

		FOR OHF USE				

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

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.

<p>I. IDPH Facility ID Number: <u>0029975</u></p> <p>Facility Name: <u>Wilson Care Inc.</u></p> <p>Address: <u>4544 N. Hazel Street</u> <u>Chicago</u> <u>60640</u> Number City Zip Code</p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(773) 561-7241</u> Fax # <u>(773) 728-2606</u></p> <p>IDPA ID Number: <u>363379568001</u></p> <p>Date of Initial License for Current Owners: <u>09/01/85</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Steve Lavenda</u> Telephone Number: <u>(847) 236 - 1111</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/03</u> to <u>12/31/03</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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td>(Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>Cary C. Buxbaum, C.P.A.</u></td> </tr> <tr> <td>(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td> </tr> <tr> <td>(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u></td> </tr> </table> <p align="right">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____	(Type or Print Name) _____ (Title) _____	Paid Preparer	(Signed) _____ (Date) _____	(Print Name and Title) <u>Cary C. Buxbaum, C.P.A.</u>	(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																															
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care Inc.

0029975 Report Period Beginning: 01/01/03 Ending: 12/31/03

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	Other		
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	64,984	1,201		66,185	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	64,984	1,201		66,185	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.58%

D. How many bed-hold days during this year were paid by Public Aid? 986 (Do not include bed-hold days in Section B.)

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

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

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

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

I. On what date did you start providing long term care at this location?
 Date started 9/1/98

J. Was the facility purchased or leased after January 1, 1978?
 YES Date 8/31/85 NO

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS
 ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/03 Fiscal Year: 12/31/03
 * All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/03 Ending: 12/31/03

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	174,386	26,255	32,196	232,837		232,837	(18,024)	214,813		1
2	Food Purchase		246,907		246,907	(18,725)	228,183	(45)	228,138		2
3	Housekeeping	126,245	35,056		161,301		161,301	(547)	160,754		3
4	Laundry		10,558	6,739	17,297		17,297		17,297		4
5	Heat and Other Utilities			121,998	121,998		121,998	2,226	124,224		5
6	Maintenance	37,347	30,224	174,648	242,219		242,219	(58,164)	184,055		6
7	Other (specify):*							8,762	8,762		7
8	TOTAL General Services	337,978	349,000	335,581	1,022,559	(18,725)	1,003,835	(65,791)	938,043		8
	B. Health Care and Programs										
9	Medical Director			2,700	2,700		2,700		2,700		9
10	Nursing and Medical Records	913,855	11,036	121,792	1,046,683		1,046,683	(19,592)	1,027,091		10
10a	Therapy	6,358		17,580	23,938		23,938	(7,315)	16,623		10a
11	Activities	100,116	6,532		106,648		106,648		106,648		11
12	Social Services	294,409	6,653	6,600	307,662		307,662		307,662		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*							6,598	6,598		15
16	TOTAL Health Care and Programs	1,314,738	24,221	148,672	1,487,631		1,487,631	(20,309)	1,467,322		16
	C. General Administration										
17	Administrative	117,238		307,092	424,330		424,330	(63,134)	361,196		17
18	Directors Fees										18
19	Professional Services			164,884	164,884	(2,641)	162,243	(118,159)	44,084		19
20	Dues, Fees, Subscriptions & Promotions			27,912	27,912		27,912	(8,623)	19,289		20
21	Clerical & General Office Expenses	127,435	21,874	65,862	215,171		215,171	24,970	240,141		21
22	Employee Benefits & Payroll Taxes			281,897	281,897	18,725	300,622	(281)	300,341		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,952	4,952		4,952	497	5,449		24
25	Other Admin. Staff Transportation			2,983	2,983		2,983	2,912	5,895		25
26	Insurance-Prop.Liab.Malpractice			154,110	154,110		154,110	1,168	155,278		26
27	Other (specify):*							33,514	33,514		27
28	TOTAL General Administration	244,673	21,874	1,009,692	1,276,239	16,084	1,292,323	(127,136)	1,165,187		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,897,389	395,095	1,493,945	3,786,429	(2,641)	3,783,788	(213,237)	3,570,551		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

Wilson Care Inc.

#0029975

Report Period Beginning:

01/01/03

Ending:

12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			85,777	85,777		85,777	95,090	180,867			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							439,807	439,807			32
33	Real Estate Taxes			73,241	73,241	2,641	75,882	6,297	82,179			33
34	Rent-Facility & Grounds			614,280	614,280		614,280	(614,280)				34
35	Rent-Equipment & Vehicles			12,105	12,105		12,105	6,600	18,705			35
36	Other (specify):*							10,991	10,991			36
37	TOTAL Ownership			785,403	785,403	2,641	788,044	(55,495)	732,549			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			108,405	108,405		108,405		108,405			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			108,405	108,405		108,405		108,405			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,897,389	395,095	2,387,753	4,680,237		4,680,237	(268,731)	4,411,506			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care Inc.

0029975

Report Period Beginning: 01/01/03

Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF 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	(1,439)	06		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	6,307	30		9
10	Interest and Other Investment Income	(32,431)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(45)	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	(360)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(18,121)	21		24
25	Fund Raising, Advertising and Promotional	(6,202)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(64,452)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (116,742)		\$	30

OHF 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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(151,989)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (151,989)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (268,731)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Wilson Care Inc.

