	$ (10,683)	$ 4,125,566	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: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 5,649,717	$ 163,027		$ 152,344	$ (10,683)	$ 4,125,566	1
2	Supply & Install 4 Steel Doors With Heavy Duty Frame	2014	7,350		20	368	368	858	2
3	1St Floor Tile Replacement	2015	2,625		20	131	131	164	3
4	Tile Removal / Concrete Repair In Lobby	2015	6,240		20	312	312	416	4
5	Electric Heaters (4) In Lobby	2015	3,475		20	174	174	188	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)		$ 5,669,407	$ 163,027		$ 153,329	$ (9,698)	$ 4,127,192	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: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 5,669,407	$ 163,027		$ 153,329	$ (9,698)	$ 4,127,192	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)		$ 5,669,407	$ 163,027		$ 153,329	$ (9,698)	$ 4,127,192	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: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 5,669,407	$ 163,027		$ 153,329	$ (9,698)	$ 4,127,192	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)		$ 5,669,407	$ 163,027		$ 153,329	$ (9,698)	$ 4,127,192	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: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 5,669,407	$ 163,027		$ 153,329	$ (9,698)	$ 4,127,192	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)		$ 5,669,407	$ 163,027		$ 153,329	$ (9,698)	$ 4,127,192	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: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Bathroom Remodel	2007	35,100		20	1,755	1,755	14,040	9
10	Various	2008	481,710		20	24,086	24,086	173,618	10
11	Bathtub Liners	2009	12,200		20	610	610	3,660	11
12	Terra Cotta Work	2010	154,950		20	7,748	7,748	38,740	12
13	HVAC Unit	2010	15,992		20	800	800	4,000	13
14	Dining Room Flooring	2010	47,092		20	2,355	2,355	10,220	14
15	Laundry Vent- Drain	2010	6,100		20	305	305	1,525	15
16	HVAC Electrical	2010	8,997		20	450	450	2,250	16
17	Flooring	2010	4,034		20	202	202	1,010	17
18	Concrete and Beams	2010	70,000		20	3,515	3,515	17,575	18
19	Oxygen Room Work- Installation of Exhaust Fan	2010	8,000		20	400	400	2,000	19
20	Fire Doors	2010	8,500		20	425	425	2,125	20
21	Nurse Station- Built in Custom Cabinets	2010	7,000		20	350	350	1,750	21
22	Fire Doors	2010	2,700		20	135	135	560	22
23	Fire Doors	2010	27,610		20	1,381	1,381	6,905	23
24	Satellite- Cableing and Installation	2010	11,362		20	881	881	4,405	24
25	Fire Doors	2010	3,650		20	183	183	915	25
26	Fire Rated Doors	2011	18,500		20	925	925	3,700	26
27	Ceiling Grid and Lighting	2011	5,685		20	284	284	1,136	27
28	Lintels and Tuckpointing	2011	47,745		20	2,387	2,387	9,548	28
29	Fired Rated Doors	2011	13,600		20	680	680	2,720	29
30	Fire Rated Doors	2011	2,200		20	110	110	440	30
31	Fire Rated Doors	2011	2,425		20	121	121	484	31
32	Gate Work	2011	2,925		20	146	146	584	32
33	Stair Treads	2011	3,771		20	189	189	756	33
34	TOTAL (lines 1 thru 33)		$ 1,001,848	$		$ 50,422	$ 50,422	$ 304,665	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: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 1,001,848	$		$ 50,422	$ 50,422	$ 304,665	1
2	Doors, Frames, Closets	2011	7,171		20	359	359	1,436	2
3	Installed Surface Mount Wiremold Raceways	2012	28,600		20	1,430	1,430	5,720	3
4	Installed Freezer Evaporator Coil and Expansion Valve	2012	3,640		20	182	182	728	4
5	Replaces Defective Cloth Covered Wires	2012	21,456		20	1,073	1,073	4,289	5
6	Replaced 496 Sprinklers	2012	21,990		20	1,100	1,100	4,400	6
7	Removed Non-working Doors, Replaced Existing Locks	2012	6,950		20	348	348	1,392	7
8	Replaced Pipe From 2nd to 3rd Floor, Plastered Drywall	2012	3,500		20	175	175	700	8
9	Installed New Window Screens	2012	2,524		20	126	126	504	9
10	Repaired walls & flooring for smoke room, office, & kitchen	2012	7,336		20	367	367	1,468	10
11	Replaced 51 exit signs & fuses & installed electric heaters	2012	17,075		20	854	854	3,416	11
