

Facility Name & ID Number Wilson Care Inc.

0029975 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	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				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	27,237	191	31,169	58,597	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,237	191	31,169	58,597	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.08%

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

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

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

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

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

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

J. Was the facility purchased or leased after January 1, 1978?
YES Date 09/01/1988 NO

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number Wilson Care Inc.# 0029975

Report Period Beginning:

01/01/15

Ending:

12/31/15**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	213,653	25,304	33,617	272,574		272,574	(16,075)	256,499		1
2	Food Purchase		283,146		283,146		283,146	(9)	283,137		2
3	Housekeeping	220,498	35,704		256,202		256,202		256,202		3
4	Laundry		17,826	21,019	38,845		38,845		38,845		4
5	Heat and Other Utilities			172,640	172,640		172,640	(11,737)	160,903		5
6	Maintenance	50,584	35,471	104,046	190,101		190,101	(24,271)	165,830		6
7	Other (specify):*							2,187	2,187		7
8	TOTAL General Services	484,735	397,451	331,322	1,213,508		1,213,508	(49,906)	1,163,602		8
	B. Health Care and Programs										
9	Medical Director			3,600	3,600		3,600		3,600		9
10	Nursing and Medical Records	1,192,748	29,666	111,758	1,334,172		1,334,172	(8,512)	1,325,660		10
10a	Therapy			33,264	33,264		33,264	(15,866)	17,398		10a
11	Activities	112,902	3,690	2,435	119,027		119,027		119,027		11
12	Social Services	241,358	12,125		253,483		253,483		253,483		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							7,297	7,297		15
16	TOTAL Health Care and Programs	1,547,008	45,481	151,057	1,743,546		1,743,546	(17,081)	1,726,465		16
	C. General Administration										
17	Administrative	112,569		224,544	337,113		337,113	(110,167)	226,946		17
18	Directors Fees										18
19	Professional Services			292,105	292,105	(9,881)	282,224	(187,858)	94,366		19
20	Dues, Fees, Subscriptions & Promotions			66,383	66,383		66,383	(36,172)	30,211		20
21	Clerical & General Office Expenses	214,066	20,265	60,279	294,610		294,610	110,473	405,083		21
22	Employee Benefits & Payroll Taxes			425,556	425,556		425,556		425,556		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,485	3,485		3,485	1,238	4,723		24
25	Other Admin. Staff Transportation			3,321	3,321		3,321	7,325	10,646		25
26	Insurance-Prop.Liab.Malpractice			141,858	141,858		141,858	17,160	159,018		26
27	Other (specify):*							41,380	41,380		27
28	TOTAL General Administration	326,635	20,265	1,217,531	1,564,431	(9,881)	1,554,550	(156,621)	1,397,929		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,358,378	463,197	1,699,910	4,521,485	(9,881)	4,511,604	(223,608)	4,287,996		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.

#0029975

Report Period Beginning:

01/01/15

Ending:

12/31/15

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			46,757	46,757		46,757	248,006	294,763			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,759	3,759		3,759	602,487	606,246			32
33	Real Estate Taxes					9,881	9,881	203,939	213,820			33
34	Rent-Facility & Grounds			1,440,000	1,440,000		1,440,000	(1,440,000)				34
35	Rent-Equipment & Vehicles			4,828	4,828		4,828	6,964	11,792			35
36	Other (specify):*							34,420	34,420			36
37	TOTAL Ownership			1,495,344	1,495,344	9,881	1,505,225	(344,184)	1,161,041			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):*	37,011			37,011		37,011	(37,011)	0			43
44	TOTAL Special Cost Centers	37,011			37,011		37,011	(37,011)	0			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,395,389	463,197	3,195,254	6,053,840		6,053,840	(604,803)	5,449,037			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.

0029975

Report Period Beginning:

01/01/15

Ending:

12/31/15

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(14,201)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	128,488	30		9
10	Interest and Other Investment Income	(33,373)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(9)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(17,733)	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	(14,604)	21		24
25	Fund Raising, Advertising and Promotional	(8,019)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,664)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(107,642)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (70,757)		\$	30

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	2	
		Amount	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)	(534,046)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (534,046)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (604,803)		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	2	3	4	
		Yes	No	Amount	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

BHF USE ONLY							
48		49		50		51	52

Wilson Care Inc.

