		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.

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

I. IDPH License ID Number: 0054221

Facility Name: Wilson Care Inc.

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

County: Cook

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

HFS ID Number:

Date of Initial License for Current Owners: 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 01/01/17 to 12/31/17 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)
** Subject to the attached Accountants' Consulting Report*
(Date)
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 9 Parkway North, Suite 200 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 Inc. # 0054221 Report Period Beginning: 01/01/17 Ending: 12/31/17

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	6,563	62	46,344	52,969	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,563	62	46,344	52,969	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.29%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve 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 9/1/1988

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 9/1/1988 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: 12/31/17 Fiscal Year: 12/31/17

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

Facility Name & ID Number Wilson Care Inc. # 0054221 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	260,994	32,003	33,744	326,741		326,741	(16,640)	310,101			1
2	Food Purchase		282,737		282,737		282,737	(1,053)	281,684			2
3	Housekeeping	254,832	38,603		293,435		293,435	(3,078)	290,357			3
4	Laundry		14,756	18,717	33,473		33,473	(54)	33,419			4
5	Heat and Other Utilities			183,507	183,507		183,507	(14,894)	168,613			5
6	Maintenance	43,454	36,505	104,564	184,523		184,523	(14,189)	170,334			6
7	Other (specify):*							2,972	2,972			7
8	**TOTAL General Services**	559,280	404,604	340,532	1,304,416		1,304,416	(46,936)	1,257,480			8
	B. Health Care and Programs											
9	Medical Director			6,100	6,100		6,100	6,259	12,359			9
10	Nursing and Medical Records	1,198,746	29,313	130,720	1,358,779		1,358,779	(8,863)	1,349,916			10
10a	Therapy			33,315	33,315		33,315	(15,412)	17,903			10a
11	Activities	103,451	14,055	2,496	120,002		120,002		120,002			11
12	Social Services	278,207		8,600	286,807		286,807		286,807			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							10,238	10,238			15
16	**TOTAL Health Care and Programs**	1,580,404	43,368	181,231	1,805,003		1,805,003	(7,778)	1,797,225			16
	C. General Administration											
17	Administrative	118,200		226,920	345,120		345,120	(92,557)	252,563			17
18	Directors Fees											18
19	Professional Services			285,060	285,060		285,060	(200,116)	84,944			19
20	Dues, Fees, Subscriptions & Promotions			67,148	67,148		67,148	(31,742)	35,406			20
21	Clerical & General Office Expenses	193,018	18,791	70,013	281,822		281,822	97,572	379,394			21
22	Employee Benefits & Payroll Taxes			400,833	400,833		400,833	(81)	400,752			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,446	4,446		4,446	175	4,621			24
25	Other Admin. Staff Transportation			7,622	7,622		7,622	10,698	18,320			25
26	Insurance-Prop.Liab.Malpractice			146,880	146,880		146,880	14,033	160,913			26
27	Other (specify):*							40,661	40,661			27
28	**TOTAL General Administration**	311,218	18,791	1,208,922	1,538,931		1,538,931	(161,357)	1,377,574			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,450,902	466,763	1,730,685	4,648,350		4,648,350	(216,071)	4,432,279			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 Inc. #0054221 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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			47,230	47,230		47,230	174,982	222,212			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			25,961	25,961		25,961	584,886	610,847			32
33	Real Estate Taxes							252,004	252,004			33
34	Rent-Facility & Grounds			1,446,000	1,446,000		1,446,000	(1,446,000)				34
35	Rent-Equipment & Vehicles			3,585	3,585		3,585	4,824	8,409			35
36	Other (specify):*							97,189	97,189			36
37	**TOTAL Ownership**			1,522,776	1,522,776		1,522,776	(332,115)	1,190,661			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee											42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**											44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,450,902	466,763	3,253,461	6,171,126		6,171,126	(548,186)	5,622,940			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 Inc. # 0054221 Report Period Beginning: 01/01/17 Ending: 12/31/17

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(16,860)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	55,951	30		9
10	Interest and Other Investment Income	(34,445)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3)	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	(1,040)	20		18
19	Entertainment				19
20	Contributions	(16,760)	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	(24,506)	21		24
25	Fund Raising, Advertising and Promotional	(3,493)	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	(47,287)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (88,443)		$	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)	(459,743)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (459,743)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (548,186)		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 Inc.

ID# 0054221

Report Period Beginning: 01/01/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Bank Fees	$ (7,834)	21	1
2	Theft & Damage Loss	(522)	21	2
3	Vending Income	(1,050)	2	3
4	Jury Duty Income	(34)	10	4
5	State Replacement Tax	(552)	21	5
6	Alliance for Living - Lobbying	(10,739)	20	6
7	Capitalized R&M	(8,512)	6	7
8	Capitalized R&M - Building Company	(3,062)	6	8
9	Building Company - Filing Fees	(350)	20	9
10	Building Company - Office Expense	(12)	21	10
11	Building Company - Audit Fees	(8,900)	19	11
12	Building Company - Amortization	(2,770)	36	12
13	Non-Allowable Legal	(2,950)	19	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**	(47,287)		49

Wilson Care Inc.