12	Replaced A/C Units	2012	6,837		20	342	342	1,368	12
13	Repaired and Installed Railing With Round Pipe, Primed & Finish Col	2012	3,935		20	197	197	788	13
14	Replaced Fire Exit Door Hardware	2012	3,598		20	180	180	720	14
15	Modernization of Two Traction Elevators	2011	185,400		20	9,270	9,270	46,350	15
16	Penthouse Elevator Project	2011	3,392		20	170	170	850	16
17	Conference Room Cabinetry	2013	6,500		20	325	325	975	17
18	Doctor's Office Cabinetry	2013	2,500		20	125	125	375	18
19	Fire Alarm Panel	2015	35,757		20	1,788	1,788	3,576	19
20	Replace Steam-Pipes- Activity Room and Bathroom	2015	3,640		20	182	182	364	20
21	Fire Rated Steel Doors	2015	2,825		20	141	141	282	21
22	Bathroom Tubs and Walls	2015	3,600		20	180	180	360	22
23	Replace Steel Bathtubs- Bathrooms 503/504/509	2015	3,450		20	173	173	346	23
24	Clean, sand, dry, mask, & refinish bathtub	2016	5,150		20	258	258	258	24
25	Air Conditioners	2016	4,977		20	249	249	249	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,393,651	$		$ 70,013	$ 70,013	$ 385,576	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: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated - S.I.R. Management/Generations HN	2009	39,486	1,012	39	1,012		7,129	3
4	Allocated - S.I.R. Properties - S.I.R. Management/Generations HN	1993	35,748	1,135	35	1,021	(114)	24,002	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated - S.I.R. Management/Generations HN	1993	9,063	252	20		(252)	9,063	9
10	Allocated - S.I.R. Management/Generations HN	1994	28		20			28	10
11	Allocated - S.I.R. Management/Generations HN	1995	207		20			207	11
12	Allocated - S.I.R. Management/Generations HN	1997	13,926		20	679	679	13,693	12
13	Allocated - S.I.R. Management/Generations HN	1999	1,095		20	55	55	944	13
14	Allocated - S.I.R. Management/Generations HN	1999	11,079		20			11,079	14
15	Allocated - S.I.R. Management/Generations HN	2000	1,293		20	65	65	1,069	15
16	Allocated - S.I.R. Management/Generations HN	2007	4,154		20	208	208	1,910	16
17	Allocated - S.I.R. Management/Generations HN	2008	11,448	1,145	20	722	(423)	6,382	17
18	Allocated - S.I.R. Management/Generations HN	2009	28,446	260	20	1,422	1,162	10,304	18
19	Allocated - S.I.R. Management/Generations HN	2011	704	70	20	70		381	19
20	Allocated - S.I.R. Management/Generations HN	2012	2,252	113	20	113		497	20
21	Allocated - S.I.R. Management/Generations HN	2014	316	32	20	16	(16)	41	21
22	Allocated - S.I.R. Management/Generations HN	2016	411	9	20	9		9	22
23	Allocated - S.I.R. Properties - S.I.R. Management/Generations HN	2012 #	2,190	110	20	109	(1)	439	23
24	Allocated - S.I.R. Properties - S.I.R. Management/Generations HN	2010	2,157		20	108	108	683	24
25	Allocated - S.I.R. Properties - S.I.R. Management/Generations HN	2009	2,146	48	20	107	59	837	25
26	Allocated - S.I.R. Properties - S.I.R. Management/Generations HN	2007	626	12	20	31	19	313	26
27	Allocated - S.I.R. Properties - S.I.R. Management/Generations HN	2002	142		20	7	7	103	27
28	Allocated - S.I.R. Properties - S.I.R. Management/Generations HN	1999	4,530		20	226	226	3,963	28
29	Allocated - S.I.R. Properties - S.I.R. Management/Generations HN	1998	2,165		20	108	108	2,002	29
30	Allocated - S.I.R. Properties - S.I.R. Management/Generations HN	1997	135		20	6	6	135	30
31	Allocated - S.I.R. Properties - S.I.R. Management/Generations HN	1994	340	9	20		(9)	340	31
32	Allocated - S.I.R. Properties - S.I.R. Management/Generations HN	1993	580	3	20		(3)	580	32
33									33
34	TOTAL (lines 1 thru 33)		$ 174,667	$ 4,210		$ 6,094	$ 1,884	$ 96,133	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: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 174,667	$ 4,210		$ 6,094	$ 1,884	$ 96,133	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)		$ 174,667	$ 4,210		$ 6,094	$ 1,884	$ 96,133	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: 01/01/16 Ending: 12/31/16