ID# 0029975

Report Period Beginning: 01/01/15

Ending: 12/31/15

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Jury Duty Income	\$ (275)	21	1
2	Bank Fees	(7,311)	21	2
3	Theft & Damage	(40)	21	3
4	PAC Dues	(12,127)	20	4
5	Building Co. - Amortization of Bond & HUD Fees	(2,770)	36	5
6	Building Co. - Filing Fees & Office Expense	(362)	21	6
7	Building Co. - Legal and Other Professional	(8,300)	19	7
8	Capitalized R&M	(12,340)	06	8
9	Additional R&M	3,304	06	9
10	Building Co. - Capitalized R&M	(17,822)	06	10
11	Non Allowable Legal Fees	(12,588)	19	11
12	Marketing Salary	(37,011)	43	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(107,642)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Wilson Care Inc.# 0029975

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary				(16,075)								(16,075)	1
2	Food Purchase	(9)											(9)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(14,201)			2,464								(11,737)	5
6	Maintenance	(26,858)	21,884	(23,343)	4,046								(24,271)	6
7	Other (specify):*				2,187								2,187	7
8	TOTAL General Services	(41,068)	21,884	(23,343)	(7,379)								(49,906)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			(16,702)	8,475	(285)							(8,512)	10
10a	Therapy				(15,866)								(15,866)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			3,676	3,621								7,297	15
16	TOTAL Health Care and Programs			(13,026)	(3,770)	(285)							(17,081)	16
	C. General Administration													
17	Administrative			(196,992)	86,825								(110,167)	17
18	Directors Fees													18
19	Professional Services	(20,888)	8,300	(191,775)	16,505								(187,858)	19
20	Fees, Subscriptions & Promotions	(37,879)		1,707									(36,172)	20
21	Clerical & General Office Expenses	(26,256)	362	136,257	110								110,473	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			1,238									1,238	24
25	Other Admin. Staff Transportation			7,325									7,325	25
26	Insurance-Prop.Liab.Malpractice		14,718	2,203	239								17,160	26
27	Other (specify):*			22,652	18,728								41,380	27
28	TOTAL General Administration	(85,023)	23,380	(217,385)	122,407								(156,621)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(126,091)	45,264	(253,754)	111,258	(285)							(223,608)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Wilson Care Inc.# 0029975

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	128,488	111,892		7,626								248,006	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(33,373)	643,837	(14,758)	6,781								602,487	32
33	Real Estate Taxes		195,137		8,802								203,939	33
34	Rent-Facility & Grounds		(1,440,000)										(1,440,000)	34
35	Rent-Equipment & Vehicles			6,964									6,964	35
36	Other (specify):*	(2,770)	37,190										34,420	36
37	TOTAL Ownership	92,345	(451,944)	(7,794)	23,209								(344,184)	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):*	(37,011)											(37,011)	43
44	TOTAL Special Cost Centers	(37,011)											(37,011)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(70,757)	(406,680)	(261,548)	134,467	(285)							(604,803)	45

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 1,440,000	Wilson Care, LLC		\$	(1,440,000)	1
2	V	21 Filing Fees		Wilson Care, LLC		350	350	2
3	V	32 Interest Income & Expense	616	Wilson Care, LLC		644,453	643,837	3
4	V	36 Mortgage Insurance		Wilson Care, LLC		92,717	92,717	4
5	V	21 Office Expense		Wilson Care, LLC		12	12	5
6	V	19 Professional Fees		Wilson Care, LLC		8,300	8,300	6
7	V	26 Property Insurance		Wilson Care, LLC		14,718	14,718	7
8	V	33 Real Estate Taxes	7,263	Wilson Care, LLC		202,400	195,137	8
9	V	06 Repairs & Maint. - Building		Wilson Care, LLC		21,884	21,884	9
10	V	30 Depreciation		Wilson Care, LLC		111,892	111,892	10
11	V	36 Amort of Bond Premium	58,297	Wilson Care, LLC			(58,297)	11
12	V	36 Amort of HUD Fees		Wilson Care, LLC		2,770	2,770	12
13	V							13
14	Total		\$ 1,506,176			\$ 1,099,496	\$ * (406,680)	14

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	6 REPAIRS AND MAINT.	\$ 28,512	S.I.R. MANAGEMENT, INC.	100.00%	\$ 5,169	\$ (23,343)
16	V						
17	V	10 NURSING	57,024	S.I.R. MANAGEMENT, INC.	100.00%	40,322	(16,702)
18	V	15 EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	3,676	3,676
19	V	19 PROFESSIONAL FEES	196,416	S.I.R. MANAGEMENT, INC.	100.00%	4,172	(192,244)
20	V	20 FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	1,707	1,707
21	V	21 CLERICAL & GENERAL	9,504	S.I.R. MANAGEMENT, INC.	100.00%	130,753	121,249
22	V	24 EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	1,238	1,238
23	V	25 OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	7,325	7,325
24	V	26 INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	2,203	2,203
25	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	6,923	6,923
26	V	32 INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(14,758)	(14,758)
27	V	35 AUTO RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	5,920	5,920
28	V	35 EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	1,044	1,044
29	V						
30	V	17 ADMINISTRATIVE	224,544	S.I.R. MANAGEMENT, INC.	100.00%	27,552	(196,992)
31	V	19 PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	469	469
32	V	21 CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	15,008	15,008
33	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	15,729	15,729
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 516,000			\$ 254,452	\$ * (261,548)

