

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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

I. IDPH License ID Number: <u>0054221</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Wilson Care</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/20</u> to <u>12/31/20</u> 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.	
Address: <u>4544 North Hazel St</u> <u>Chicago</u> <u>60640</u>			
NumberCityZip Code			
County: <u>Cook</u>			
Telephone Number: <u>(773) 561-7241</u> Fax # <u>(773) 728-2606</u>			
HFS ID Number: _____			
Date of Initial License for Current Owners: <u>9/1/1985</u>			
Type of Ownership:			
☐ VOLUNTARY, NON-PROFIT ☐ Charitable Corp. ☐ Trust IRS Exemption Code _____ ☒ PROPRIETARY ☐ Individual ☐ Partnership ☐ Corporation ☒ "Sub-S" Corp. ☐ Limited Liability Co. ☐ Trust ☐ Other _____			

☐ GOVERNMENTAL☐ State☐ County☐ Other _____

#	0054221	Report Period Beginning:	01/01/20	Ending:	12/31/20
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D. How many bed reserve days during this year were paid by the Department?

None (Do not include bed reserve days in Section B.)

N/A

None

Yes

YES ☐ NO ☒

YES ☐ NO ☒

Date started 9/1/1988

YES ☒ Date 9/1/1988 NO ☐

YES ☐ NO ☒ If YES, enter number
of beds certified and days of care provided

IV. ACCOUNTING BASIS

MODIFIED

ACCRUAL	X
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CASH*	
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CASH* ☐

YES ☒ NO ☐

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

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	4,440	136	48,114	52,690	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	4,440	136	48,114	52,690	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.)	72.71%
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Facility Name & ID Number Wilson Care # 0054221 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	352,563	31,881	38,709	423,153		423,153	(22,034)	401,119			1
2	Food Purchase		295,576		295,576		295,576	(3,827)	291,749			2
3	Housekeeping	353,787	37,598		391,385		391,385	(3,326)	388,059			3
4	Laundry		18,055	18,333	36,388		36,388	(294)	36,094			4
5	Heat and Other Utilities			196,739	196,739		196,739	(20,543)	176,196			5
6	Maintenance	81,075	34,889	68,543	184,507		184,507	562	185,069			6
7	Other (specify):*							3,111	3,111			7
8	TOTAL General Services	787,425	417,999	322,324	1,527,748		1,527,748	(46,350)	1,481,398			8
	B. Health Care and Programs											
9	Medical Director			7,500	7,500		7,500		7,500			9
10	Nursing and Medical Records	1,649,693	49,739	109,258	1,808,690		1,808,690	(23,241)	1,785,449			10
10a	Therapy											10a
11	Activities	97,316	12,814		110,130		110,130		110,130			11
12	Social Services	220,445			220,445		220,445		220,445			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							12,944	12,944			15
16	TOTAL Health Care and Programs	1,967,454	62,553	116,758	2,146,765		2,146,765	(10,297)	2,136,468			16
	C. General Administration											
17	Administrative	132,924		274,440	407,364		407,364	(119,870)	287,494			17
18	Directors Fees											18
19	Professional Services			422,021	422,021	(6,134)	415,887	(287,881)	128,007			19
20	Dues, Fees, Subscriptions & Promotions			79,099	79,099		79,099	(41,934)	37,165			20
21	Clerical & General Office Expenses	239,755	13,421	76,223	329,399		329,399	211,147	540,546			21
22	Employee Benefits & Payroll Taxes			544,470	544,470		544,470	(246)	544,224			22
23	Inservice Training & Education											23
24	Travel and Seminar			128	128		128	398	526			24
25	Other Admin. Staff Transportation			2,264	2,264		2,264	7,138	9,402			25
26	Insurance-Prop.Liab.Malpractice			140,361	140,361		140,361	17,229	157,590			26
27	Other (specify):*							54,289	54,289			27
28	TOTAL General Administration	372,679	13,421	1,539,006	1,925,106	(6,134)	1,918,972	(159,729)	1,759,243			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,127,558	493,973	1,978,088	5,599,619	(6,134)	5,593,485	(216,377)	5,377,109			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.

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			47,281	47,281		47,281	175,185	222,466			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			17,632	17,632		17,632	450,340	467,972			32
33	Real Estate Taxes					6,134	6,134	238,152	244,286			33
34	Rent-Facility & Grounds			1,434,000	1,434,000		1,434,000	(1,434,000)				34
35	Rent-Equipment & Vehicles			2,783	2,783		2,783	4,896	7,679			35
36	Other (specify):*							87,749	87,749			36
37	TOTAL Ownership			1,501,696	1,501,696	6,134	1,507,830	(477,678)	1,030,152			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):*	42,844			42,844		42,844	(42,844)				43
44	TOTAL Special Cost Centers	42,844			42,844		42,844	(42,844)				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,170,402	493,973	3,479,784	7,144,159		7,144,159	(736,898)	6,407,261			45

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(22,309)	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	86,827	30		9
10	Interest and Other Investment Income	(54,728)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(8)	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	(25,100)	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	(19,848)	21		24
25	Fund Raising, Advertising and Promotional	(3,524)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,000)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(132,428)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (173,118)		\$	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)	(563,780)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (563,780)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (736,898)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Building Co. - Professional Fees	\$ (11,900)	19	1
2	Bank Charges	(12,569)	21	2
3	Theft and Damage Loss	(70)	21	3
4	Cafe Income	(850)	02	4
5	PAC Dues	(16,075)	20	5
6	Miscellaneous Income	(50)	21	6
7	Building Co. - Office Expense	(14)	21	7
8	Building Co. - Amortization	(2,770)	36	8
9	Building Co. - State Replacement Tax	(12,000)	21	9
10	Building Co Filing Fees	(519)	21	10
11	Building Co Amort of HUD Fees	(2,770)	36	11
12	Building Co State Replacement Tax	(12,000)	21	12
13	Annual Report	(106)	20	13
14	Line of Credit	(250)	20	14
15	Non Allowable Legal	(17,321)	19	15
16	Prior Year Equipment Rental	(320)	35	16
17	Marketing Salaries	(42,844)	43	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	(132,428)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Wilson Care# 0054221