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,055,326	$ 2,567	$ 83,531	$ 80,964	10	$ 652,465	71
72	Current Year Purchases	742	27	27		10	27	72
73	Fully Depreciated Assets	680,647		25	25	10	680,647	73
74								74
75	TOTALS	$ 1,736,715	$ 2,594	$ 83,583	$ 80,989		$ 1,333,139	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 SIR/Generations]	2016	$ 2,776	$ 243	$ 240	$ (3)	5	$ 2,136	76
77										77
78										78
79										79
80	TOTALS			$ 2,776	$ 243	$ 240	$ (3)		$ 2,136	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)	$ 7,434,099	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 165,864	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 237,152	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 71,288	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,462,467	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/16 Ending: 12/31/16

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2017	$
13.	/2018	$
14.	/2019	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 5,894 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 SIR/Generations HN		$	$ 5,106	17
18					18
19					19
20					20
21	TOTAL		$ -	$ 5,106	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: 01/01/16 Ending: 12/31/16

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		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		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:** 01/01/16 **Ending:** 12/31/16

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

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 53,055	$ 216,530	1
2	Cash-Patient Deposits	38,207	38,207	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	708,146	708,146	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	23,678	57,769	6
7	Other Prepaid Expenses	7,520	7,520	7
8	Accounts Receivable (owners or related parties)	200,000	200,000	8
9	Other(specify):		962,573	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,030,606	$ 2,190,745	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	2,728,856	15
16	Equipment, at Historical Cost	1,418,392	2,164,598	16
17	Accumulated Depreciation (book methods)	(2,340,829)	(4,678,158)	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):		77,335	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 792,865	$ 1,857,631	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,823,471	$ 4,048,376	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 144,517	$ 144,517	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	38,229	38,229	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	115,627	115,627	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,636	4,636	31
32	Accrued Real Estate Taxes(Sch.IX-B)		215,400	32
33	Accrued Interest Payable		52,146	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	9,996	9,996	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 313,005	$ 580,551	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		17,878,523	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43			1,128,411	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 19,006,934	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 313,005	$ 19,587,485	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,510,466	$ (15,539,109)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,823,471	$ 4,048,376	48

***(See instructions.)**

Facility Name & ID Number Wilson Care **#** 0029975 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,424,928	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)**	$ 1,424,931	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	85,535	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 85,535	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)**	$ 1,510,466	24 *