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1	DIETARY SALARIES	\$ 23,760	S.I.R. MANAGEMENT, INC.	100.00%	\$ 7,685	\$ (16,075)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	1,072	1,072	16
17	V	10	NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	8,475	8,475	17
18	V	15	EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	1,173	1,173	18
19	V	17	ADMIN./LEGAL SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	86,825	86,825	19
20	V	19	FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	16,424	16,424	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	18,728	18,728	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	33,264	S.I.R. MANAGEMENT, INC.	100.00%	17,398	(15,866)	24
25	V	15	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	2,448	2,448	25
26	V								26
27	V	6	MAINTENANCE SALARIES	4,786	S.I.R. MANAGEMENT, INC.	100.00%	7,448	2,662	27
28	V	7	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	1,115	1,115	28
29	V								29
30	V	5	UTILITIES		S.I.R. MANAGEMENT, INC.	100.00%	2,464	2,464	30
31	V	6	REPAIRS AND MAINT.		S.I.R. MANAGEMENT, INC.	100.00%	1,384	1,384	31
32	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	81	81	32
33	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	110	110	33
34	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	239	239	34
35	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	7,626	7,626	35
36	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	6,781	6,781	36
37	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	8,802	8,802	37
38	V								38
39	Total		\$ 61,810				\$ 196,277	\$ * 134,467	39

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

Facility Name & ID Number Wilson Care Inc.

0029975

Report Period Beginning: 01/01/15

Ending: 12/31/15

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	10 Nursing and Medical Records	\$ 21,601	MAC Rx, LLC	100.00%	\$ 21,316	\$ (285)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 21,601			\$ 21,316	\$ * (285)

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

Facility Name & ID Number Wilson Care Inc.

0029975

Report Period Beginning: 01/01/15

Ending: 12/31/15

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	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.

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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.

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

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

Facility Name & ID Number Wilson Care Inc.

0029975

Report Period Beginning: 01/01/15

Ending: 12/31/15

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	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.

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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.

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

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

Facility Name & ID Number

Wilson Care Inc.

#

0029975

Report Period Beginning:

01/01/15

Ending:

12/31/15

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference		
						Hours	Percent	Description	Amount			
1	Bryan Barrish	Relative	Administrative	0%	See Attached	3.25	7.22%	Alloc. Salary	\$ 16,249	17-07	1	
2	Kirsten Schloss	Owner	Maintenance	0.278%	See Attached	4.06	8.12%	Alloc. Salary	7,826	6-7	2	
3	Sarah Barrish	Owner	Administrative	0.556%	See Attached	3.66	8.13%	Alloc. Salary	8,559	17-07	3	
4	Nenita Guzman	Relative	Dietary	0%	See Attached	4.06	8.12%	Alloc. Salary	7,685	01-07	4	
5											5	
6											6	
7											7	
8											8	
9											9	
10											10	
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts											11
12	anticipated to be considered allowable by the IL. Dept. of HFS.											12
13								TOTAL	\$ 40,319		13	

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

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

Facility Name & ID Number Wilson Care Inc.

0029975

Report Period Beginning:

01/01/15

Ending: 12/31/15

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

Facility Name & ID Number Wilson Care Inc.

0029975

Report Period Beginning:

01/01/15

Ending: 12/31/15

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	6	REPAIRS AND MAINT.	PATIENT DAYS	721,222	14	\$ 63,617	\$ 58,597	\$ 5,169	1	
2									2	
3	10	NURSING	PATIENT DAYS	721,222	14	496,290	496,290	58,597	40,322	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	721,222	14	45,246	58,597	3,676	4	
5	19	PROFESSIONAL FEES	PATIENT DAYS	721,222	14	51,349	58,597	4,172	5	
6	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	721,222	14	21,010	58,597	1,707	6	
7	21	CLERICAL & GENERAL	PATIENT DAYS	721,222	14	1,609,327	1,193,369	58,597	130,753	7
8	24	EDUCATION & SEMINAR	PATIENT DAYS	721,222	14	15,238	58,597	1,238	8	
9	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	721,222	14	90,162	58,597	7,325	9	
10	26	INSURANCE	PATIENT DAYS	721,222	14	27,120	58,597	2,203	10	
11	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	721,222	14	85,206	58,597	6,923	11	
12	32	INTEREST	PATIENT DAYS	721,222	14	(181,648)	58,597	(14,758)	12	
13	35	AUTO RENTAL	PATIENT DAYS	721,222	14	72,863	58,597	5,920	13	
14	35	EQUIPMENT RENTAL	PATIENT DAYS	721,222	14	12,850	58,597	1,044	14	
15									15	
16	17	ADMINISTRATIVE	PATIENT DAYS	721,222	14	339,119	339,119	58,597	27,552	16
17	19	PROFESSIONAL FEES	PATIENT DAYS	721,222	14	5,774	58,597	469	17	
18	21	CLERICAL & GENERAL	PATIENT DAYS	721,222	14	184,716	77,164	58,597	15,008	18
19	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	721,222	14	193,599	58,597	15,729	19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 3,131,838	\$ 2,105,942	\$ 254,452	25	

Facility Name & ID Number Wilson Care Inc.