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary				(21,938)		(96)						(22,034)	1
2	Food Purchase	(858)		(2,969)									(3,827)	2
3	Housekeeping						(3,326)						(3,326)	3
4	Laundry						(294)						(294)	4
5	Heat and Other Utilities	(22,309)			1,766								(20,543)	5
6	Maintenance		5,959	(6,929)	1,532								562	6
7	Other (specify):*			1,822	1,289								3,111	7
8	TOTAL General Services	(23,167)	5,959	(8,076)	(17,351)		(3,716)						(46,350)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			(18,551)		(1,660)	(3,030)						(23,241)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			12,944									12,944	15
16	TOTAL Health Care and Programs			(5,607)		(1,660)	(3,030)						(10,297)	16
	C. General Administration													
17	Administrative			(252,433)	132,563								(119,870)	17
18	Directors Fees													18
19	Professional Services	(29,221)	11,900	(284,218)	13,658								(287,881)	19
20	Fees, Subscriptions & Promotions	(45,055)		3,121									(41,934)	20
21	Clerical & General Office Expenses	(59,071)	12,533	257,586	111	(12)							211,147	21
22	Employee Benefits & Payroll Taxes					(246)							(246)	22
23	Inservice Training & Education													23
24	Travel and Seminar			398									398	24
25	Other Admin. Staff Transportation			7,138									7,138	25
26	Insurance-Prop.Liab.Malpractice		14,961	2,053	215								17,229	26
27	Other (specify):*			23,553	30,736								54,289	27
28	TOTAL General Administration	(133,346)	39,394	(242,802)	177,283	(258)							(159,729)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(156,513)	45,353	(256,485)	159,932	(1,918)	(6,745)						(216,377)	29

STATE OF ILLINOIS

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	86,827	83,854		4,504								175,185	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(54,728)	503,565	(1,764)	3,267								450,340	32
33	Real Estate Taxes		230,320		7,832								238,152	33
34	Rent-Facility & Grounds		(1,434,000)										(1,434,000)	34
35	Rent-Equipment & Vehicles	(320)		5,216									4,896	35
36	Other (specify):*	(5,540)	93,289										87,749	36
37	TOTAL Ownership	26,239	(522,972)	3,452	15,603								(477,678)	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):*	(42,844)											(42,844)	43
44	TOTAL Special Cost Centers	(42,844)											(42,844)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(173,118)	(477,619)	(253,033)	175,535	(1,918)	(6,745)						(736,898)	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 Page 6-Supplemental		See Page 6-Supplemental		See Page 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	Rental-Base	\$ 1,434,000	Wilson Care LLC		\$	(1,434,000)	1
2	V	21	Filling Fees		Wilson Care LLC		519	519	2
3	V	32	Interest-Mortgage		Wilson Care LLC		503,756	503,756	3
4	V	36	Mortgage Insurance		Wilson Care LLC		90,519	90,519	4
5	V	21	Office Expense		Wilson Care LLC		14	14	5
6	V	19	Professional Fees		Wilson Care LLC		11,900	11,900	6
7	V	26	Property Insurance		Wilson Care LLC		14,961	14,961	7
8	V	33	Real Estate Taxes	4,680	Wilson Care LLC		235,000	230,320	8
9	V	30	Depreciation		Wilson Care LLC		83,854	83,854	9
10	V	06	Repairs & Maint-Building		Wilson Care LLC		5,959	5,959	10
11	V	32	Interest Income	190	Wilson Care LLC			(190)	11
12	V	36	Amort. Of HUD Fees		Wilson Care LLC		2,770	2,770	12
13	V	21	State Replacement Tax		Wilson Care LLC		12,000	12,000	13
14	Total			\$ 1,438,870			\$ 961,251	\$ * (477,619)	14