ID# 0054221

Report Period Beginning: 01/01/17

Ending: 12/31/17

	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 Inc. # 0054221 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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				(16,640)								(16,640)	1
2	Food Purchase	(1,053)											(1,053)	2
3	Housekeeping						(3,078)						(3,078)	3
4	Laundry						(54)						(54)	4
5	Heat and Other Utilities	(16,860)			1,966								(14,894)	5
6	Maintenance	(11,574)	11,707	(15,549)	1,285		(58)						(14,189)	6
7	Other (specify):*			1,268	1,704								2,972	7
8	**TOTAL General Services**	(29,487)	11,707	(14,281)	(11,685)		(3,190)						(46,936)	8
	B. Health Care and Programs													
9	Medical Director			6,259									6,259	9
10	Nursing and Medical Records	(34)		(13,222)	8,200	(1,785)	(2,022)						(8,863)	10
10a	Therapy				(15,412)								(15,412)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			5,609	4,629								10,238	15
16	**TOTAL Health Care and Programs**	(34)		(1,354)	(2,583)	(1,785)	(2,022)						(7,778)	16
	C. General Administration													
17	Administrative			(201,036)	108,479								(92,557)	17
18	Directors Fees													18
19	Professional Services	(11,850)	8,900	(212,518)	15,352								(200,116)	19
20	Fees, Subscriptions & Promotions	(32,382)	350	290									(31,742)	20
21	Clerical & General Office Expenses	(33,426)	12	130,939	157	(82)	(28)						97,572	21
22	Employee Benefits & Payroll Taxes					(81)							(81)	22
23	Inservice Training & Education													23
24	Travel and Seminar			175									175	24
25	Other Admin. Staff Transportation			10,698									10,698	25
26	Insurance-Prop.Liab.Malpractice		12,042	1,786	205								14,033	26
27	Other (specify):*			13,941	26,720								40,661	27
28	**TOTAL General Administration**	(77,658)	21,304	(255,725)	150,913	(163)	(28)						(161,357)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(107,179)	33,011	(271,360)	136,645	(1,948)	(5,240)						(216,071)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Wilson Care Inc. # 0054221 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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	55,951	112,093		6,938								174,982	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(34,445)	617,886	(4,339)	5,784								584,886	32
33	Real Estate Taxes		243,361		8,643								252,004	33
34	Rent-Facility & Grounds		(1,446,000)										(1,446,000)	34
35	Rent-Equipment & Vehicles			4,824									4,824	35
36	Other (specify):*	(2,770)	99,959										97,189	36
37	TOTAL Ownership	18,736	(372,701)	485	21,365								(332,115)	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)	(88,443)	(339,690)	(270,875)	158,010	(1,948)	(5,240)						(548,186)	45

Facility Name & ID Number Wilson Care Inc. # 0054221 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 1,446,000	Wilson Care, LLC	100.00%	$	$ (1,446,000)	1
2	V	32	Interest	642	Wilson Care, LLC	100.00%	618,528	617,886	2
3	V	6	Building R&M		Wilson Care, LLC	100.00%	11,707	11,707	3
4	V	20	Filing Fees		Wilson Care, LLC	100.00%	350	350	4
5	V	36	Mortgage Insurance		Wilson Care, LLC	100.00%	97,189	97,189	5
6	V	21	Office Expense		Wilson Care, LLC	100.00%	12	12	6
7	V	26	Property Insurance		Wilson Care, LLC	100.00%	12,042	12,042	7
8	V	33	Real Estate Tax		Wilson Care, LLC	100.00%	243,361	243,361	8
9	V	30	Depreciation		Wilson Care, LLC	100.00%	112,093	112,093	9
10	V	19	Audit Fees		Wilson Care, LLC	100.00%	8,900	8,900	10
11	V	36	Amortization		Wilson Care, LLC	100.00%	2,770	2,770	11
12	V								12
13	V								13
14	Total			$ 1,446,642			$ 1,106,952	$ * (339,690)	14

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

Facility Name & ID Number Wilson Care Inc. # 0054221 Report Period Beginning: 01/01/17 Ending: 12/31/17

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.	$ 29,112	GENERATIONS HC NETWORK, LLC	100.00%	$ 13,563	$ (15,549)	15
16	V	7	EMP. BEN.-GEN. SERV.		GENERATIONS HC NETWORK, LLC	100.00%	1,268	1,268	16
17	V	9	MEDICAL DIRECTOR CONSULTS		GENERATIONS HC NETWORK, LLC	100.00%	6,259	6,259	17
18	V	10	NURSING	58,212	GENERATIONS HC NETWORK, LLC	100.00%	44,990	(13,222)	18
19	V	15	EMP. BEN.-H.C.		GENERATIONS HC NETWORK, LLC	100.00%	5,609	5,609	19
20	V	17	ADMINISTRATIVE	226,920	GENERATIONS HC NETWORK, LLC	100.00%	25,884	(201,036)	20
21	V	19	PROFESSIONAL FEES	214,152	GENERATIONS HC NETWORK, LLC	100.00%	1,634	(212,518)	21
22	V	20	FEES,SUBSCRIPTIONS		GENERATIONS HC NETWORK, LLC	100.00%	290	290	22
23	V	21	CLERICAL & GENERAL	9,744	GENERATIONS HC NETWORK, LLC	100.00%	140,683	130,939	23
24	V	24	EDUCATION & SEMINAR		GENERATIONS HC NETWORK, LLC	100.00%	175	175	24
25	V	25	OTHER ADMIN. STAFF TRANS.		GENERATIONS HC NETWORK, LLC	100.00%	10,698	10,698	25
26	V	26	INSURANCE		GENERATIONS HC NETWORK, LLC	100.00%	1,786	1,786	26
27	V	27	EMP. BEN.-GEN. ADMIN.		GENERATIONS HC NETWORK, LLC	100.00%	13,941	13,941	27
28	V	32	INTEREST		GENERATIONS HC NETWORK, LLC	100.00%	(4,339)	(4,339)	28
29	V	35	AUTO RENTAL		GENERATIONS HC NETWORK, LLC	100.00%	3,956	3,956	29
30	V	35	EQUIPMENT RENTAL		GENERATIONS HC NETWORK, LLC	100.00%	868	868	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			$ 538,140			$ 267,265	$ * (270,875)	39