0029975

Report Period Beginning:

01/01/15

Ending: 12/31/15

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	DIETARY SALARIES	PATIENT DAYS	721,222	14	\$ 94,587	\$ 94,587	58,597	\$ 7,685	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	721,222	14	13,188	58,597	1,072		2
3	10	NURSING SALARIES	PATIENT DAYS	721,222	14	104,315	104,315	58,597	8,475	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	721,222	14	14,440	58,597	1,173		4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	721,222	14	1,068,659	1,068,659	58,597	86,825	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	721,222	14	202,147	58,597	16,424		6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	721,222	14	230,505	58,597	18,728		7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	322,920	13	168,894	168,894	33,264	17,398	10
11	15	EMPLOYEE BENEFITS	SPECIAL REHAB INC.	322,920	13	23,767	33,264	2,448		11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	319,657	14	497,427	497,427	4,786	7,448	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	319,657	14	74,439	4,786	1,115		14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,878	14	30,338	1,046	2,464		16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,878	14	17,037	1,046	1,384		17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,878	14	1,002	1,046	81		18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,878	14	1,351	1,046	110		19
20	26	INSURANCE	ALLOCATED SQ FT	12,878	14	2,937	1,046	239		20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,878	14	93,883	1,046	7,626		21
22	32	INTEREST	ALLOCATED SQ FT	12,878	14	83,486	1,046	6,781		22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,878	14	108,372	1,046	8,802		23
24										24
25	TOTALS					\$ 2,830,774	\$ 1,933,882	\$ 196,277		25

Facility Name & ID Number Wilson Care Inc.

0029975

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	10	Nursing And Medical Records	Direct Allocation		\$	\$		\$ 21,316	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				\$	\$		\$ 21,316	25

Facility Name & ID Number Wilson Care Inc.

0029975

Report Period Beginning:

01/01/15

Ending: 12/31/15

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

Facility Name & ID Number Wilson Care Inc.

0029975

Report Period Beginning:

01/01/15

Ending: 12/31/15

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

Facility Name & ID Number Wilson Care Inc.

0029975

Report Period Beginning:

01/01/15

Ending: 12/31/15

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

Facility Name & ID Number Wilson Care Inc.

0029975

Report Period Beginning:

01/01/15

Ending: 12/31/15

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

Facility Name & ID Number Wilson Care Inc.

0029975 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

Facility Name & ID Number Wilson Care Inc.

0029975

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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.

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

Facility Name & ID Number

Wilson Care Inc.

0029975

Report Period Beginning:

01/01/15

Ending:

12/31/15

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2	3	4	5	6	7	8	9	10											
											Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
												YES	NO				Original	Balance			
	A. Directly Facility Related																				
	Long-Term																				
1	Private Bank		X	Mortgage Payable			\$	\$ 18,248,283			\$ 644,453	1									
2												2									
3												3									
4												4									
5												5									
	Working Capital																				
6	Lake Forest Bank		X	Line of Credit				100,000			3,759	6									
7												7									
8												8									
9	TOTAL Facility Related						\$	\$ 18,348,283			\$ 648,213	9									
	B. Non-Facility Related*																				
10	Interest Income		X								(33,373)	10									
11	Interest Income - Bldg Co.		X								(616)	11									
12	Alloc. From SIR Management	X									(7,977)	12									
13												13									
14	TOTAL Non-Facility Related						\$	\$			\$ (41,967)	14									
15	TOTALS (line 9+line14)						\$	\$ 18,348,283			\$ 606,246	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 92,717 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.

0029975

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

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

	1	2	3	4	5	6		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							\$	\$			\$	1							
2												2							
3												3							
4												4							
5												5							
6												6							
7	TOTAL Long-Term																		
	Working Capital																		
8							\$	\$			\$	8							
9												9							
10												10							
11												11							
12												12							
13												13							
14	TOTAL Working Capital																		
	B. Non-Facility Related*																		
15							\$	\$			\$	15							
16												16							
17												17							
18												18							
19												19							
20	TOTAL Non-Facility Related																		

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2014 report.		\$	200,000		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	201,539		2
3. Under or (over) accrual (line 2 minus line 1).		\$	1,539		3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	202,400		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	9,881		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.		\$	213,820		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2010	<u>223,625</u>		8	
	2011	<u>222,565</u>		9	
	2012	<u>187,952</u>		10	
	2013	<u>190,038</u>		11	
	2014	<u>192,737</u>		12	
2015 Accrual - \$192,737 x 1.05 = \$202,374 (Rounded)					
Allocated from SIR Management = \$8,802					
FOR BHF USE ONLY					
	13	FROM R. E. TAX STATEMENT FOR 2014	\$		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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Wilson Care Inc. COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0029975

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2014 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 2014.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>14-17-220-009-0000</u>	<u>Long Term Care Property</u>	\$ <u>192,736.68</u>	\$ <u>192,736.68</u>
2. <u>See Attached</u>	<u>Allocated from SIR Management</u>	\$ <u>118,674.75</u>	\$ <u>7,549.01</u>
3. <u>10-31-401-046-0000</u>	<u>Allocated from Regency Property</u>	\$ <u>862,948.02</u>	\$ <u>850.91</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>1,174,359.45</u>	\$ <u>201,136.60</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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.