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

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	<u>ARI WOLFF</u>	<u>2.22%</u>	<u>ALBANY CARE, INC.</u>	<u>EVANSTON</u>	<u>WILSON CARE, LLC</u>	<u>LINCOLNWOOD</u>	<u>BUILDING CO.</u>	<u>1</u>
2	<u>ASHLEY BARRISH</u>	<u>0.28%</u>	<u>AUBURN VILLAGE</u>	<u>AUBURN, IN</u>	<u>GENERATIONS HEALTH NETWORK</u>	<u>LINCOLNWOOD</u>	<u>CONSULTING CO.</u>	<u>2</u>
3	<u>B. BART BARRISH</u>	<u>0.28%</u>	<u>BRYN MAWR CARE INC.</u>	<u>CHICAGO</u>	<u>SIR PROPERTIES</u>	<u>LINCOLNWOOD</u>	<u>BUILDING CO.</u>	<u>3</u>
4	<u>BETH ALTER</u>	<u>5.56%</u>	<u>DECATUR MANOR HEALTHCARE, LLC</u>	<u>DECATUR</u>	<u>OAKTON ARMS</u>	<u>DES PLAINES</u>	<u>ASSISTED LIVING</u>	<u>4</u>
5	<u>BRYAN BARRISH TRUST DTD 09/01/04</u>	<u>11.11%</u>	<u>GENERATIONS AT APPLEWOOD, LLC</u>	<u>MATTESON</u>	<u>MAC Rx LLC</u>	<u>DES PLAINES</u>	<u>PHARMACY</u>	<u>5</u>
6	<u>CHERYL MAGENCE</u>	<u>4.72%</u>	<u>GENERATIONS AT ELMWOOD PARK, INC</u>	<u>ELMWOOD PARK</u>	<u>BIG TEN SUPPLY, LLC</u>	<u>LIBERTYVILLE</u>	<u>SUPPLY CO.</u>	<u>6</u>
7	<u>DANIEL ROTHNER</u>	<u>0.97%</u>	<u>GENERATIONS AT LINCOLN, LLC</u>	<u>LINCOLN</u>	<u>TRANSITIONS INDIANA</u>	<u>HUNTLEY</u>	<u>HOSPICE</u>	<u>7</u>
8	<u>DARCEY BARRISH</u>	<u>0.28%</u>	<u>GENERATIONS AT NEIGHBORS, LLC</u>	<u>BYRON</u>	<u>GENERATIONS AT RIVERVIEW</u>		<u>ASSISTED & INDEPENDENT</u>	<u>8</u>
9	<u>ERIC ROTHNER</u>	<u>20.00%</u>	<u>GENERATIONS AT OAKTON PAVILION, LLC</u>	<u>DES PLAINES</u>	<u>SENIOR LIVING</u>	<u>EAST PEORIA</u>	<u>LIVING</u>	<u>9</u>
10	<u>HOWARD GELLER TRUST</u>	<u>9.44%</u>	<u>GENERATIONS AT PEORIA, LLC</u>	<u>PEORIA</u>				<u>10</u>
11	<u>JESSE REYNOLDS DESCENDANTS TRUST</u>	<u>0.56%</u>	<u>GENERATIONS AT REGENCY, LLC</u>	<u>NILES</u>				<u>11</u>
12	<u>KIRSTEN BARRISH</u>	<u>0.28%</u>	<u>GENERATIONS AT RIVERVIEW, LLC</u>	<u>EAST PEORIA</u>				<u>12</u>
13	<u>LAURI WOLFF POLEN</u>	<u>2.22%</u>	<u>GENERATIONS AT ROCK ISLAND, LLC</u>	<u>ROCK ISLAND</u>				<u>13</u>
14	<u>LINDA VARDI</u>	<u>1.11%</u>	<u>GREENWOOD CARE, INC.</u>	<u>EVANSTON</u>				<u>14</u>
15	<u>MARC GELLER</u>	<u>5.56%</u>	<u>PRAIRIE CREEK VILLAGE, LLC</u>	<u>DECATUR</u>				<u>15</u>
16	<u>MARILYN WOLFF</u>	<u>5.56%</u>	<u>VILLA CLARA POST ACUTE, LLC</u>	<u>DECATUR</u>				<u>16</u>
17	<u>MARK STEINBERG</u>	<u>2.50%</u>						<u>17</u>
18	<u>MAYER MAGENCE</u>	<u>4.72%</u>						<u>18</u>
19	<u>MELISSA ROTHNER</u>	<u>0.97%</u>						<u>19</u>
20	<u>NOAH WOLFF</u>	<u>5.56%</u>						<u>20</u>
21	<u>RACHEL ROTHNER</u>	<u>0.97%</u>						<u>21</u>
22	<u>RANAN WOLFF</u>	<u>2.22%</u>						<u>22</u>
23	<u>WILLIAM ROTHNER</u>	<u>0.97%</u>						<u>23</u>
24	<u>SANDRA KLIERS</u>	<u>1.11%</u>						<u>24</u>
25	<u>SARAH BARRISH</u>	<u>0.56%</u>						<u>25</u>
26	<u>SHIRLEY DRELICH</u>	<u>2.50%</u>						<u>26</u>
27	<u>STEVEN GELLER</u>	<u>5.56%</u>						<u>27</u>
28	<u>TZIONA ZEFFREN</u>	<u>2.22%</u>						<u>28</u>
29								<u>29</u>
30								<u>30</u>