ID# 0029975

Report Period Beginning: 01/01/03
Ending: 12/31/03

Sch. V Line Reference

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Other Income	(17)	21
2	Theft & Damage	(10)	21
3	State Replacement Tax	(14,637)	21
4	Ill. Council Costs	(2,098)	28
5	Capitalize R&M	(8,727)	6
6	Contributions-Building Company	(250)	20
7	Over Year Legal	(9,711)	19
8	Nonallowable Legal	(1,406)	19
9			9
10			10
11			11
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99			99
100			100
101	Total	(64,457)	101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Wilson Care Inc.# 0029975 Report Period Beginning:01/01/03

Ending:

12/31/03

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					(18,024)							(18,024)	1
2	Food Purchase	(45)											(45)	2
3	Housekeeping			685				(1,232)					(547)	3
4	Laundry													4
5	Heat and Other Utilities			884	1,342								2,226	5
6	Maintenance	(37,166)		698	(11,430)	(10,266)							(58,164)	6
7	Other (specify):*				1,001	7,761							8,762	7
8	TOTAL General Services	(37,211)		2,267	(9,087)	(20,529)		(1,232)					(65,791)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records				(18,456)			(1,136)					(19,592)	10
10a	Therapy					(7,315)							(7,315)	10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*				4,414	2,184							6,598	15
16	TOTAL Health Care and Programs				(14,042)	(5,131)		(1,136)					(20,309)	16
	C. General Administration													
17	Administrative			16,982	(60,581)	(19,535)							(63,134)	17
18	Directors Fees													18
19	Professional Services	(11,118)		(100,459)	(15,802)	9,220							(118,159)	19
20	Fees, Subscriptions & Promotions	(9,150)	250	197	80								(8,623)	20
21	Clerical & General Office Expenses	(33,140)	39	56,093	1,978								24,970	21
22	Employee Benefits & Payroll Taxes						(281)						(281)	22
23	Inservice Training & Education													23
24	Travel and Seminar			165	332								497	24
25	Other Admin. Staff Transportation			771	2,141								2,912	25
26	Insurance-Prop.Liab.Malpractice			390	778								1,168	26
27	Other (specify):*			9,982	3,325	20,207							33,514	27
28	TOTAL General Administration	(53,408)	289	(15,879)	(67,749)	9,892	(281)						(127,136)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(90,619)	289	(13,612)	(90,878)	(15,768)	(281)	(2,368)					(213,237)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Wilson Care Inc.# 0029975 Report Period Beginning:01/01/03 Ending:12/31/03

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	6,307	83,266	2,462	3,055								95,090	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(32,431)	468,867	671	2,700								439,807	32
33	Real Estate Taxes			2,266	4,031								6,297	33
34	Rent-Facility & Grounds		(614,280)										(614,280)	34
35	Rent-Equipment & Vehicles			2,219	4,381								6,600	35
36	Other (specify):*		10,991										10,991	36
37	TOTAL Ownership	(26,124)	(51,156)	7,618	14,167								(55,495)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers													44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(116,742)	(50,867)	(5,994)	(76,711)	(15,768)	(281)	(2,368)					(268,731)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

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

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 Income	\$ 614,280	Wilson Care LLC		\$	\$ (614,280)
2	V						2
3	V	32 Interest Income	29	Wilson Care LLC			(29)
4	V						4
5	V	36 Amortization		Wilson Care LLC		10,991	10,991
6	V	30 Depreciation		Wilson Care LLC		83,266	83,266
7	V	32 Interest Expense		Wilson Care LLC		468,896	468,896
8	V	20 Contributions		Wilson Care LLC		250	250
9	V	21 Office Expense		Wilson Care LLC		39	39
10	V						10
11	V						11
12	V						12
13	V						13
14	Total		\$ 614,309			\$ 563,442	\$ * (50,867)

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care Inc.# 0029975Report Period Beginning: 01/01/03Ending: 12/31/03

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	3 HOUSEKEEPING	\$	PREFERRED BOOKKEEPING	100.00%	\$ 685	\$ 685
16	V	5 UTILITIES		PREFERRED BOOKKEEPING	100.00%	884	884
17	V	6 REPAIRS AND MAINT.		PREFERRED BOOKKEEPING	100.00%	698	698
18	V	17 ADMIN. FINANCIAL SAL.		PREFERRED BOOKKEEPING	100.00%	16,982	16,982
19	V	19 PROFESSIONAL FEES		PREFERRED BOOKKEEPING	100.00%	2,167	2,167
20	V	20 DUES,SUBSCRIPTIONS		PREFERRED BOOKKEEPING	100.00%	197	197
21	V	21 CLERICAL		PREFERRED BOOKKEEPING	100.00%	56,093	56,093
22	V	24 SEMINARS		PREFERRED BOOKKEEPING	100.00%	165	165
23	V	25 ADMIN. STAFF TRAVEL		PREFERRED BOOKKEEPING	100.00%	771	771
24	V	26 INSURANCE		PREFERRED BOOKKEEPING	100.00%	390	390
25	V	27 EMPLOYEE BENEFITS		PREFERRED BOOKKEEPING	100.00%	9,982	9,982
26	V	30 DEPRECIATION		PREFERRED BOOKKEEPING	100.00%	2,462	2,462
27	V	32 INTEREST		PREFERRED BOOKKEEPING	100.00%	671	671
28	V	33 REAL ESTATE TAXES		PREFERRED BOOKKEEPING	100.00%	2,266	2,266
29	V	35 EQUIPMENT RENTAL		PREFERRED BOOKKEEPING	100.00%	2,219	2,219
30	V						
31	V						
32	V	19 ACCOUNT./BOOKKEEPING	102,626	PREFERRED BOOKKEEPING	100.00%		(102,626)
33	V	19 COMPUTER	4,752	PREFERRED BOOKKEEPING	100.00%	4,752	
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 107,378			\$ 101,384	\$ * (5,994)