0029975 Report Period Beginning:

01/01/15 Ending:

12/31/15

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 (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? (a) Own the Equipment (b) Rent equipment from a Related Organization. (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 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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1985</u>	<u>\$ 25,200</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 25,200	3

Facility Name & ID Number Wilson Care Inc.

0029975

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	198		1985	1967	\$ 1,539,800	\$ 111,892	35	\$ 43,994	\$ (67,898)	\$ 1,627,788	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	1,584	1,584	86,566	18
19	Various		1996		303,393		20	15,170	15,170	294,870	19
20	Various		1997		145,411		20	7,347	7,347	130,570	20
21	Various		1998		34,959		20	1,748	1,748	30,673	21
22	Various		1999		53,478		20	2,674	2,674	44,319	22
23	Various		2000		221,871		20	11,094	11,094	169,619	23
24	Various		2001		102,633		20	5,132	5,132	75,250	24
25	Various		2002		67,986		20			67,986	25
26	Various		2003		97,187		20	3,693	3,693	69,385	26
27	Various		2004		62,333		20	1,900	1,900	46,164	27
28	Various		2005		214,966		20	10,153	10,153	138,714	28
29	Various		2006		56,219		20	2,958	2,958	27,818	29
30	Various		2007		362,270		20	19,637	19,637	165,591	30
31	Various		2008		29,574		20	1,479	1,479	11,276	31
32	Various		2009		22,564		20	1,361	1,361	9,351	32
33	Various		2010		11,969		20	1,044	1,044	6,225	33
34	Various		2011		16,984		20	1,303	1,303	5,529	34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Wilson Care Inc.

0029975

Report Period Beginning:

01/01/15

Ending:

12/31/15

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	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		1,383,524			69,506	69,506	315,563	67
68		178,908	4,735		6,159	1,424	91,994	68
69			46,757			(46,757)		69
70		\$ 5,640,914	\$ 163,384		\$ 207,935	\$ 44,551	\$ 4,062,679	70

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

Facility Name & ID Number Wilson Care Inc.

0029975

Report Period Beginning:

01/01/15

Ending:

12/31/15

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		\$ 5,640,914	\$ 163,384		\$ 207,935	\$ 44,551	\$ 4,062,679	1
2	Sprinkler Heads	2012	2,917		20	146	146	486	2
3	Supply & Install 4 Steel Doors With Heavy Duty Frame	2014	7,350		20	368	368	490	3
4	1St Floor Tile Replacement	2015	2,625		20	131	131	131	4
5	Tile Removal/Concrete Repair In Lobby	2015	6,240		20	312	312	312	5
6	Electric Heaters (4) In Lobby	2015	3,475		20	174	174	174	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)		\$ 5,663,521	\$ 163,384		\$ 209,066	\$ 45,682	\$ 4,064,272	34

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

Facility Name & ID Number Wilson Care Inc.

0029975

Report Period Beginning:

01/01/15

Ending:

12/31/15

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 5,663,521	\$ 163,384		\$ 209,066	\$ 45,682	\$ 4,064,272	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		\$ 5,663,521	\$ 163,384		\$ 209,066	\$ 45,682	\$ 4,064,272	34

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

Facility Name & ID Number Wilson Care Inc.

0029975

Report Period Beginning:

01/01/15

Ending:

12/31/15

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1		\$ 5,663,521	\$ 163,384		\$ 209,066	\$ 45,682	\$ 4,064,272
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34		\$ 5,663,521	\$ 163,384		\$ 209,066	\$ 45,682	\$ 4,064,272

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

Facility Name & ID Number Wilson Care Inc.

0029975

Report Period Beginning:

01/01/15

Ending:

12/31/15

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 5,663,521	\$ 163,384		\$ 209,066	\$ 45,682	\$ 4,064,272	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)	\$ 5,663,521	\$ 163,384		\$ 209,066	\$ 45,682	\$ 4,064,272	34

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

Facility Name & ID Number Wilson Care Inc.