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

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	4	5 Cost to Related Organization	6	7	8 Difference:	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	2 Dietary Other and Rebates	\$	Generations HC Network, LLC		\$ (2,969)	\$ (2,969)	15
16	V	6 Repairs & Maintenance	21,384	Generations HC Network, LLC		14,455	(6,929)	16
17	V	7 Emp. Ben. - General Svc.		Generations HC Network, LLC		1,822	1,822	17
18	V	9 Medical Director Consults		Generations HC Network, LLC				18
19	V	10 Nursing	87,912	Generations HC Network, LLC		69,361	(18,551)	19
20	V	15 Emp. Ben. - Health Care		Generations HC Network, LLC		12,944	12,944	20
21	V	17 Administrative	274,440	Generations HC Network, LLC		22,007	(252,433)	21
22	V	19 Professional Fees	293,004	Generations HC Network, LLC		8,786	(284,218)	22
23	V	20 Fee, Subscriptions		Generations HC Network, LLC		3,121	3,121	23
24	V	21 Clerical & General	10,692	Generations HC Network, LLC		268,278	257,586	24
25	V	24 Education & Seminar		Generations HC Network, LLC		398	398	25
26	V	25 Other Admin. Staff Transportation		Generations HC Network, LLC		7,138	7,138	26
27	V	26 Insurance		Generations HC Network, LLC		2,053	2,053	27
28	V	27 Emp. Ben. - Gen. Admin.		Generations HC Network, LLC		23,553	23,553	28
29	V	32 Interest		Generations HC Network, LLC		(1,764)	(1,764)	29
30	V	35 Auto Rental		Generations HC Network, LLC		4,432	4,432	30
31	V	35 Equipment Rental		Generations HC Network, LLC		784	784	31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 687,432			\$ 434,399	\$ * (253,033)	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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	<u>1</u> Dietary Salaries	\$ 28,512	<u>Generations HC Network, LLC</u>		\$ 6,574	\$ (21,938)	15
16	V	<u>7</u> Emp. Ben. - Dietary		<u>Generations HC Network, LLC</u>		1,229	1,229	16
17	V	<u>17</u> Admin./Legal Salaries		<u>Generations HC Network, LLC</u>		132,563	132,563	17
18	V	<u>19</u> Fin. Consult./Regl. Dir.		<u>Generations HC Network, LLC</u>		13,228	13,228	18
19	V	<u>27</u> Emp. Ben. - Administrative		<u>Generations HC Network, LLC</u>		30,736	30,736	19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V	<u>6</u> Maintenance Salaries	300	<u>Generations HC Network, LLC</u>		310	10	25
26	V	<u>7</u> Employee Benefits		<u>Generations HC Network, LLC</u>		60	60	26
27	V							27
28	V	<u>5</u> Utilities		<u>Generations HC Network, LLC</u>		1,766	1,766	28
29	V	<u>6</u> Repairs & Maintenance		<u>Generations HC Network, LLC</u>		1,522	1,522	29
30	V	<u>19</u> Professional Fees		<u>Generations HC Network, LLC</u>		430	430	30
31	V	<u>21</u> Clerical & General		<u>Generations HC Network, LLC</u>		111	111	31
32	V	<u>26</u> Insurance		<u>Generations HC Network, LLC</u>		215	215	32
33	V	<u>30</u> Depreciation		<u>Generations HC Network, LLC</u>		4,504	4,504	33
34	V	<u>32</u> Interest		<u>Generations HC Network, LLC</u>		3,267	3,267	34
35	V	<u>33</u> Real Estate Taxes		<u>Generations HC Network, LLC</u>		7,832	7,832	35
36	V							36
37	V							37
38	V							38
39	Total		\$ 28,812			\$ 204,347	\$ * 175,535	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	10	Nursing and Medical Records	\$ 17,765	MAC Rx, LLC		\$ 16,105	\$ (1,660)	15
16	V	21	Clerical & General Office Expenses	124	MAC Rx, LLC		113	(12)	16
17	V	22	Employee Benefits	2,631	MAC Rx, LLC		2,386	(246)	17
18	V	39	Ancillary		MAC Rx, LLC				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			\$ 20,521			\$ 18,603	\$ * (1,918)	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	1	Dietary	\$ 999	Big Ten Supply, LLC		\$ 903	\$ (96)	15
16	V	3	Housekeeping	34,600	Big Ten Supply, LLC		31,274	(3,326)	16
17	V	4	Laundry	3,059	Big Ten Supply, LLC		2,765	(294)	17
18	V	6	Repairs & Maintenance		Big Ten Supply, LLC				18
19	V	10	Nursing And Medical Records	31,523	Big Ten Supply, LLC		28,494	(3,030)	19
20	V	10A	Therapy		Big Ten Supply, LLC				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			\$ 70,181			\$ 63,436	\$ * (6,745)	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.

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:	
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:	
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:	
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)

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	2.22	5.54%	Alloc. Salary	\$ 15,830	17-7	1
2	Kirsten Schloss	Owner	Maintenance	0.278%	See Attached	2.53	6.33%	Alloc. Salary	9,872	6-7	2
3	Sarah Barrish	Owner	Administrative	0.556%	See Attached	3.17	6.33%	Alloc. Salary	8,139	17-7	3
4	Nenita Guzman	Relative	Dietary	0%	See Attached	2.53	6.33%	Alloc. Salary	6,574	1-7	4
5	Clark Collins	Relative	Administrative	0%	See Attached	0.60	1.50%	Alloc. Salary	797	Var.	5
6	Burton Barrish	Relative	Administrative	0%	See Attached	2.53	6.33%	Alloc. Salary	6,855	17-7	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	\$ 48,066		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 # 0054221 Report Period Beginning: 01/01/20 Ending: 12/31/20

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# 0054221

Report Period Beginning:

01/01/20Ending: 12/31/20

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

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	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	2	Dietary Other and Rebates	Patient Days	19	\$ (46,886)	\$	52,690	\$ (2,969)	1
2	6	Repairs & Maintenance	Patient Days	19	228,292	155,904	52,690	14,455	2
3	7	Emp. Ben. - General Svc.	Patient Days	19	28,781		52,690	1,822	3
4	9	Medical Director Consults	Patient Days	19			52,690		4
5	10	Nursing	Patient Days	19	1,095,433	1,094,370	52,690	69,361	5
6	15	Emp. Ben. - Health Care	Patient Days	19	204,429		52,690	12,944	6
7	17	Administrative	Patient Days	19	347,566	347,566	52,690	22,007	7
8	19	Professional Fees	Patient Days	19	138,762		52,690	8,786	8
9	20	Fee, Subscriptions	Patient Days	19	49,284		52,690	3,121	9
10	21	Clerical & General	Patient Days	19	4,236,976	3,850,828	52,690	268,278	10
11	24	Education & Seminar	Patient Days	19	6,287		52,690	398	11
12	25	Other Admin. Staff Transportation	Patient Days	19	112,731		52,690	7,138	12
13	26	Insurance	Patient Days	19	32,419		52,690	2,053	13
14	27	Emp. Ben. - Gen. Admin.	Patient Days	19	371,977		52,690	23,553	14
15	32	Interest	Patient Days	19	(27,854)		52,690	(1,764)	15
16	35	Auto Rental	Patient Days	19	70,001		52,690	4,432	16
17	35	Equipment Rental	Patient Days	19	12,377		52,690	784	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 6,860,575	\$ 5,448,668		\$ 434,399	25