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

Facility Name & ID Number Wilson Care Inc. # 0054221 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 24,240	GENERATIONS HC NETWORK, LLC	100.00%	$ 7,600	$ (16,640)	15
16	V	7	EMP. BEN.-DIETARY		GENERATIONS HC NETWORK, LLC	100.00%	1,317	1,317	16
17	V	10	NURSING SALARIES		GENERATIONS HC NETWORK, LLC	100.00%	8,200	8,200	17
18	V	15	EMP. BEN.-NURSING		GENERATIONS HC NETWORK, LLC	100.00%	1,415	1,415	18
19	V	17	ADMIN./LEGAL SALARIES		GENERATIONS HC NETWORK, LLC	100.00%	108,479	108,479	19
20	V	19	FIN. CONSULT./REGL. DIR.		GENERATIONS HC NETWORK, LLC	100.00%	15,265	15,265	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		GENERATIONS HC NETWORK, LLC	100.00%	26,720	26,720	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	33,864	GENERATIONS HC NETWORK, LLC	100.00%	18,452	(15,412)	24
25	V	15	EMPLOYEE BENFITS		GENERATIONS HC NETWORK, LLC	100.00%	3,214	3,214	25
26	V								26
27	V	6	MAINTENANCE SALARIES	2,079	GENERATIONS HC NETWORK, LLC	100.00%	2,133	54	27
28	V	7	EMPLOYEE BENEFITS		GENERATIONS HC NETWORK, LLC	100.00%	387	387	28
29	V								29
30	V	5	UTILITIES		GENERATIONS HC NETWORK, LLC	100.00%	1,966	1,966	30
31	V	6	REPAIRS AND MAINT.		GENERATIONS HC NETWORK, LLC	100.00%	1,231	1,231	31
32	V	19	PROFESSIONAL FEES		GENERATIONS HC NETWORK, LLC	100.00%	87	87	32
33	V	21	CLERICAL & GENERAL		GENERATIONS HC NETWORK, LLC	100.00%	157	157	33
34	V	26	INSURANCE		GENERATIONS HC NETWORK, LLC	100.00%	205	205	34
35	V	30	DEPRECIATION		GENERATIONS HC NETWORK, LLC	100.00%	6,938	6,938	35
36	V	32	INTEREST		GENERATIONS HC NETWORK, LLC	100.00%	5,784	5,784	36
37	V	33	REAL ESTATE TAXES		GENERATIONS HC NETWORK, LLC	100.00%	8,643	8,643	37
38	V								38
39	Total			$ 60,183			$ 218,193	$ * 158,010	39

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

Facility Name & ID Number Wilson Care Inc. # 0054221 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	06	Maintenance	$	MAC Rx, LLC	100.00%	$	$	15
16	V	10	Nursing and Medical Records	21,606	MAC Rx, LLC	100.00%	19,821	(1,785)	16
17	V	10A	Therapy		MAC Rx, LLC	100.00%			17
18	V	19	Professional Services		MAC Rx, LLC	100.00%			18
19	V	21	Clerical & General Office Expenses	996	MAC Rx, LLC	100.00%	914	(82)	19
20	V	22	Employee Benefits	978	MAC Rx, LLC	100.00%	897	(81)	20
21	V	39	Ancillary		MAC Rx, LLC	100.00%			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			$ 23,580			$ 21,632	$ * (1,948)	39

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

Facility Name & ID Number Wilson Care Inc. # 0054221 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$	Big Ten Supply, LLC	100.00%	$	$	15
16	V	3	Housekeeping	35,508	Big Ten Supply, LLC	100.00%	32,430	(3,078)	16
17	V	4	Laundry	627	Big Ten Supply, LLC	100.00%	572	(54)	17
18	V	6	Repairs & Maintenance	667	Big Ten Supply, LLC	100.00%	609	(58)	18
19	V	10	Nursing And Medical Records	23,329	Big Ten Supply, LLC	100.00%	21,307	(2,022)	19
20	V	10A	Therapy		Big Ten Supply, LLC	100.00%			20
21	V	21	Clerical & General	324	Big Ten Supply, LLC	100.00%	296	(28)	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			$ 60,455			$ 55,215	$ * (5,240)	39