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/03 Ending: 12/31/03

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	5 UTILITIES	\$	S.I.R. MANAGEMENT, INC.	100.00%	\$ 1,342	\$ 1,342
16	V	6 REPAIRS AND MAINT.	17,820	S.I.R. MANAGEMENT, INC.	100.00%	6,390	(11,430)
17	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	1,001	1,001
18	V	10 NURSING	39,204	S.I.R. MANAGEMENT, INC.	100.00%	20,748	(18,456)
19	V	15 EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	4,414	4,414
20	V	17 ADMINISTRATIVE	69,492	S.I.R. MANAGEMENT, INC.	100.00%	8,911	(60,581)
21	V	19 PROFESSIONAL FEES	16,044	S.I.R. MANAGEMENT, INC.	100.00%	242	(15,802)
22	V	20 FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	80	80
23	V	21 CLERICAL & GENERAL	20,196	S.I.R. MANAGEMENT, INC.	100.00%	22,174	1,978
24	V	24 EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	332	332
25	V	25 OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	2,141	2,141
26	V	26 INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	778	778
27	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	3,325	3,325
28	V	30 DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	3,055	3,055
29	V	32 INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	2,700	2,700
30	V	33 REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	4,031	4,031
31	V	35 EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	4,381	4,381
32	V						
33	V	35 LEASED EQUIPMENT		S.I.R. MANAGEMENT, INC.	100.00%		
34	V	30 DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%		
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 162,756			\$ 86,045	\$ * (76,711)

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1	DIETARY SALARIES	\$ 20,196	S.I.R. MANAGEMENT, INC.	100.00%	\$ 6,544	\$ (13,652)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	1,392	1,392	16
17	V	17	ADMIN./LEGAL SALARIES	120,000	S.I.R. MANAGEMENT, INC.	100.00%	53,935	(66,065)	17
18	V	19	FINANCIAL CONSULTANT		S.I.R. MANAGEMENT, INC.	100.00%	13,972	13,972	18
19	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	8,114	8,114	19
20	V								20
21	V	17	ADMIN. SALARY		S.I.R. MANAGEMENT, INC.	100.00%	36,090	36,090	21
22	V	27	EMP. BEN.-ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	6,114	6,114	22
23	V								23
24	V	17	ADMIN SALARY		S.I.R. MANAGEMENT, INC.	100.00%	32,040	32,040	24
25	V	27	EMP. BEN.-ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	5,978	5,978	25
26	V								26
27	V	10A	SPECIAL REHAB	17,580	S.I.R. MANAGEMENT, INC.	100.00%	10,265	(7,315)	27
28	V	15	EMP. BEN.-HEALTH CARE & PROG.		S.I.R. MANAGEMENT, INC.	100.00%	2,184	2,184	28
29	V								29
30	V	6	REPAIRS AND MAINT.	32,544	S.I.R. MANAGEMENT, INC.	100.00%	22,278	(10,266)	30
31	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	4,739	4,739	31
32	V								32
33	V	1	DIETICIAN SALARIES	12,000	S.I.R. MANAGEMENT, INC.	100.00%	7,628	(4,372)	33
34	V	7	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	1,630	1,630	34
35	V								35
36	V	19	LEGAL FEES	4,752	S.I.R. MANAGEMENT, INC.	100.00%		(4,752)	36
37	V								37
38	V	17	COUNCIL DUES	21,600	S.I.R. MANAGEMENT, INC.	100.00%		(21,600)	38
39	Total		\$ 228,672				\$ 212,904	\$ * (15,768)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care Inc.

0029975

Report Period Beginning: 01/01/03

Ending: 12/31/03

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	22 EMPLOYEE HEALTH INSURANCE	\$	CCS EMPLOYEE BENEFIT GROUP	100.00%	\$ 66,552	\$ 66,552	15
16	V							16
17	V							17
18	V							18
19	V	22 EMPLOYEE HEALTH INSURANCE	66,833	CCS EMPLOYEE BENEFIT GROUP	100.00%		(66,833)	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		\$ 66,833			\$ 66,552	\$ * (281)	39

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

Facility Name & ID Number Wilson Care Inc.

0029975

Report Period Beginning: 01/01/03

Ending: 12/31/03

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	01 DIETARY	\$	XCEL MEDICAL SUPPLY, LLC	100.00%	\$	\$	15
16	V	02 FOOD		XCEL MEDICAL SUPPLY, LLC	100.00%			16
17	V	03 HOUSEKEEPING	9,358	XCEL MEDICAL SUPPLY, LLC	100.00%	8,126	(1,232)	17
18	V	04 LAUNDRY		XCEL MEDICAL SUPPLY, LLC	100.00%			18
19	V	06 REPAIRS & MAINTENANCE		XCEL MEDICAL SUPPLY, LLC	100.00%			19
20	V	10 NURSING	8,633	XCEL MEDICAL SUPPLY, LLC	100.00%	7,497	(1,136)	20
21	V	10A THERAPY		XCEL MEDICAL SUPPLY, LLC	100.00%			21
22	V	12 SOCIAL SERVICE		XCEL MEDICAL SUPPLY, LLC	100.00%			22
23	V	21 CLERICAL & GENERAL OFFICE		XCEL MEDICAL SUPPLY, LLC	100.00%			23
24	V	22 EMPLOYEE BENEFITS		XCEL MEDICAL SUPPLY, LLC	100.00%			24
25	V	39 ANCILLARY		XCEL MEDICAL SUPPLY, LLC	100.00%			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		\$ 17,991			\$ 15,623	\$ * (2,368)	39

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

Facility Name & ID Number Wilson Care Inc.