0029975

Report Period Beginning:

01/01/15

Ending:

12/31/15

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Building Company		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Bathroom Remodel	2007	35,100		20	1,755	1,755	12,285	9
10	Various	2008	481,710		20	24,086	24,086	149,532	10
11	Bathtub Liners	2009	12,200		20	610	610	3,050	11
12	Terra Cotta Work	2010	154,950		20	7,748	7,748	30,992	12
13	HVAC Unit	2010	15,992		20	800	800	3,200	13
14	Dining Room Flooring	2010	47,092		20	2,355	2,355	7,865	14
15	Laundry Vent- Drain	2010	6,100		20	305	305	1,220	15
16	HVAC Electrical	2010	8,997		20	450	450	1,800	16
17	Flooring	2010	4,034		20	202	202	808	17
18	Concrete and Beams	2010	70,000		20	3,515	3,515	14,060	18
19	Oxygen Room Work- Installation of Exhaust Fan	2010	8,000		20	400	400	1,600	19
20	Fire Doors	2010	8,500		20	425	425	1,700	20
21	Nurse Station- Built in Custom Cabinets	2010	7,000		20	350	350	1,400	21
22	Fire Doors	2010	2,700		20	135	135	425	22
23	Fire Doors	2010	27,610		20	1,381	1,381	5,524	23
24	Satellite- Cableing and Installation	2010	11,362		20	881	881	3,524	24
25	Fire Doors	2010	3,650		20	183	183	732	25
26	Fire Rated Doors	2011	18,500		20	925	925	2,775	26
27	Ceiling Grid and Lighting	2011	5,685		20	284	284	852	27
28	Lintels and Tuckpointing	2011	47,745		20	2,387	2,387	7,161	28
29	Fired Rated Doors	2011	13,600		20	680	680	2,040	29
30	Fire Rated Doors	2011	2,200		20	110	110	330	30
31	Fire Rated Doors	2011	2,425		20	121	121	363	31
32	Gate Work	2011	2,925		20	146	146	438	32
33	Stair Treads	2011	3,771		20	189	189	567	33
34	TOTAL (lines 1 thru 33)		\$ 1,001,848	\$		\$ 50,422	\$ 50,422	\$ 254,243	34

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

Facility Name & ID Number Wilson Care Inc.

0029975

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 1,001,848	\$		\$ 50,422	\$ 50,422	\$ 254,243	1
2	Doors, Frames, Closets	2011	7,171		20	359	359	1,077	2
3	Installed Surface Mount Wiremold Raceways	2012	28,600		20	1,430	1,430	4,290	3
4	Installed Freezer Evaporator Coil and Expansion Valve	2012	3,640		20	182	182	546	4
5	Replaces Defective Cloth Covered Wires	2012	21,456		20	1,073	1,073	3,219	5
6	Replaced 496 Sprinklers	2012	21,990		20	1,100	1,100	3,300	6
7	Removed Non-working Doors, Replaced Existing Locks	2012	6,950		20	348	348	1,044	7
8	Replaced Pipe From 2nd to 3rd Floor, Plastered Drywall	2012	3,500		20	175	175	525	8
9	Installed New Window Screens	2012	2,524		20	126	126	378	9
10	Repaired walls & flooring for smoke room, office, & kitchen	2012	7,336		20	367	367	1,101	10
11	Replaced 51 exit signs & fuses & installed electric heaters	2012	17,075		20	854	854	2,562	11
12	Replaced A/C Units	2012	6,837		20	342	342	1,026	12
13	Repaired and Installed Railing With Round Pipe, Primed & Finish Col	2012	3,935		20	197	197	591	13
14	Replaced Fire Exit Door Hardware	2012	3,598		20	180	180	540	14
15	Modernization of Two Traction Elevators	2011	185,400		20	9,270	9,270	37,080	15
16	Penthouse Elevator Project	2011	3,392		20	170	170	680	16
17	Conference Room Cabinetry	2013	6,500		20	325	325	650	17
18	Doctor's Office Cabinetry	2013	2,500		20	125	125	250	18
19	Fire Alarm Panel	2015	35,757		20	1,788	1,788	1,788	19
20	Replace Steam-Pipes- Activity Room and Bathroom	2015	3,640		20	182	182	182	20
21	Fire Rated Steel Doors	2015	2,825		20	141	141	141	21
22	Bathroom Tubs and Walls	2015	3,600		20	180	180	180	22
23	Replace Steel Bathtubs- Bathrooms 503/504/509	2015	3,450		20	173	173	173	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)		\$ 1,383,524	\$		\$ 69,506	\$ 69,506	\$ 315,563	34

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

Facility Name & ID Number Wilson Care Inc.