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

Facility Name & ID Number Wilson Care Inc. # 0054221 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Wilson Care Inc. # 0054221 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Wilson Care Inc. # 0054221 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Wilson Care Inc. # 0054221 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Wilson Care Inc. # 0054221 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number Wilson Care Inc. # 0054221 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 PROPERTIES	LINCOLNWOOD	BUILDING CO.	2
3	B. BART BARRISH	0.278%	BRYN MAWR CARE INC.	CHICAGO	OAKTON ARMS	DES PLAINES	ASSISTED LIVING	3
4	BETH ALTER	5.556%	GENERATIONS AT COLUMBUS PARK, INC	CHICAGO	MAC Rx LLC	DES PLAINES	PHARMACY CONSULT	4
5	BRYAN BARRISH TRUST DTD 09/01/04	11.111%	DECATUR MANOR HEALTHCARE,LLC	DECATUR	GENERATIONS HEALTH NETW	LINCOLNWOOD	MANAGEMENT CO.	5
6	CHERYL MAGENCE	4.722%	GENERATIONS AT ELMWOOD PARK, INC	ELMWOOD PARK	BIG TEN SUPPLY, LLC	LIBERTYVILLE	SUPPLY CO.	6
7	DANIEL ROTHNER	0.972%	GREENWOOD CARE, INC.	EVANSTON				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								29
30								30

Facility Name & ID Number Wilson Care Inc. # 0054221 Report Period Beginning: 01/01/17 Ending: 12/31/17

VII. RELATED PARTIES

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

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

Facility Name & ID Number Wilson Care Inc. # 0054221 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	2.67	6.68%	Alloc. Salary	$ 15,265	17-7	1
2	Kirsten Schloss	Owner	Maintenance	0.278%	See Attached	3.82	7.64%	Alloc. Salary	7,262	6-7	2
3	Sarah Barrish	Owner	Administrative	0.556%	See Attached	3.82	7.64%	Alloc. Salary	9,524	17-7	3
4	Nenita Guzman	Relative	Dietary	0%	See Attached	3.82	7.64%	Alloc. Salary	7,600	1-7	4
5	Clark Collins	Relative	Administrative	0%	See Attached	1.05	2.63%	Alloc. Salary	1,309	Various	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	$ 40,960		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Wilson Care Inc. # 0054221 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Wilson Care Inc. # 0054221 Report Period Beginning: 01/01/17 Ending: 12/31/17

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: GENERATIONS HC NETWORK, LLC
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	693,985	14	$ 177,702	$ 95,737	52,969	$ 13,563	1
2	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	693,985	14	16,617		52,969	1,268	2
3	9	MEDICAL DIRECTOR CONSUL	PATIENT DAYS	693,985	14	82,000		52,969	6,259	3
4	10	NURSING	PATIENT DAYS	693,985	14	589,441	589,441	52,969	44,990	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	693,985	14	73,484		52,969	5,609	5
6	17	ADMINISTRATIVE	PATIENT DAYS	693,985	14	339,126	339,126	52,969	25,884	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	693,985	14	21,409		52,969	1,634	7
8	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	693,985	14	3,801		52,969	290	8
9	21	CLERICAL & GENERAL	PATIENT DAYS	693,985	14	1,843,191	1,656,700	52,969	140,683	9
10	24	EDUCATION & SEMINAR	PATIENT DAYS	693,985	14	2,295		52,969	175	10
11	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	693,985	14	140,164		52,969	10,698	11
12	26	INSURANCE	PATIENT DAYS	693,985	14	23,394		52,969	1,786	12
13	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	693,985	14	182,645		52,969	13,941	13
14	32	INTEREST	PATIENT DAYS	693,985	14	(56,845)		52,969	(4,339)	14
15	35	AUTO RENTAL	PATIENT DAYS	693,985	14	51,827		52,969	3,956	15
16	35	EQUIPMENT RENTAL	PATIENT DAYS	693,985	14	11,377		52,969	868	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,501,628	$ 2,681,003		$ 267,265	25

Facility Name & ID Number Wilson Care Inc. # 0054221 Report Period Beginning: 01/01/17 Ending: 12/31/17

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: GENERATIONS HC NETWORK, LLC
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	693,985	14	$ 99,579	$ 99,579	52,969	$ 7,600	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	693,985	14	17,250		52,969	1,317	2
3	10	NURSING SALARIES	PATIENT DAYS	693,985	14	107,435	107,435	52,969	8,200	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	693,985	14	18,544		52,969	1,415	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	693,985	14	1,421,258	1,421,258	52,969	108,479	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	693,985	14	200,000		52,969	15,265	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	693,985	14	350,079		52,969	26,720	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	329,142	13	179,343	179,343	33,864	18,452	10
11	15	EMPLOYEE BENFITS	SPECIAL REHAB INC.	329,142	13	31,236		33,864	3,214	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	366,497	14	376,026	376,026	2,079	2,133	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	366,497	14	68,296		2,079	387	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,877	14	25,758		983	1,966	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,877	14	16,130		983	1,231	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,877	14	1,139		983	87	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,877	14	2,063		983	157	19
20	26	INSURANCE	ALLOCATED SQ FT	12,877	14	2,682		983	205	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,877	14	90,892		983	6,938	21
22	32	INTEREST	ALLOCATED SQ FT	12,877	14	75,767		983	5,784	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,877	14	113,223		983	8,643	23
24										24
25	TOTALS					$ 3,196,700	$ 2,183,641		$ 218,193	25