0029975

Report Period Beginning: 01/01/03

Ending: 12/31/03

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care Inc.

0029975

Report Period Beginning: 01/01/03

Ending: 12/31/03

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

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

Facility Name & ID Number Wilson Care Inc.

0029975

Report Period Beginning: 01/01/03

Ending: 12/31/03

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

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

Facility Name & ID Number Wilson Care Inc.

0029975

Report Period Beginning: 01/01/03

Ending: 12/31/03

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

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

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/03 Ending: 12/31/03

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	Adam Vales	Relative	Clerical		See Attached	0.34	0.85%	Alloc. Salary	\$ 266	22-7	1
2	Nenita Guzman	Relative	Dietary		See Attached	5.16	10.32%	Alloc. Salary	6,544	1-7	2
3	Howard Geller	Owner	Administrative	4.44%	See Attached	2.00	3.33%	Mgmt Fees	48,000	17-3	3
4	Eric Rothner	Owner	Administrative	20.00%	See Attached	0.57	1.04%	Alloc. Salary	14,880	17-7	4
5	Bryan Barrish	Owner	Administrative	4.86%	See Attached	6.35	15.88%	Alloc. Salary	36,090	17-7	5
6	Noah Wolff	Owner	Administrative	5.56%	See Attached	3.00	7.50%	Mgmt Fees	48,000	17-3	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 153,780		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/03 Ending: 12/31/03

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/03 Ending: 12/31/03

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

Name of Related Organization PREFERRED BOOKKEEPING SERVICES
 Street Address 4100 WEST PRATT AVE.
 City / State / Zip Code LINCOLNWOOD, IL. 60712
 Phone Number (847) 674-5200
 Fax Number (847) 674-5267

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

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	3	HOUSEKEEPING	BOOK./ACCNT.INCOME	935,658	11	\$ 6,250	\$ 102,626	\$ 685	1
2	5	UTILITIES	BOOK./ACCNT.INCOME	935,658	11	8,058	102,626	884	2
3	6	REPAIRS AND MAINT.	BOOK./ACCNT.INCOME	935,658	11	6,361	102,626	698	3
4	17	ADMIN. FINANCIAL SAL.	BOOK./ACCNT.INCOME	935,658	11	154,828	154,828	16,982	4
5	19	PROFESSIONAL FEES	BOOK./ACCNT.INCOME	935,658	11	19,761	102,626	2,167	5
6	20	DUES,SUBSCRIPTIONS	BOOK./ACCNT.INCOME	935,658	11	1,793	102,626	197	6
7	21	CLERICAL	BOOK./ACCNT.INCOME	935,658	11	511,408	453,848	56,093	7
8	24	SEMINARS	BOOK./ACCNT.INCOME	935,658	11	1,508	102,626	165	8
9	25	ADMIN. STAFF TRAVEL	BOOK./ACCNT.INCOME	935,658	11	7,028	102,626	771	9
10	26	INSURANCE	BOOK./ACCNT.INCOME	935,658	11	3,553	102,626	390	10
11	27	EMPLOYEE BENEFITS	BOOK./ACCNT.INCOME	935,658	11	91,005	102,626	9,982	11
12	30	DEPRECIATION	BOOK./ACCNT.INCOME	935,658	11	22,443	102,626	2,462	12
13	32	INTEREST	BOOK./ACCNT.INCOME	935,658	11	6,117	102,626	671	13
14	33	REAL ESTATE TAXES	BOOK./ACCNT.INCOME	935,658	11	20,656	102,626	2,266	14
15	35	EQUIPMENT RENTAL	BOOK./ACCNT.INCOME	935,658	11	20,229	102,626	2,219	15
16									16
17									17
18									18
19	19	COMPUTER	DIRECT ALLOCATION					4,752	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 880,998	\$ 608,675	\$ 101,384	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/03 Ending: 12/31/03

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

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

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

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	5 UTILITIES	PATIENT DAYS	641,706	10	\$ 13,016	\$	66,185	\$ 1,342	1
2	6 REPAIRS AND MAINT.	PATIENT DAYS	641,706	10	61,951	45,622	66,185	6,390	2
3	7 EMP. BEN.-GEN. SERV.	PATIENT DAYS	641,706	10	9,705		66,185	1,001	3
4	10 NURSING	PATIENT DAYS	641,706	10	201,162	201,162	66,185	20,748	4
5	15 EMP. BEN.-H.C.	PATIENT DAYS	641,706	10	42,801		66,185	4,414	5
6	17 ADMINISTRATIVE	PATIENT DAYS	641,706	10	86,401	86,401	66,185	8,911	6
7	19 PROFESSIONAL FEES	PATIENT DAYS	641,706	10	2,349		66,185	242	7
8	20 FEES,SUBSCRIPTIONS	PATIENT DAYS	641,706	10	773		66,185	80	8
9	21 CLERICAL & GENERAL	PATIENT DAYS	641,706	10	214,995	167,138	66,185	22,174	9
10	24 EDUCATION & SEMINAR	PATIENT DAYS	641,706	10	3,219		66,185	332	10
11	25 OTHER ADMIN. STAFF TRANS	PATIENT DAYS	641,706	10	20,755		66,185	2,141	11
12	26 INSURANCE	PATIENT DAYS	641,706	10	7,541		66,185	778	12
13	27 EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	641,706	10	32,233		66,185	3,325	13
14	30 DEPRECIATION	PATIENT DAYS	641,706	10	29,623		66,185	3,055	14
15	32 INTEREST	PATIENT DAYS	641,706	10	26,178		66,185	2,700	15
16	33 REAL ESTATE TAXES	PATIENT DAYS	641,706	10	39,087		66,185	4,031	16
17	35 EQUIPMENT RENTAL	PATIENT DAYS	641,706	10	42,473		66,185	4,381	17
18									18
19	35 LEASED EQUIPMENT	LEASING INCOME	24,090	1					19
20	30 DEPRECIATION	LEASING INCOME	24,090	1	91,098				20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 925,360	\$ 500,323	\$	\$ 86,045	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/03 Ending: 12/31/03