Facility Name & ID Number Wilson Care# 0054221

Report Period Beginning:

01/01/20Ending: 12/31/20

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

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	832,144	19	\$ 103,820	\$ 103,820	52,690	\$ 6,574	1
2	7	Emp. Ben. - Dietary	Patient Days	832,144	19	19,413		52,690	1,229	2
3	17	Admin./Legal Salaries	Patient Days	832,144	19	2,093,591	2,093,591	52,690	132,563	3
4	19	Fin. Consult./Regl. Dir.	Patient Days	832,144	19	208,920		52,690	13,228	4
5	27	Emp. Ben. - Administrative	Patient Days	832,144	19	485,424		52,690	30,736	5
6										6
7										7
8										8
9										9
10										10
11	6	Maintenance Salaries	Maintenance Income	702,930	17	726,469	726,469	300	310	11
12	7	Employee Benefits	Maintenance Income	702,930	17	141,032		300	60	12
13										13
14	5	Utilities	Allocated Sq. Ft.	12,879	19	27,900		815	1,766	14
15	6	Repairs & Maintenance	Allocated Sq. Ft.	12,879	19	24,049		815	1,522	15
16	19	Professional Fees	Allocated Sq. Ft.	12,879	19	6,801		815	430	16
17	21	Clerical & General	Allocated Sq. Ft.	12,879	19	1,754		815	111	17
18	26	Insurance	Allocated Sq. Ft.	12,879	19	3,403		815	215	18
19	30	Depreciation	Allocated Sq. Ft.	12,879	19	71,181		815	4,504	19
20	32	Interest	Allocated Sq. Ft.	12,879	19	51,631		815	3,267	20
21	33	Real Estate Taxes	Allocated Sq. Ft.	12,879	19	123,763		815	7,832	21
22										22
23										23
24										24
25	TOTALS					\$ 4,089,151	\$ 2,923,880		\$ 204,347	25

Facility Name & ID Number Wilson Care# 0054221 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

MAC Rx, LLC

Street Address

2307 S. Mount Prospect Road

City / State / Zip Code

Des Plaines, IL 60018

Phone Number

(224)220-2700

Fax Number

(224)220-2730

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Nursing And Medical Records	Direct Allocation			\$	\$		16,105	1
2	21	Clerical & General Office Expense	Direct Allocation						113	2
3	22	Employee Benefits	Direct Allocation						2,386	3
4	39	Ancillary	Direct Allocation							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					\$	\$		18,603	25

Facility Name & ID Number Wilson Care # 0054221 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 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	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	Direct Allocation			\$	\$		\$ 903	1
2	3	Housekeeping	Direct Allocation						31,274	2
3	4	Laundry	Direct Allocation						2,765	3
4	6	Repairs & Maintenance	Direct Allocation							4
5	10	Nursing And Medical Records	Direct Allocation						28,494	5
6	10A	Therapy	Direct Allocation							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					\$	\$		\$ 63,436	25

Facility Name & ID Number Wilson Care # 0054221 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 # 0054221 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 # 0054221 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 # 0054221 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 # 0054221 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

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	Cambridge Realty Capital		X	Mortgage			\$	16,273,623			\$ 503,756	1
2							\$				\$	2
3							\$				\$	3
4							\$				\$	4
5							\$				\$	5
	Working Capital											
6	Lake Forest Bank	X		Line of Credit				-			17,632	6
7	Unamortized Bond Premium	X		Unamortized Bond Premium				898,432			-	7
8												
9	TOTAL Facility Related						\$	17,172,055			\$ 521,388	9
	B. Non-Facility Related*											
10	Interest Income	X									(54,728)	10
11	Interest Income-Building Co	X									(190)	11
12	Allocated from Generations HC	X									(1,764)	12
13	Allocated from Generations HC	X									3,267	13
14	TOTAL Non-Facility Related						\$				\$ (53,415)	14
15	TOTALS (line 9+line14)						\$	17,172,055			\$ 467,973	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 90,519 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.)

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 2019 report.				\$	228,400	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.)				\$	231,552	2
3. Under or (over) accrual (line 2 minus line 1).				\$	3,152	3
4. Real Estate Tax accrual used for 2020 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.)				\$	6,134	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	244,285	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2015	205,152	8		
		2016	223,760	9		
		2017	241,047	10		
		2018	217,479	11		
		2019	223,720	12		
2020 Accrual= \$223,720 x 1.05 = \$235,000						
Allocated from Generations HC \$7,832						

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	\$	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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Wilson Care COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0054221

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE (847) 282-6330 FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2019 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 2019.

	(A)	(B)	(C)	(D)
				<u>Tax</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
				<u>Nursing Home</u>
1.	<u>14-17-220-009-0000</u>	<u>Long Term Care Property</u>	\$ <u>223,719.84</u>	\$ <u>223,719.84</u>
2.	<u>10-31-401-046-0000</u>	<u>Allocated from Regency Property</u>	\$ <u>796,746.36</u>	\$ <u>612.59</u>
3.	<u>Various</u>	<u>Allocated from SIR Properties</u>	\$ <u>148,905.51</u>	\$ <u>7,379.63</u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
		TOTALS	\$ <u><u>1,169,372</u></u>	\$ <u><u>231,712</u></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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2019 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 2019 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2019.

Please complete the Real Estate Tax Statement below and include it in the 2020 cost report along with a copy of your 2019 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.

FACILITY NAME Wilson Care COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0054221

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE () FAX #: ()

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.