Facility Name & ID Number Wilson Care Inc. # 0054221 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	06	Maintenance	Direct Allocation			$	$		$	1
2	10	Nursing And Medical Records	Direct Allocation						19,821	2
3	10A	Therapy	Direct Allocation							3
4	19	Professional Services	Direct Allocation							4
5	21	Clerical & General Office Expense	Direct Allocation						914	5
6	22	Employee Benefits	Direct Allocation						897	6
7	39	Ancillary	Direct Allocation							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					$	$		$ 21,632	25

Facility Name & ID Number Wilson Care Inc. # 0054221 Report Period Beginning: 01/01/17 Ending: 12/31/17

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			$	$		$	1
2	3	Housekeeping	Direct Allocation						32,430	2
3	4	Laundry	Direct Allocation						572	3
4	6	Repairs & Maintenance	Direct Allocation						609	4
5	10	Nursing And Medical Records	Direct Allocation						21,307	5
6	10A	Therapy	Direct Allocation							6
7	21	Clerical & General	Direct Allocation						296	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					$	$		$ 55,215	25

Facility Name & ID Number Wilson Care Inc. # 0054221 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Wilson Care Inc. # 0054221 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Wilson Care Inc. # 0054221 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Wilson Care Inc. # 0054221 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Wilson Care Inc. # 0054221 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Wilson Care Inc. # 0054221 Report Period Beginning: 01/01/17 Ending: 12/31/17

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			$	$ 17,495,612			$ 618,528	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Lake Forest Bank		X	Line of Credit				400,000			25,961	6
7												7
8												8
9	TOTAL Facility Related						$	$ 17,895,612			$ 644,489	9
	B. Non-Facility Related*											
10	Interest Income		X								(34,445)	10
11	Interest Income - Bldg Co.		X								(642)	11
12	Alloc Generations Healthcare Network										1,445	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (33,642)	14
15	TOTALS (line 9+line14)						$	$ 17,895,612			$ 610,847	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 97,189 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 Inc. # 0054221 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	215,400	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.)	$	232,403	2
3. Under or (over) accrual (line 2 minus line 1).	$	17,003	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)	$	235,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		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.	$	252,003	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	187,952	8
	2013	190,038	9
	2014	192,737	10
	2015	205,152	11
	2016	223,760	12

2017 Accrual = 2016 tax + 5% (223,760 x 1.05 = 235,000 rounded)

Allocated from Generations Healthcare Network $8643

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Wilson Care Inc. COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0054221

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-17-220-009-0000	Long Term Care Property	$ 223,760.93	$ 223,760.93
2.	See Attached	Alloc. Regency Property LLC	$ 848,962.66	$ 393.71
3.	See Attached	Alloc. SIR Properties/GHN	$ 131,017.00	$ 7,832.73
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 1,203,740.59	$ 231,987.37

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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 Inc. COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0054221

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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 Inc. # 0054221 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Inc. # 0054221 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 112,093	35	$	$ (112,093)	$ 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			302,525	19
20	Various			1997	145,411		20	2,908	2,908	140,061	20
21	Various			1998	34,959		20	1,748	1,748	34,169	21
22	Various			1999	53,478		20	2,674	2,674	49,666	22
23	Various			2000	221,871		20	11,094	11,094	191,806	23
24	Various			2001	102,633		20	5,132	5,132	85,513	24
25	Various			2002	67,986		20			67,986	25
26	Various			2003	97,187		20	3,693	3,693	76,772	26
27	Various			2004	62,333		20	1,900	1,900	49,964	27
28	Various			2005	214,966		20	8,027	8,027	154,768	28
29	Various			2006	56,219		20	2,663	2,663	33,243	29
30	Various			2007	362,270		20	17,872	17,872	203,100	30
31	Various			2008	29,574		20	1,479	1,479	14,234	31
32	Various			2009	22,564		20	1,361	1,361	12,073	32
33	Various			2010	11,969		20	1,044	1,044	8,313	33
34	Various			2011	16,984		20	1,303	1,303	8,136	34
35	Various			2012	2,917		20	146	146	778	35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Wilson Care Inc. # 0054221 Report Period Beginning: 01/01/17 Ending: 12/31/17

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)		1,397,631			70,215	70,215	455,796	67
68	Related Party Allocations (Pages 12H & 12I)		147,499	4,151		4,852	701	92,451	68
69	Financial Statement Depreciation			47,230			(47,230)		69
70	TOTAL (lines 4 thru 69)		$ 5,626,529	$ 163,474		$ 138,111	$ (25,363)	$ 4,255,149	70

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

Facility Name & ID Number Wilson Care Inc. # 0054221 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 5,626,529	$ 163,474		$ 138,111	$ (25,363)	$ 4,255,149	1
2	Supply & Install 4 Steel Doors With Heavy Duty Frame	2014	7,350		20	368	368	1,225	2
3	1St Floor Tile Replacement	2015	2,625		20	131	131	295	3
4	Tile Removal / Concrete Repair In Lobby	2015	6,240		20	312	312	728	4
5	Electric Heaters (4) In Lobby	2015	3,475		20	174	174	362	5
6	Break Concrete & Repair Underground Piping	2016	3,985		20	199	199	199	6
7	Dining Room A/C Compressing Unit	2017	4,250		20	142	142	142	7
8	Break Floor In Hallway And Repair Broken Water Line	2017	4,527		20	226	226	226	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)		$ 5,658,981	$ 163,474		$ 139,663	$ (23,811)	$ 4,258,326	34