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

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

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

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	DIETARY SALARIES	PATIENT DAYS	641,706	10	\$ 63,448	\$ 63,448	66,185	\$ 6,544	1
2	EMP. BEN.-DIETARY	PATIENT DAYS	641,706	10	13,496		66,185	1,392	2
3	ADMIN./LEGAL SALARIES	PATIENT DAYS	641,706	10	522,936	522,936	66,185	53,935	3
4	FINANCIAL CONSULTANT	PATIENT DAYS	641,706	10	135,472		66,185	13,972	4
5	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	641,706	10	\$ 78,674	\$	66,185	\$ 8,114	5
6									6
7	17 ADMIN. SALARY	AVG HRS WKD	30	4	170,502	170,502	6	36,090	7
8	27 EMP. BEN.-ADMIN.	AVG HRS WKD	30	4	28,886		6	6,114	8
9					\$	\$		\$	9
10	17 ADMIN SALARY	AVG HRS WKD	30	4	151,372	151,372	6	32,040	10
11	27 EMP. BEN.-ADMIN.	AVG HRS WKD	30	4	28,244		6	5,978	11
12									12
13	10A SPECIAL REHAB	SPECIAL REHAB INC.	107,736	7	\$ 62,910	\$ 62,910	17,580	\$ 10,265	13
14	15 EMP. BEN.-HEALTH CARE & P	SPECIAL REHAB INC.	107,736	7	13,382		17,580	2,184	14
15									15
16	6 REPAIRS AND MAINT.	MAINTENANCE INC.	163,332	10	111,809	111,809	32,544	22,278	16
17	7 EMP. BEN.-GEN. SERV.	MAINTENANCE INC.	163,332	10	23,783		32,544	4,739	17
18									18
19	1 DIETICIAN SALARIES	DIETICIAN SERVICE INC.	125,400	10	79,717	79,717	12,000	7,628	19
20	7 EMP. BEN.-GEN. ADMIN.	DIETICIAN SERVICE INC.	125,400	10	17,031		12,000	1,630	20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,501,663	\$ 1,162,695		\$ 212,904	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/03 Ending: 12/31/03

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

Name of Related Organization CCS EMPLOYEE BENEFITS GROUP, INC.
 Street Address 4101 W. MAIN ST.
 City / State / Zip Code SKOKIE, IL 60076
 Phone Number (847)905-4000
 Fax Number (847)905-4040

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

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	22	EMPLOYEE HEALTH INSURANCE	DIRECT ALLOCATION		\$	\$		\$ 66,552	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				\$	\$		\$ 66,552	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/03 Ending: 12/31/03

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

Name of Related Organization XCEL MEDICAL SUPPLY, LLC
 Street Address 2201 MAIN STREET
 City / State / Zip Code EVANSTON, IL 60202
 Phone Number (847)328-7600
 Fax Number (847)328-7615

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	01	DIETARY	Direct Allocation		\$	\$		\$	1
2	02	FOOD	Direct Allocation						2
3	03	HOUSEKEEPING	Direct Allocation					8,126	3
4	04	LAUNDRY	Direct Allocation						4
5	06	REPAIRS & MAINTENANCE	Direct Allocation						5
6	10	NURSING	Direct Allocation					7,497	6
7	10A	THERAPY	Direct Allocation						7
8	12	SOCIAL SERVICE	Direct Allocation						8
9	21	CLERICAL & GENERAL OFFIC	Direct Allocation						9
10	22	EMPLOYEE BENEFITS	Direct Allocation						10
11	39	ANCILLARY	Direct Allocation						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				\$	\$		\$	15,623

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/03 Ending: 12/31/03

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/03 Ending: 12/31/03

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/03 Ending: 12/31/03

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/03 Ending: 12/31/03

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/03 Ending: 12/31/03

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	Nomura		X	Mortgage	\$48,561.00	03/01/95	\$ 5,817,265	\$ 5,266,585	02/21/08		\$ 468,896	1								
2												2								
3												3								
4												4								
5	See Supplemental Schedule											5								
	Working Capital																			
6	Allocate Preferred		X								671	6								
7	Allocate S.I.R.		X								2,700	7								
8	See Supplemental Schedule											8								
9	TOTAL Facility Related				\$48,561.00		\$ 5,817,265	\$ 5,266,585			\$ 472,267	9								
	B. Non-Facility Related*																			
10												10								
11	Interest Income		X								(32,431)	11								
12	Interest Income - Bldg Comp		X								(29)	12								
13	See Supplemental Schedule											13								
14	TOTAL Non-Facility Related						\$	\$			\$ (32,460)	14								
15	TOTALS (line 9+line14)						\$ 5,817,265	\$ 5,266,585			\$ 439,807	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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