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

Facility Name & ID Number Wilson Care **#** 0029975 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,081,506	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,081,506	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***	30,794	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 30,794	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	10,202	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 10,202	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,122,502	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,237,899	31
32	Health Care	1,708,504	32
33	General Administration	1,587,399	33
	B. Capital Expense		
34	Ownership	1,503,165	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)***	$ 6,036,967	40
41	**Income before Income Taxes (line 30 minus line 40)****	85,535	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 85,535	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,972,187	44
45	Private Pay - Net Inpatient Revenue	35,082	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) Managed Care	4,074,237	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,081,506	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: 01/01/16 Ending: 12/31/16

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,943	2,206	$ 92,596	$ 41.97	1
2	Assistant Director of Nursing	299	299	9,646	32.26	2
3	Registered Nurses	4,072	4,132	117,853	28.52	3
4	Licensed Practical Nurses	8,823	9,540	229,576	24.06	4
5	CNAs & Orderlies	52,192	56,200	598,217	10.64	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	7,828	8,488	116,549	13.73	10
11	Social Service Workers	10,918	12,001	217,336	18.11	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,481	20,744	238,132	11.48	15
16	Dishwashers					16
17	Maintenance Workers	3,735	4,100	50,518	12.32	17
18	Housekeepers	19,597	21,295	233,980	10.99	18
19	Laundry					19
20	Administrator	1,878	2,091	116,404	55.67	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,766	17,645	227,647	12.90	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	3,774	4,062	91,207	22.45	31
32	Other Health Care(specify)					32
33	Other(specify)	1,784	1,784	9,155	5.13	33
34	TOTAL (lines 1 - 33)	151,090	164,587	$ 2,348,816 *	$ 14.27	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	$ 33,264	01-03	35
36	Medical Director	Monthly	3,600	09-03	36
37	Medical Records Consultant	Monthly	4,800	10-03	37
38	Nurse Consultant	Monthly	57,024	10-03	38
39	Pharmacist Consultant	Monthly	17,537	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	2,455	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Psychiatric Consultant	Monthly	8,100	12-03	47
48	Specialized Rehab Consultant	Monthly	33,264	10A-03	48
49	TOTAL (lines 35 - 48)		$ 160,044		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,485	$ 52,920	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,485	$ 52,920		53

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/16 Ending: 12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Augusto Beley	Administrator	0.00	$ 116,404
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 116,404

B. Administrative - Other

Description	Amount
SIR/Generations HN - Director of Admin Services	$ 57,024
SIR/Generations HN - Ancillary Admin Charges	47,520
SIR/Generations HN - Consulting Fee	120,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 224,544
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
SIR Management/Generations HN	Dir. Of Financial Services	$ 42,000
SIR Management/Generations HN	Dir. Of Marketing & Admissions	40,392
SIR Management/Generations HN	Dir. Of Regulatory Services	28,512
SIR Management/Generations HN	Dir. Of IT	11,880
SIR Management/Generations HN	Bookkeeping Services	87,912
SIR Management/Generations HN	Computer Support	26,136
See Attached	Legal Fees	4,590
Personnel Planners	Unemployment Consultant	1,512
Marcum LLP	Accounting Services	16,200
Burke, Warren, MacKay, & Serritella	R/E Tax Appeal	5,008
Legat Architects	Architecture Consulting	1,679
See Supplemental Schedule		12,486
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 278,307

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 28,805
Unemployment Compensation Insurance	26,509
FICA Taxes	178,888
Employee Health Insurance	35,911
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Union Pension Plan	24,619
Union Health & Welfare	88,292
401K Matching Contribution	600
Employee Benefits - Other	6,409
TOTAL (agree to Schedule V, line 22, col.8)	$ 390,033

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	927
Health Care Worker Background Check	
(Indicate # of checks performed 524)	5,243
Patient Background Checks 160	1,600
Dues & Subscriptions	16,574
Licenses and Permits	38,438
Allocated from SIR/Generations HN	1,936
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 66,710

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,570
Allocated from SIR/Generations HN	555
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,125

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Wilson Care # 0029975 **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Alliance for Living - $25,692**

(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. $ **137** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $
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. $ Has any meal income been offset against related costs? **NlA** 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. $ **No**

(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