B. Real Estate Tax Cost Allocations

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.)

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.

Page 10B

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).

[illegible]

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:

A. Land.

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

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	198		1985	1967	\$ 1,539,800	\$ 83,854	36	\$	\$ (83,854)	\$ 1,539,800	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1985	65,366		20	26	26	65,366	9
10	Various			1986	161,365		20	19	19	161,365	10
11	Various			1987	49,380		20	32	32	49,380	11
12	Various			1989	49,210		20	13	13	49,210	12
13	Various			1990	105,470		20	198	198	105,470	13
14	Various			1991	29,903		20	12	12	29,903	14
15	Various			1992	69,669		20	3	3	69,669	15
16	Various			1993	61,688		20	5	5	61,688	16
17	Various			1994	55,691		20	3	3	55,691	17
18	Various			1995	87,144		20	577	577	87,144	18
19	Various			1996	303,393		20	867	867	303,393	19
20	Various			1997	145,411		20	1,452	1,452	141,513	20
21	Various			1998	34,959		20	3	3	34,959	21
22	Various			1999	53,478		20	137	137	53,387	22
23	Various			2000	221,871		20	7,876	7,876	221,870	23
24	Various			2001	102,633		20	5,131	5,131	100,909	24
25	Various			2002	67,986		20			67,986	25
26	Various			2003	97,187		20	3,695	3,695	87,854	26
27	Various			2004	62,333		20	1,901	1,901	55,667	27
28	Various			2005	214,966		20	8,029	8,029	178,853	28
29	Various			2006	56,219		20	2,664	2,664	41,233	29
30	Various			2007	362,270		20	16,592	16,592	252,870	30
31	Various			2008	29,574		20	1,479	1,479	18,670	31
32	Various			2009	22,564		20	896	896	15,226	32
33	Various			2010	11,969		20	153	153	10,554	33
34	Various			2011	16,984		20	850	850	11,592	34
35	Various			2012	2,917		20	146	146	1,216	35
36	Various			2014	7,350		20	368		2,328	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

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	Various	2015	\$ 12,340	\$	20	\$ 617	\$ 617	\$ 3,236	37
38	Various	2016	3,985		20	199	199	847	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)		1,498,562			74,928	74,928	675,947	67
68	Related Party Allocations (Pages 12H & 12I)		142,968	2,522		3,981	1,459	92,384	68
69	Financial Statement Depreciation			47,281			(47,281)		69
70	TOTAL (lines 4 thru 69)		\$ 5,746,605	\$ 133,657		\$ 132,852	\$ (1,173)	\$ 4,647,180	70

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

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		\$5,746,605	\$133,657		\$132,852	\$ (805)	\$4,647,180	1
2	Dining Room A/C Compressing Unit	2017	4,250		20	213	213	780	2
3	Break Floor In Hallway & Repair Broken Water Line	2017	4,527		20	226	226	811	3
4	Bathroom Remodeling - New Walls, Tile, Paint, Lighting	2018	5,650		20	283	283	683	4
5	Masonry Work - Tuckpointing	2018	102,095		20	5,105	5,105	12,337	5
6	Kitchen Drain Pipe And Grease Trap	2018	7,385		20	369	369	984	6
7	Cast Iron Steam Boiler	2018	65,000		20	3,250	3,250	6,771	7
8	Stream Trap Installation	2018	3,700		20	185	185	540	8
9	Fence Repair	2018	3,900		20	195	195	471	9
10	New Copper Lines In Boiler Room	2019	4,189		20	209	209	244	10
11	Installed Security Cameras And Equipment	2019	3,721		20	186	186	186	11
12	Installed Boiler Pump And Motor	2020	4,300		20	215	215	215	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)		\$5,955,322	\$133,657		\$143,288	\$9,631	\$4,671,202	34

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

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		\$ 5,955,322	\$ 133,657		\$ 143,288	\$ 9,631	\$ 4,671,202	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)		\$ 5,955,322	\$ 133,657		\$ 143,288	\$ 9,631	\$ 4,671,202	34

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

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		\$ 5,955,322	\$ 133,657		\$ 143,288	\$ 9,631	\$ 4,671,202	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)		\$ 5,955,322	\$ 133,657		\$ 143,288	\$ 9,631	\$ 4,671,202	34

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

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		\$ 5,955,322	\$ 133,657		\$ 143,288	\$ 9,631	\$ 4,671,202	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		\$ 5,955,322	\$ 133,657		\$ 143,288	\$ 9,631	\$ 4,671,202	34

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

Facility Name & ID Number Wilson Care

0054221

Report Period Beginning:

01/01/20

Ending:

12/31/20

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	35100		20	1755	1,755	21,070	9
10	Various	2008	481710		20	24085.5	24,086	269,961	10
11	Bathtub Liners	2009	12200		20	610	610	6,100	11
12	Various	2010	375987		20	18799.35	18,799	169,838	12
13	Fire Rated Doors	2011	18500		20	925	925	7,400	13
14	Ceiling Grid and Lighting	2011	5685		20	284.25	284	2,272	14
15	Lintels and Tuckpointing	2011	47745		20	2387.25	2,387	19,096	15
16	Fired Rated Doors	2011	13600		20	680	680	5,440	16
17	Fire Rated Doors	2011	2200		20	110	110	880	17
18	Fire Rated Doors	2011	2425		20	121.25	121	968	18
19	Gate Work	2011	2925		20	146.25	146	1,168	19
20	Stair Treads	2011	3771		20	188.55	189	1,512	20
21	Doors, Frames, Closets	2011	7171		20	358.55	359	2,872	21
22	Installed Surface Mount Wiremold Raceways	2012	28600		20	1430	1,430	11,440	22
23	Installed Freezer Evaporator Coil and Expansion Valve	2012	3640		20	182	182	1,456	23
24	Replaces Defective Cloth Covered Wires	2012	21456		20	1072.8	1,073	8,581	24
25	Replaced 496 Sprinklers	2012	21990		20	1099.5	1,100	8,800	25
26	Removed Non-working Doors, Replaced Existing Locks	2012	6950		20	347.5	348	2,784	26
27	Replaced Pipe From 2nd to 3rd Floor, Plastered Drywall	2012	3500		20	175	175	1,400	27
28	Installed New Window Screens	2012	2524		20	126.2	126	1,008	28
29	Repaired walls & flooring for smoke room, office, & kitchen	2012	7336		20	366.8	367	2,936	29
30	Replaced 51 exit signs & fuses & installed electric heaters	2012	17075		20	853.75	854	6,832	30
31	Replaced A/C Units	2012	6837		20	341.85	342	2,736	31
32	Repaired and Installed Railing With Round Pipe, Primed & Finish	2012	3935		20	196.75	197	1,576	32
33	Replaced Fire Exit Door Hardware	2012	3598		20	179.9	180	1,440	33
34	TOTAL (lines 1 thru 33)		\$ 1,136,460	\$		\$ 56,823	\$ 56,823	\$ 559,566	34

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

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		\$ 1,136,460	\$		\$ 56,823	\$ 56,823	\$ 559,566	1
2	Modernization of Two Traction Elevators	2011	185400		20	9270	9,270	83,430	2
3	Penthouse Elevator Project	2011	3392		20	169.6	170	1,530	3
4	Conference Room Cabinetry	2013	6500		20	325	325	2,275	4
5	Doctor's Office Cabinetry	2013	2500		20	125	125	875	5
6	Fire Alarm Panel	2015	35757		20	1787.85	1,788	10,728	6
7	Replace Steam-Pipes- Activity Room and Bathroom	2015	3640		20	182	182	1,092	7
8	Fire Rated Steel Doors	2015	2825		20	141.25	141	846	8
9	Bathroom Tubs and Walls	2015	3600		20	180	180	1,080	9
10	Replace Steel Bathtubs- Bathrooms 503/504/509	2015	3450		20	172.5	173	1,038	10
11	Clean, sand, dry, mask, & refinish bathtub	2016	5150		20	257.5	258	1,290	11
12	Air Conditioners	2016	4977		20	248.85	249	1,245	12
13	Boiler & Steam Pipe Work	2017	3980		20	199	199	796	13
14	Steam Pipe/Trap Repair	2018	7991.67		20	399.5835	400	1,199	14
15	Replace Drains	2018	7642.68		20	382.134	382	1,146	15
16	Wifi Upgrade	2018	8405		20	420.25	420	1,261	16
17	Weatherhead Installation	2019	2575		20	128.75	129	258	17
18	Plumbing Install New Kitchen	2019	16666		20	833.3	833	1,666	18
19	Replaced Leaking Return Line	2019	24648		20	1232.4	1,232	2,464	19
20	Women's Restroom Work	2019	4987		20	249.35	249	498	20
21	New Underground Sewer Line	2019	5252		20	262.6	263	526	21
22	Hot Water Heater	2020	15520		20	776	776	776	22
23	Replace A/C Units	2020	7244		20	362.2	362	362	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)		\$ 1,498,562	\$		\$ 74,928	\$ 74,928	\$ 675,947	34

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

Facility Name & ID Number Wilson Care

0054221

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from Generations Healthcare Network, LLC	2009	31,641	844	39	811	(33)	8,958	3
4	Allocated from S.I.R. Properties/GHN	1993	28,645	909	35	818	(91)	21,688	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Generations Healthcare Network, LLC	1993	7,262	202	20		(202)	7,262	9
10	Allocated from Generations Healthcare Network, LLC	1994	23		20			23	10
11	Allocated from Generations Healthcare Network, LLC	1995	166		20			166	11
12	Allocated from Generations Healthcare Network, LLC	1997	11,159	250	20		(250)	11,159	12
13	Allocated from Generations Healthcare Network, LLC	1999	877		20	33	33	877	13
14	Allocated from Generations Healthcare Network, LLC	1999	11,079		20			11,079	14
15	Allocated from Generations Healthcare Network, LLC	2000	1,036		20	24	24	1,036	15
16	Allocated from Generations Healthcare Network, LLC	2007	3,329		20	166	166	2,196	16
17	Allocated from Generations Healthcare Network, LLC	2008	9,173		20	339	339	6,709	17
18	Allocated from Generations Healthcare Network, LLC	2009	22,794		20	1,140	1,140	12,816	18
19	Allocated from Generations Healthcare Network, LLC	2011	564	56	20	56		531	19
20	Allocated from Generations Healthcare Network, LLC	2012	1,805	90	20	90		669	20
21	Allocated from Generations Healthcare Network, LLC	2014	253	25	20	13	(13)	83	21
22	Allocated from Generations Healthcare Network, LLC	2016	329	16	20	16		73	22
23	Allocated from Generations Healthcare Network, LLC	2019	1,642	81	20	81		103	23
24	Allocated from Generations Healthcare Network, LLC	2020	1,337	28	20	28	0	28	24
25									25
26	Allocated from S.I.R. Properties/GHN	2012	1,755		20	88	88	615	26
27	Allocated from S.I.R. Properties/GHN	2010	1,729		20	86	86	807	27
28	Allocated from S.I.R. Properties/GHN	2009	1,720		20	86	86	929	28
29	Allocated from S.I.R. Properties/GHN	2007	169	10	20	8	(2)	110	29
30	Allocated from S.I.R. Properties/GHN	2002	113		20	6	6	100	30
31	Allocated from S.I.R. Properties/GHN	1999	3,630		20	91	91	3,630	31
32	Allocated from S.I.R. Properties/GHN	1994	273	7	20		(7)	273	32
33	Allocated from S.I.R. Properties/GHN	1993	465	2	20		(2)	465	33
34	TOTAL (lines 1 thru 33)		\$ 142,968	\$ 2,522		\$ 3,981	\$ 1,459	\$ 92,384	34