	1	2	3	4	5	6		7	8	9	10									
						Name of Lender	Related**					Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES								NO	Original				Balance
	A. Directly Facility Related																			
	Long-Term																			
1						\$	\$			\$	1									
2											2									
3											3									
4											4									
5											5									
6											6									
7	TOTAL Long-Term										7									
	Working Capital																			
8						\$	\$			\$	8									
9											9									
10											10									
11											11									
12											12									
13											13									
14	TOTAL Working Capital										14									
	B. Non-Facility Related*																			
15						\$	\$			\$	15									
16											16									
17											17									
18											18									
19											19									
20	TOTAL Non-Facility Related										20									

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Wilson Care Inc.**# **0029975** Report Period Beginning: **01/01/03** Ending: **12/31/03****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 2002 report.			\$	73,800	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.)			\$	78,938	2
3.	Under or (over) accrual (line 2 minus line 1).			\$	5,138	3
4.	Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	74,400	4
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	2,641	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.			\$	82,179	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		1998	77,554	8	FOR OHF USE ONLY	
		1999	77,033	9		
		2000	70,014	10	13	FROM R. E. TAX STATEMENT FOR 2002 \$ 13
		2001	71,835	11	14	PLUS APPEAL COST FROM LINE 5 \$ 14
		2002	72,641	12	15	LESS REFUND FROM LINE 6 \$ 15
Accrual for 2003 \$72,641*1.024=74,400					16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
Allocation of R/E Tax SIR \$4,031						
Allocation of R/E Tax Preferred \$2,266						

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.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 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 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Wilson Care Inc. COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0029975

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2002 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 2002.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>14-17-220-009-0000</u>	<u>Long Term Care Property</u>	\$ <u>72,640.69</u>	\$ <u>72,640.69</u>
2. <u>See Attached</u>	<u>See Attached</u>	\$ <u>74,287.87</u>	\$ <u>5,532.73</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>146,928.56</u>	\$ <u>78,173.42</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 & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Wilson Care Inc. COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0029975

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Wilson Care Inc.# 0029975 Report Period Beginning:01/01/03 Ending:12/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 42,020 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 5C. 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, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONEF. 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			1985	\$ 13,300	1
2					2
3	TOTALS			\$ 13,300	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care Inc.

0029975

Report Period Beginning:

01/01/03

Ending:

12/31/03

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1985		65,366		20	3,441	3,441	62,491	9
10	Various		1986		161,365		20	8,493	8,493	149,117	10
11	Various		1987		49,380		20	2,598	2,598	43,384	11
12	Various		1989		49,210		20	2,461	(2,461)	35,829	12
13	Various		1990		105,470		20	5,274	5,274	69,009	13
14	Various		1991		29,903		20	1,494	1,494	18,778	14
15	Various		1992		69,669		20	3,484	3,484	40,260	15
16	Various		1993		61,688		20	3,087	3,087	32,364	16
17	Various		1994		55,691		20	2,917	2,917	27,513	17
18	Various		1995		87,144		20	4,360	4,360	37,053	18
19	Various		1996		303,393		20	15,172	15,172	112,834	19
20	Various		1997		145,411		20	7,348	7,348	42,406	20
21	Various		1998		34,959		20	1,748	1,748	9,700	21
22	Various		1999		64,557		20	3,229	3,229	14,587	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

*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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care Inc.

0029975

Report Period Beginning:

01/01/03

Ending:

12/31/03

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	2	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37				\$	\$		\$	\$	\$	37
38										38
39										39
40										40
41										41
42										42
43										43
44										44
45										45
46										46
47										47
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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 12-BLDG & 12A-BLDG)			1,539,800	83,266		43,994	(39,272)	1,520,712	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)			87,222	2,974		3,444	470	29,300	68
69	Financial Statement Depreciation				85,776			(85,776)		69
70	TOTAL (lines 4 thru 69)			\$ 2,910,228	\$ 172,016		\$ 112,544	\$ (64,394)	\$ 2,245,337	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Wilson Care Inc.

0029975

Report Period Beginning:

01/01/03

Ending:

12/31/03

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,910,228	\$ 172,016		\$ 112,544	\$ (59,472)	\$ 2,245,337	1
2	Painting	2000	15,000		20	750	750	2,688	2
3	Floor & Wall Tile	2000	13,197		20	660	660	2,255	3
4	Kitchen Tiles	2000	13,147		20	657	657	2,191	4
5	Pump	2000	5,677		20	284	284	923	5
6	Tile Work	2000	62,060		20	3,103	3,103	10,085	6
7	Dining Room	2000	24,287		20	1,214	1,214	3,947	7
8	Tile Work	2000	2,013		20	101	101	319	8
9	Painting	2000	15,000		20	750	750	2,625	9
10	Painting	2000	30,000		20	1,500	1,500	5,125	10
11	Painting	2000	30,000		20	1,500	1,500	4,875	11
12	Fire Doors	2000	35,264		20	1,763	1,763	6,464	12
13	Room Divider	2000	20,600		20	1,030	1,030	3,262	13
14	Window Treatment	2000	1,046		20	52	52	200	14
15	Window Treatment	2000	1,044		20	52	52	182	15
16	Kitchen Remodel	2000			20				16
17	Electric Work	2000	2,585		20	129	129	453	17
18	Stowell Remodel	2000	1,798		20	90	90	308	18
19	Painting	2000	5,900		20	295	295	910	19
20	Painting	2000	24,447		20	1,222	1,222	3,769	20
21	Tile Work	2000	8,474		20	424	424	1,306	21
22	Kitchen Remodel	2000	6,623		20	331	331	993	22
23	Radiator	2000	1,055		20	53	53	159	23
24	Mixing Valve	2000	1,138		20	57	57	171	24
25	Concrete	2000	1,500		20	75	75	225	25
26	Borders	2000	542		20	27	27	81	26
27	Carpet	2000	633		20	32	32	95	27
28	Interior Supply	2000	1,582		20	79	79	237	28
29	Dining A/C	2000	1,239		20	62	62	186	29
30	Concrete	2000	1,000		20	50	50	150	30
31	Water Heater	2000	5,120		20	256	256	768	31
32	Lights Fixture	2000	7,807		20	390	390	1,171	32
33	Tuckpointing	2000	2,440		20	122	122	366	33
34	TOTAL (lines 1 thru 33)		\$ 3,252,446	\$ 172,016		\$ 129,654	\$ (42,362)	\$ 2,301,826	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Wilson Care Inc.