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

Facility Name & ID Number Wilson Care Inc. # 0054221 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 5,658,981	$ 163,474		$ 139,663	$ (23,811)	$ 4,258,326	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)		$ 5,658,981	$ 163,474		$ 139,663	$ (23,811)	$ 4,258,326	34

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

Facility Name & ID Number Wilson Care Inc. # 0054221 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 5,658,981	$ 163,474		$ 139,663	$ (23,811)	$ 4,258,326	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,658,981	$ 163,474		$ 139,663	$ (23,811)	$ 4,258,326	34

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

Facility Name & ID Number Wilson Care Inc. # 0054221 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 5,658,981	$ 163,474		$ 139,663	$ (23,811)	$ 4,258,326	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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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)		$ 5,658,981	$ 163,474		$ 139,663	$ (23,811)	$ 4,258,326	34

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

Facility Name & ID Number Wilson Care Inc. # 0054221 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	15,795	9
10	Various	2008	481,710		20	24,086	24,086	197,704	10
11	Bathtub Liners	2009	12,200		20	610	610	4,270	11
12	Terra Cotta Work	2010	154,950		20	7,748	7,748	46,488	12
13	HVAC Unit	2010	15,992		20	800	800	4,800	13
14	Dining Room Flooring	2010	47,092		20	2,355	2,355	12,575	14
15	Laundry Vent- Drain	2010	6,100		20	305	305	1,830	15
16	HVAC Electrical	2010	8,997		20	450	450	2,700	16
17	Flooring	2010	4,034		20	202	202	1,212	17
18	Concrete and Beams	2010	70,000		20	3,515	3,515	21,090	18
19	Oxygen Room Work- Installation of Exhaust Fan	2010	8,000		20	400	400	2,400	19
20	Fire Doors	2010	8,500		20	425	425	2,550	20
21	Nurse Station- Built in Custom Cabinets	2010	7,000		20	350	350	2,100	21
22	Fire Doors	2010	2,700		20	135	135	695	22
23	Fire Doors	2010	27,610		20	1,381	1,381	8,286	23
24	Satellite- Cableing and Installation	2010	11,362		20	881	881	5,286	24
25	Fire Doors	2010	3,650		20	183	183	1,098	25
26	Fire Rated Doors	2011	18,500		20	925	925	4,625	26
27	Ceiling Grid and Lighting	2011	5,685		20	284	284	1,420	27
28	Lintels and Tuckpointing	2011	47,745		20	2,387	2,387	11,935	28
29	Fired Rated Doors	2011	13,600		20	680	680	3,400	29
30	Fire Rated Doors	2011	2,200		20	110	110	550	30
31	Fire Rated Doors	2011	2,425		20	121	121	605	31
32	Gate Work	2011	2,925		20	146	146	730	32
33	Stair Treads	2011	3,771		20	189	189	945	33
34	TOTAL (lines 1 thru 33)		$ 1,001,848	$		$ 50,422	$ 50,422	$ 355,089	34

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

Facility Name & ID Number Wilson Care Inc. # 0054221 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$	$ 355,089	1
2	Doors, Frames, Closets	2011	7,171		20	359	359	1,795	2
3	Installed Surface Mount Wiremold Raceways	2012	28,600		20	1,430	1,430	7,150	3
4	Installed Freezer Evaporator Coil and Expansion Valve	2012	3,640		20	182	182	910	4
5	Replaces Defective Cloth Covered Wires	2012	21,456		20	1,073	1,073	5,362	5
6	Replaced 496 Sprinklers	2012	21,990		20	1,100	1,100	5,500	6
7	Removed Non-working Doors, Replaced Existing Locks	2012	6,950		20	348	348	1,740	7
8	Replaced Pipe From 2nd to 3rd Floor, Plastered Drywall	2012	3,500		20	175	175	875	8
9	Installed New Window Screens	2012	2,524		20	126	126	630	9
10	Repaired walls & flooring for smoke room, office, & kitchen	2012	7,336		20	367	367	1,835	10
11	Replaced 51 exit signs & fuses & installed electric heaters	2012	17,075		20	854	854	4,270	11
12	Replaced A/C Units	2012	6,837		20	342	342	1,710	12
13	Repaired and Installed Railing With Round Pipe, Primed & Finish Col	2012	3,935		20	197	197	985	13
14	Replaced Fire Exit Door Hardware	2012	3,598		20	180	180	900	14
15	Modernization of Two Traction Elevators	2011	185,400		20	9,270	9,270	55,620	15
16	Penthouse Elevator Project	2011	3,392		20	170	170	1,020	16
17	Conference Room Cabinetry	2013	6,500		20	325	325	1,300	17
18	Doctor's Office Cabinetry	2013	2,500		20	125	125	500	18
19	Fire Alarm Panel	2015	35,757		20	1,788	1,788	5,364	19
20	Replace Steam-Pipes- Activity Room and Bathroom	2015	3,640		20	182	182	546	20
21	Fire Rated Steel Doors	2015	2,825		20	141	141	423	21
22	Bathroom Tubs and Walls	2015	3,600		20	180	180	540	22
23	Replace Steel Bathtubs- Bathrooms 503/504/509	2015	3,450		20	173	173	519	23
24	Clean, sand, dry, mask, & refinish bathtub	2016	5,150		20	258	258	516	24
25	Air Conditioners	2016	4,977		20	249	249	498	25
26	Boiler & Steam Pipe Work	2017	3,980		20	199	199	199	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,397,631	$		$ 70,215	$ 19,793	$ 455,796	34