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

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		\$ 142,968	\$ 2,522		\$ 3,981	\$ 1,459	\$ 92,384	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		\$ 142,968	\$ 2,522		\$ 3,981	\$ 1,459	\$ 92,384	34

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

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	\$934,860	\$1,342	\$78,033	\$76,691	10	\$825,468	71
72	Current Year Purchases	266	18	18	0	10	18	72
73	Fully Depreciated Assets	809,105				10	809,105	73
74								74
75	TOTALS	\$1,744,231	\$1,360	\$78,050	\$76,691		\$1,634,590	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				\$	\$	\$	\$		\$	76
77										77
78										78
79		See Attached		7,462	622	1,127	505		3,998	79
80	TOTALS			\$7,462	\$622	\$1,127	\$505		\$3,998	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$7,732,215	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$135,639	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$222,466	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$86,827	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$6,309,790	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:
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:
- *

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: \$3,247
- Description: See Attached

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Generation		\$	\$4,432	17
18					18
19					19
20					20
21	TOTAL		\$	\$4,432	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.	/2021	\$
13.	/2022	\$
14.	/2023	\$

* 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.

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

☒ 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)	\$					

(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.

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	

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

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

1		2		3	4	5		6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
1	Licensed Occupational Therapist					hrs	\$		\$	\$	
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):										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.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 323,909	\$ 657,806	1
2	Cash-Patient Deposits	78,702	78,702	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	972,124	972,124	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	24,633	55,808	6
7	Other Prepaid Expenses	147,751	147,751	7
8	Accounts Receivable (owners or related parties)	1,700,000	1,700,000	8
9	Other(specify):		831,629	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,247,119	\$ 4,443,820	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	1,908,171	3,008,412	15
16	Equipment, at Historical Cost	1,422,112	2,171,013	16
17	Accumulated Depreciation (book methods)	(2,538,799)	(5,273,141)	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):	28,723	66,255	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 820,207	\$ 1,537,539	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,067,326	\$ 5,981,359	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,481,771	\$ 1,481,771	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	78,749	78,749	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	236,128	236,128	30
31	Accrued Taxes Payable (excluding real estate taxes)	159,635	159,635	31
32	Accrued Real Estate Taxes(Sch.IX-B)		235,000	32
33	Accrued Interest Payable		36,616	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36		1,081,344	1,081,344	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,037,627	\$ 3,309,243	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		16,273,623	40
41	Bonds Payable		898,432	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 17,172,055	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,037,627	\$ 20,481,298	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,029,699	\$ (14,499,939)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,067,326	\$ 5,981,359	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,457,805	1
2	Restatements (describe):		2
3	Rounding	1	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,457,806	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(428,107)	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)	\$ (428,107)	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)	\$ 1,029,699	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Wilson Care

0054221

Report Period Beginning:

01/01/20

Ending:

12/31/20

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	\$ 6,515,510	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,515,510	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***	54,728	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 54,728	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28		145,814	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 145,814	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,716,052	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,527,748	31
32	Health Care	2,146,765	32
33	General Administration	1,925,106	33
	B. Capital Expense		
34	Ownership	1,501,696	34
	C. Ancillary Expense		
35	Special Cost Centers	42,844	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)*	\$ 7,144,159	40
41	Income before Income Taxes (line 30 minus line 40)**	(428,107)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (428,107)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 590,421	44
45	Private Pay - Net Inpatient Revenue	18,263	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) <u>Managed Care</u>	5,906,826	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,515,510	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete 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.

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	1,850	2,091	\$ 106,424	\$ 50.90	1
2	Assistant Director of Nursing	1,654	2,091	73,343	35.08	2
3	Registered Nurses	1,578	1,663	58,086	34.93	3
4	Licensed Practical Nurses	12,347	13,273	371,874	28.02	4
5	CNAs & Orderlies	54,046	58,399	1,007,950	17.26	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,192	5,778	97,316	16.84	10
11	Social Service Workers	10,245	11,410	220,445	19.32	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,382	20,443	352,563	17.25	15
16	Dishwashers					16
17	Maintenance Workers	4,745	4,910	81,075	16.51	17
18	Housekeepers	18,223	20,687	353,787	17.10	18
19	Laundry					19
20	Administrator	1,926	2,091	132,924	63.57	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,227	1,364	23,025	16.88	23
24	Clerical	11,666	12,962	216,730	16.72	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	2,032	2,145	32,016	14.93	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	2,306	2,562	42,844	16.72	33
34	TOTAL (lines 1 - 33)	147,419	161,869	\$ 3,170,402 *	\$ 19.59	34

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	\$ 38,709	01-03	35
36	Medical Director	Monthly	7,500	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	87,912	10-03	38
39	Pharmacist Consultant	Monthly	11,277	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				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 145,398		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	238	\$ 10,069	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	238	\$ 10,069		53

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

** See instructions.

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?
If YES, give association name and amount.

Yes

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?
What was the average life used for new equipment added during this period?

Yes

10 Years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 216

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?
If YES, give effective date of lease.

No

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?

N/A

Indicate the amount.

\$

(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% Ln 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?
Indicate the amount of income earned from providing such transportation during this reporting period.

No

\$ 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.