0029975

Report Period Beginning:

01/01/15

Ending:

12/31/15

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated - S.I.R. Management	2009	40,612	1,041	39	1,041		6,291	3
4	Allocated - S.I.R. Properties - S.I.R. Management	1993	36,767	1,167	35	1,050	(117)	23,636	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated - S.I.R. Management	1993	9,322	260	20		(260)	9,322	9
10	Allocated - S.I.R. Management	1994	29		20			29	10
11	Allocated - S.I.R. Management	1995	213		20	6	6	213	11
12	Allocated - S.I.R. Management	1997	14,323	321	20	698	377	13,385	12
13	Allocated - S.I.R. Management	1999	1,126		20	56	56	915	13
14	Allocated - S.I.R. Management	1999	11,079		20			11,079	14
15	Allocated - S.I.R. Management	2000	1,330		20	66	66	1,033	15
16	Allocated - S.I.R. Management	2007	4,272		20	214	214	1,750	16
17	Allocated - S.I.R. Management	2008	11,774	1,177	20	742	(435)	5,822	17
18	Allocated - S.I.R. Management	2009	29,257	268	20	1,463	1,195	9,135	18
19	Allocated - S.I.R. Management	2011	724	72	20	72		320	19
20	Allocated - S.I.R. Management	2012	2,316	116	20	116		396	20
21	Allocated - S.I.R. Management	2014	325	32	20	16	(16)	26	21
22									22
23	Allocated - S.I.R. Properties - S.I.R. Management	2012	2,252	158	20	8	(150)	40	23
24	Allocated - S.I.R. Properties - S.I.R. Management	2010	2,219		20	111	111	592	24
25	Allocated - S.I.R. Properties - S.I.R. Management	2009	2,208	98	20	110	12	751	25
26	Allocated - S.I.R. Properties - S.I.R. Management	2007	644	13	20	32	19	290	26
27	Allocated - S.I.R. Properties - S.I.R. Management	2002	146		20	7	7	99	27
28	Allocated - S.I.R. Properties - S.I.R. Management	1999	4,659		20	233	233	3,844	28
29	Allocated - S.I.R. Properties - S.I.R. Management	1998	2,226		20	111	111	1,948	29
30	Allocated - S.I.R. Properties - S.I.R. Management	1997	139		20	7	7	132	30
31	Allocated - S.I.R. Properties - S.I.R. Management	1994	350	9	20		(9)	350	31
32	Allocated - S.I.R. Properties - S.I.R. Management	1993	596	3	20		(3)	596	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 178,908	\$ 4,735		\$ 6,159	\$ 1,424	\$ 91,994	34

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

Facility Name & ID Number Wilson Care Inc.

0029975

Report Period Beginning:

01/01/15

Ending:

12/31/15

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 178,908	\$ 4,735		\$ 6,159	\$ 1,424	\$ 91,994	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)	\$ 178,908	\$ 4,735		\$ 6,159	\$ 1,424	\$ 91,994	34

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

Facility Name & ID Number Wilson Care Inc.

0029975

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	\$ 1,082,830	\$ 2,640	\$ 84,956	\$ 82,316	10	\$ 599,546	71
72	Current Year Purchases	4,307		431	431	10	431	72
73	Fully Depreciated Assets	651,862		5	5	10	651,862	73
74								74
75	TOTALS	\$ 1,738,999	\$ 2,640	\$ 85,392	\$ 82,752		\$ 1,251,840	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from SIR Management	2015	\$ 2,855	\$ 250	\$ 305	\$ 55	5	\$ 1,950	76
77										77
78										78
79										79
80	TOTALS			\$ 2,855	\$ 250	\$ 305	\$ 55		\$ 1,950	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)	\$ 7,430,575	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 166,274	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 294,762	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 128,488	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,318,062	85

**

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

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

G. Construction-in-Progress

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

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

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

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? YES NO

If NO, see instructions.

		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: _____ *

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

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ 5,872 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	<u>Allocated from SIR Management</u>		\$	\$ <u>5,920</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$ <u>5,920</u>	21

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. /2016 \$ _____

13. /2017 \$ _____

14. /2018 \$ _____

* 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.

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5					
					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 prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>See Supplemental</u>									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.

Facility Name & ID Number Wilson Care Inc.# 0029975Report Period Beginning: 01/01/15

Ending:

12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/15

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 90,272	\$ 244,105	1
2	Cash-Patient Deposits	24,961	24,961	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	680,056	680,056	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	19,205	53,969	6
7	Other Prepaid Expenses	1,822	1,822	7
8	Accounts Receivable (owners or related parties)	200,000	200,000	8
9	Other(specify):		945,190	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,016,316	\$ 2,150,103	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		25,200	13
14	Buildings, at Historical Cost		1,539,800	14
15	Leasehold Improvements, at Historical Cost	1,715,302	2,728,856	15
16	Equipment, at Historical Cost	1,416,443	2,162,649	16
17	Accumulated Depreciation (book methods)	(2,293,904)	(4,519,341)	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):		80,105	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 837,841	\$ 2,017,269	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,854,157	\$ 4,167,372	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 152,487	\$ 152,486	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	24,980	24,980	28
29	Short-Term Notes Payable	100,000	100,000	29
30	Accrued Salaries Payable	130,084	130,084	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,725	3,725	31
32	Accrued Real Estate Taxes(Sch.IX-B)		202,400	32
33	Accrued Interest Payable		53,224	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	See Attached Schedule	17,953	17,953	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 429,229	\$ 684,852	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		18,248,283	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43			1,186,585	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 19,434,868	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 429,229	\$ 20,119,720	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,424,928	\$ (15,952,348)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,854,157	\$ 4,167,372	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,494,641	1
2	Restatements (describe):		2
3			3
4	Rounding	(1)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,494,640	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	200,288	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	(270,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (69,712)	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)	\$ 1,424,928	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Wilson Care Inc.