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

Facility Name & ID Number Wilson Care Inc. # 0054221 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	Allocation from Generations Healthcare Network	2009	19,084	506	39	489	(17)	3,935	3
4	Allocation from SIR Properties/Generations Healthcare Network	1993	34,555	1,097	35	987	(110)	24,188	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocation from Generations Healthcare Network	1993	8,761	244	20		(244)	8,761	9
10	Allocation from Generations Healthcare Network	1994	27		20			27	10
11	Allocation from Generations Healthcare Network	1995	200		20			200	11
12	Allocation from Generations Healthcare Network	1997	13,462	603	20	226	(377)	13,462	12
13	Allocation from Generations Healthcare Network	1999	1,058		20	53	53	965	13
14	Allocation from Generations Healthcare Network	1999	11,079		20			11,079	14
15	Allocation from Generations Healthcare Network	2000	1,250		20	62	62	1,096	15
16	Allocation from Generations Healthcare Network	2007	4,015		20	201	201	2,047	16
17	Allocation from Generations Healthcare Network	2008	11,066	1,107	20	697	(410)	6,866	17
18	Allocation from Generations Healthcare Network	2009	27,497	251	20	1,375	1,124	11,335	18
19	Allocation from Generations Healthcare Network	2011	680	68	20	68		436	19
20	Allocation from Generations Healthcare Network	2012	2,177	109	20	109		605	20
21	Allocation from Generations Healthcare Network	2014	305	31	20	15	(16)	55	21
22	Allocation from Generations Healthcare Network	2016	397	20	20	20		28	22
23	Allocation from SIR Properties/Generations Healthcare Network	2012	2,117	92	20	106	14	530	23
24	Allocation from SIR Properties/Generations Healthcare Network	2010	2,085		20	104	104	765	24
25	Allocation from SIR Properties/Generations Healthcare Network	2009	2,075		20	104	104	913	25
26	Allocation from SIR Properties/Generations Healthcare Network	2007	204	12	20	10	(2)	112	26
27	Allocation from SIR Properties/Generations Healthcare Network	2002	137		20	7	7	107	27
28	Allocation from SIR Properties/Generations Healthcare Network	1999	4,379		20	219	219	4,050	28
29	Allocation from SIR Properties/Generations Healthcare Network	1994	329	8	20		(8)	329	29
30	Allocation from SIR Properties/Generations Healthcare Network	1993	560	3	20		(3)	560	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 147,499	$ 4,151		$ 4,852	$ 701	$ 92,451	34

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

Facility Name & ID Number Wilson Care Inc. # 0054221 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 147,499	$ 4,151		$ 4,852	$ 701	$ 92,451	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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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)		$ 147,499	$ 4,151		$ 4,852	$ 701	$ 92,451	34

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

Facility Name & ID Number Wilson Care Inc. # 0054221 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 1,034,723	$ 2,553	$ 80,871	$ 78,318	10	$ 713,889	71
72	Current Year Purchases	3,062		306	306	10	306	72
73	Fully Depreciated Assets	698,396		1,196	1,196	10	698,396	73
74								74
75	TOTALS	$ 1,736,181	$ 2,553	$ 82,373	$ 79,820		$ 1,412,591	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Alloc from Generations HN		$ 2,683	$ 235	$ 177	$ (58)	5	$ 2,242	76
77										77
78										78
79										79
80	TOTALS			$ 2,683	$ 235	$ 177	$ (58)		$ 2,242	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)	$ 7,423,046	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 166,262	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 222,213	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 55,951	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,673,159	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	Deposit on Pipe Repair	$ 1,850	92
93			93
94			94
95		$	95

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

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

Facility Name & ID Number Wilson Care Inc. # 0054221 Report Period Beginning: 01/01/17 Ending: 12/31/17

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.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 4,453 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 Generations Healthcare Network		$	$ 3,956	17
18					18
19					19
20					20
21	TOTAL		$	$ 3,956	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 Inc. # 0054221 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Wilson Care Inc. # 0054221 Report Period Beginning: 01/01/17 Ending: 12/31/17

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):									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 Inc. **#** 0054221 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/17 **(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	$ 33,705	$ 201,623	1
2	Cash-Patient Deposits	17,013	17,013	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	925,277	925,277	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	31,718	64,864	6
7	Other Prepaid Expenses	4,720	4,720	7
8	Accounts Receivable (owners or related parties)	350,000	350,000	8
9	Other(specify): See Attached Schedule		973,221	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,362,433	$ 2,536,718	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	1,719,552	2,737,086	15
16	Equipment, at Historical Cost	1,418,392	2,164,598	16
17	Accumulated Depreciation (book methods)	(2,388,059)	(4,837,481)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	1,850	76,415	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 751,735	$ 1,705,618	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,114,168	$ 4,242,336	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 364,841	$ 364,840	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	17,191	17,191	28
29	Short-Term Notes Payable	400,000	796,530	29
30	Accrued Salaries Payable	130,714	130,714	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,370	5,370	31
32	Accrued Real Estate Taxes(Sch.IX-B)		235,000	32
33	Accrued Interest Payable		51,029	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	9,000	9,000	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 927,116	$ 1,609,674	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		17,099,082	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule		1,070,431	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 18,169,513	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 927,116	$ 19,779,187	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,187,052	$ (15,536,851)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,114,168	$ 4,242,336	48