0029975

Report Period Beginning: 01/01/15

Ending:

12/31/15

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

1

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,219,280	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,219,280	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***	33,373	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 33,373	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	1,475	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,475	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,254,128	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,213,508	31
32	Health Care	1,743,546	32
33	General Administration	1,564,431	33
B. Capital Expense			
34	Ownership	1,495,344	34
C. Ancillary Expense			
35	Special Cost Centers	37,011	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)*	\$ 6,053,840	40
41	Income before Income Taxes (line 30 minus line 40)**	200,288	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 200,288	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,869,269	44
45	Private Pay - Net Inpatient Revenue	24,523	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) <u>Managed Care</u>	3,324,170	47
48	Other-(specify) <u>Hospice</u>	1,318	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,219,280	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.**

0029975

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,925	2,119	\$ 87,828	\$ 41.45	1
2	Assistant Director of Nursing	1,225	1,558	57,225	36.73	2
3	Registered Nurses	1,903	1,973	57,559	29.17	3
4	Licensed Practical Nurses	11,888	12,541	320,211	25.53	4
5	CNAs & Orderlies	53,544	57,370	583,155	10.16	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	7,091	7,958	102,422	12.87	10
11	Social Service Workers	12,100	13,456	241,358	17.94	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,467	19,008	213,653	11.24	15
16	Dishwashers					16
17	Maintenance Workers	3,764	4,080	50,584	12.40	17
18	Housekeepers	19,310	20,969	220,498	10.52	18
19	Laundry					19
20	Administrator	1,670	2,086	112,569	53.96	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,355	18,125	214,066	11.81	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,746	4,107	86,770	21.13	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	4,505	4,505	47,491	10.54	33
34	TOTAL (lines 1 - 33)	156,493	169,855	\$ 2,395,389 *	\$ 14.10	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly	\$ 33,617	01-03	35
36	Medical Director	Monthly	3,600	09-03	36
37	Medical Records Consultant	Monthly	4,704	10-03	37
38	Nurse Consultant	Monthly	57,024	10-03	38
39	Pharmacist Consultant	Monthly	15,835	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	2,435	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	<u>Specialized Rehab Consultant</u>	Monthly	33,264	10A-03	47
48	<u>Psychiatric Consultant</u>	Monthly	8,775	10-03	48
49	TOTAL (lines 35 - 48)		\$ 159,254		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	695	\$ 25,420	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	695	\$ 25,420		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Augusto Beley	Administrator	0.00	\$ 112,569	Workers' Compensation Insurance	\$ 32,752	IDPH License Fee	\$ 1,992	
				Unemployment Compensation Insurance	36,291	Advertising: Employee Recruitment	4,366	
				FICA Taxes	180,831	Health Care Worker Background Check		
				Employee Health Insurance	47,945	(Indicate # of checks performed)	5,851	
				Employee Meals		Patient Background Checks	188 1,880	
				Illinois Municipal Retirement Fund (IMRF)*		Licenses and Permits	600	
				Union Pension Expense	24,314	Dues & Subscriptions	13,815	
				Union Health & Welfare	93,760	Allocated from SIR Management	1,707	
				401k Contributions	925			
				Other Employee Benefits	8,738			
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						TOTAL (agree to Sch. V, line 20, col. 8)		
					\$ 425,556	\$ 30,210		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description				Description			Description	
Amount				Line #			Amount	
SIR Management- Consulting Fee							Out-of-State Travel	
\$ 120,000							\$	
SIR - Director of Admin Services								
57,024								
SIR - Ancillary Admin Charges							In-State Travel	
47,520								
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			Seminar Expense	
							3,485	
							Allocated from SIR Management	
\$ 224,544							1,238	
C. Professional Services							Entertainment Expense	
Vendor/Payee							()	
Type							(agree to Sch. V, line 24, col. 8)	
Amount							\$ 4,723	
SIR Management								
Dir. Of Regulatory Services								
28,512								
SIR Management								
Accounting								
2,700								
SIR Management								
Bookkeeping								
83,160								
SIR Management								
Admissions Coordinator								
33,264								
McGladrey								
Accounting Services								
1,455								
FRR/Marcum LLP								
Accounting Services								
16,950								
Legat Architects								
Architecture Consulting								
1,635								
AllScripts								
Computer Services								
3,649								
Pinnacle								
Customer Satisfaction								
1,026								
HK Payroll Services								
Payroll								
52								
Madison Appraisal								
Appraisal Services								
3,800								
See Supplemental Schedule								
115,903								
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)								
\$ 292,104								

* Attach copy of IMRF notifications

**See instructions.