***(See instructions.)**

Facility Name & ID Number Wilson Care Inc. # 0054221 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,510,466	1
2	Restatements (describe):		2
3	Rounding	3	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,510,469	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(323,417)	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)**	$ (323,417)	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)**	$ 1,187,052	24 *

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

Facility Name & ID Number Wilson Care Inc. # 0054221 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 5,812,180	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,812,180	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***	34,445	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 34,445	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	1,084	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,084	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,847,709	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,304,416	31
32	Health Care	1,805,003	32
33	General Administration	1,538,931	33
	B. Capital Expense		
34	Ownership	1,522,776	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)***	$ 6,171,126	40
41	**Income before Income Taxes (line 30 minus line 40)****	(323,417)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (323,417)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 721,170	44
45	Private Pay - Net Inpatient Revenue	8,215	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) Managed Care	5,082,795	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,812,180	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 Inc. # 0054221 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,008	2,102	$ 96,822	$ 46.06	1
2	Assistant Director of Nursing	1,359	1,566	51,651	32.98	2
3	Registered Nurses	3,414	3,708	108,837	29.35	3
4	Licensed Practical Nurses	9,399	10,312	246,325	23.89	4
5	CNAs & Orderlies	50,632	54,378	643,831	11.84	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	7,389	7,945	103,451	13.02	10
11	Social Service Workers	14,116	15,007	269,158	17.94	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,477	20,715	260,994	12.60	15
16	Dishwashers					16
17	Maintenance Workers	3,680	3,848	43,454	11.29	17
18	Housekeepers	19,119	20,607	254,832	12.37	18
19	Laundry					19
20	Administrator	1,825	2,086	118,200	56.66	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,197	13,235	193,018	14.58	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	2,866	3,126	51,280	16.40	31
32	Other Health Care(specify)					32
33	Other(specify)	1,685	1,685	9,049	5.37	33
34	TOTAL (lines 1 - 33)	148,166	160,320	$ 2,450,902 *	$ 15.29	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	$ 33,744	01-03	35
36	Medical Director	Monthly	6,100	09-03	36
37	Medical Records Consultant	Monthly	4,800	10-03	37
38	Nurse Consultant	Monthly	58,212	10-03	38
39	Pharmacist Consultant	Monthly	17,139	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	2,496	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Psychiatric Consultant	Monthly	8,600	12-03	47
48	Specialized Rehab Consultant	Monthly	33,315	10A-03	48
49	TOTAL (lines 35 - 48)		$ 164,406		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,418	$ 50,074	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	23	495	10-03	52
53	TOTAL (lines 50 - 52)	1,441	$ 50,569		53

Facility Name & ID Number Wilson Care Inc. # 0054221 Report Period Beginning: 01/01/17 Ending: 12/31/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Augie Beley	Administrator	0	$ 118,200
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 118,200

B. Administrative - Other

Description	Amount
Generations Healthcare - Director of Administrative Services	$ 58,212
Generations Healthcare - Ancillary Administrative Charges	48,708
Generations Healthcare - Consulting Fees	120,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 226,920
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting Services	$ 15,525
Generations Healthcare Network	Director of Financial Svc	42,000
Generations Healthcare Network	Dir of Marketing/Admissions	41,220
Generations Healthcare Network	Dir of Regulatory Services	29,112
Generations Healthcare Network	Dir of Information Technology	12,120
Generations Healthcare Network	Bookkeeping Services	89,700
Generations Healthcare Network	Computer Support	26,736
Various - See Attached	Legal	10,783
Plante & Moran PLLC	401K Plan Audit	1,125
RSM US LLP	Procedures Review	1,751
PayChex	Payroll Services	12,287
See Supplemental Schedule		2,701
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 285,060

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 30,590
Unemployment Compensation Insurance	15,207
FICA Taxes	183,218
Employee Health Insurance	138,632
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Union Pension Plan	23,527
Employee Life Insurance	220
Other Employee Benefits	8,757
401K Matching Contribution	600
TOTAL (agree to Schedule V, line 22, col.8)	$ 400,751

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	$ 1,820
Advertising: Employee Recruitment	6,727
Health Care Worker Background Check	
(Indicate # of checks performed 527)	5,266
Patient Background Checks 162	1,620
Dues & Subscriptions	2,385
Alliance for Living Dues (net of adj)	14,953
Licenses & Permits	2,345
Alloc from Generations Healthcare Network	290
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 35,406

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,446
Alloc from Generations Healthcare Network	175
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,621

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Wilson Care Inc. # 0054221 Report Period Beginning: 01/01/17 Ending: 12/31/17

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. $ **173** 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? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% line 14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **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