0029975

Report Period Beginning:

01/01/03

Ending:

12/31/03

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,252,446	\$ 172,016		\$ 129,654	\$ (42,362)	\$ 2,301,826	1
2	Flooring	2001	24,235		20	1,212	1,212	3,636	2
3	Window Treatment	2001	6,946		20	347	347	1,042	3
4	Doors	2001	6,905		20	345	345	1,036	4
5	Elevator Work	2001	5,690		20	285	285	735	5
6	Security System	2001	8,340		20	417	417	1,043	6
7	Hvac System	2001	5,175		20	259	259	626	7
8	Hvac Work	2001	11,902		20	595	595	1,240	8
9	Paint	2001	718		20	36	36	108	9
10	Booster Heater	2001	1,523		20	76	76	165	10
11	Fire Door	2001	1,221		20	61	61	168	11
12	Doors	2001	1,851		20	93	93	247	12
13	Blinds	2001	1,187		20	59	59	158	13
14	Aquastat	2001	1,064		20	53	53	146	14
15	Fire Door	2001	1,227		20	61	61	154	15
16	Blinds	2001	1,194		20	60	60	149	16
17	Fire Door	2001	1,495		20	75	75	188	17
18	Blinds	2001	1,194		20	60	60	139	18
19	Camera	2001	951		20	48	48	107	19
20	Window Treatment	2001	6,946		20	347	347	1,042	20
21	Bathub Liner	2001	3,186		20	159	159	346	21
22	Refinish Tub	2001	2,610		20	131	131	294	22
23	Hot Water Heater	2001	1,789		20	89	89	268	23
24	Water Heater	2001	1,276		20	64	64	176	24
25	Lighting	2001	2,060		20	103	103	249	25
26	Plumbing Repair	2001	1,948		20	97	97	211	26
27	Recep.Furniture	2002	3,851		20	770	770	1,412	27
28	Plumbing	2002	24,086		20	2,409	2,409	3,211	28
29	Module & Cable	2002	9,897		20	1,979	1,979	2,474	29
30	Plumbing Repair	2002	1,076		20	108	108	215	30
31	Freezer Motor	2002	1,151		20	230	230	441	31
32	Repair Walk In Freezer	2002	1,007		20	201	201	386	32
33	Strainer Basket On Sinks	2002	1,150		20	115	115	211	33
34	TOTAL (lines 1 thru 33)		\$ 3,397,297	\$ 172,016		\$ 140,598	\$ (31,418)	\$ 2,323,849	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Wilson Care Inc.

0029975

Report Period Beginning:

01/01/03

Ending:

12/31/03

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 3,397,297	\$ 172,016		\$ 140,598	\$ (31,418)	\$ 2,323,849	1
2	Wall Repair	2002	2,950		20	295	295	516	2
3	Hot Water Heater	2002	1,120		20	112	112	196	3
4	Wall Repair	2002	440		20	44	44	73	4
5	Blinds	2002	1,194		20	119	119	179	5
6	Install Tile	2002	992		20	99	99	141	6
7	Bathtub Liner	2002	716		20	72	72	119	7
8	Door	2002	1,608		20	161	161	228	8
9	Window Treatments	2002	2,493		20	249	249	353	9
10	Paint	2002	814		20	543	543	814	10
11	Paint	2002	949		20	633	633	949	11
12	Heater	2002	1,698		20	170	170	226	12
13	Dry Wall	2002	3,000		20	300	300	400	13
14	Bathtub Liner	2002	631		20	63	63	79	14
15	Curtain	2002	489		20	49	49	61	15
16	Boiler	2002	2,004		20	200	200	251	16
17	Paint	2002	512		20	384	384	512	17
18	Bathtub Liner	2002	1,848		20	185	185	231	18
19	Wall Cover	2002	5,031		20	2,935	2,935	5,031	19
20	Dry Wall	2002	4,000		20	400	400	500	20
21	Elevator Door Lock	2003	2,341		20	176	176	176	21
22	Roofing Work	2003	2,475		20	52	52	52	22
23	Plumbing	2003	13,800		20	288	288	288	23
24	Sewer Pipe Work	2003	4,300		20	72	72	72	24
25	Sewer Pipe Work	2003	3,000		20	50	50	50	25
26	Steam Pipes	2003	4,279		20	214	214	214	26
27	Fire Alarm Wiring	2003	2,935		20	122	122	122	27
28	Elevator Work	2003	2,020		20	76	76	76	28
29	Elevator Work	2003	3,239		20	121	121	121	29
30	Elevator Work	2003	3,547		20	44	44	44	30
31	Fire Proof Door	2003	17,075		20	427	427	427	31
32	New Windows	2003	3,300		20	14	14	14	32
33	Handrails	2003	3,906		20	33	33	33	33
34	TOTAL (lines 1 thru 33)		\$ 3,496,003	\$ 172,016		\$ 149,300	\$ (22,716)	\$ 2,336,397	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12D, Carried Forward	\$ 3,496,003	\$ 172,016		\$ 149,300	\$ (22,716)	\$ 2,336,397		1
2	Elevator Work	2003 3,429		20	14	14	14		2
3	Elevator Work	2003 3,547		20	15	15	15		3
4	Upgrade Kitchen System	2003 1,785		20	89	89	89		4
5	Sprinkler System	2003 5,130		20	257	257	257		5
6	Cubicle Curtains	2003 2,123		20	106	106	106		6
7	Exit Devices	2003 1,470		20	74	74	74		7
8	Doors	2003 921		20	46	46	46		8
9	Blinds	2003 1,305		20	65	65	65		9
10	Bathub Liner	2003 1,250		20	63	63	63		10
11	Electrical Work	2003 1,673		20	84	84	84		11
12	Bath Tub Wall Panel	2003 1,013		20	51	51	51		12
13	10 Windows	2003 1,317		20	71	71	71		13
14	Repair Dining Room A/C	2003 1,207		20	60	60	60		14
15	Wall Tiles	2003 2,875		20	144	144	144		15
16	A/C Window Supports	2003 2,349		20	117	117	117		16
17	Emt Installation	2003 1,458		20	73	73	73		17
18	Stair Risers	2003 329		20	16	16	16		18
19	Courtyard Fence Work	2003 2,772		20	139	139	139		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)	\$ 3,532,055	\$ 172,016		\$ 150,783	\$ (21,233)	\$ 2,337,880		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12E, Carried Forward	\$ 3,532,055	\$ 172,016		\$ 150,783	\$ (21,233)	\$ 2,337,880		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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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)	\$ 3,532,055	\$ 172,016		\$ 150,783	\$ (21,233)	\$ 2,337,880		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12F, Carried Forward	\$ 3,532,055	\$ 172,016		\$ 150,783	\$ (21,233)	\$ 2,337,880		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
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18									18
19									19
20									20
21									21
22									22
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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)	\$ 3,532,055	\$ 172,016		\$ 150,783	\$ (21,233)	\$ 2,337,880		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12G, Carried Forward	\$ 3,532,055	\$ 172,016		\$ 150,783	\$ (21,233)	\$ 2,337,880		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
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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)	\$ 3,532,055	\$ 172,016		\$ 150,783	\$ (21,233)	\$ 2,337,880		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12H, Carried Forward	\$ 3,532,055	\$ 172,016		\$ 150,783	\$ (21,233)	\$ 2,337,880		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
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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)	\$ 3,532,055	\$ 172,016		\$ 150,783	\$ (21,233)	\$ 2,337,880		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12I, Carried Forward	\$ 3,532,055	\$ 172,016		\$ 150,783	\$ (21,233)	\$ 2,337,880		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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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)	\$ 3,532,055	\$ 172,016		\$ 150,783	\$ (21,233)	\$ 2,337,880		34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 3,532,055	\$ 172,016		\$ 150,783	\$ (21,233)	\$ 2,337,880	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)		\$ 3,532,055	\$ 172,016		\$ 150,783	\$ (21,233)	\$ 2,337,880	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Wilson Care Inc.

0029975

Report Period Beginning:

01/01/03

Ending:

12/31/03

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	198		1985		\$ 1,539,800	\$ 83,266		\$ 43,994	\$ (39,272)	\$ 1,520,712	4
5											5
6											6
7											7
8											8
	Improvement Type**										
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											34
35											35
36											36

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

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

See Page 12A-BLDG, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37			\$	\$		\$	\$	\$		37
38										38
39										39
40										40
41										41
42										42
43										43
44										44
45										45
46										46
47										47
48										48
49										49
50										50
51										51
52										52
53										53
54										54
55										55
56										56
57										57
58										58
59										59
60										60
61										61
62										62
63										63
64										64
65										65
66										66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 1,539,800	\$ 83,266		\$ 43,994	\$ (39,272)	\$ 1,520,712		70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Wilson Care Inc.

0029975

Report Period Beginning:

01/01/03

Ending:

12/31/03

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	Alloc. SIR	1993		\$ 27,560	\$ 875	35	\$ 787	\$ (88)	\$ 8,268
5	Alloc. SIR	1993		15,488	492	35	443	(49)	4,646
6									
7									
8									
Improvement Type**									
9	Preferred Bookkeeping - Allocation	1997		19,342	433	20	967	534	6,585
10	Preferred Bookkeeping - Allocation	1999		153	-	20	8	8	35
11	Preferred Bookkeeping - Allocation	2000		970	-	20	48	48	166
12									
13	S.I.R. Properties - S.I.R. Management - Allocation	2002		109	-	20	5	5	8
14	S.I.R. Properties - S.I.R. Management - Allocation	1999		3,492	349	20	175	(174)	786
15	S.I.R. Properties - S.I.R. Management - Allocation	1998		1,669	167	20	83	(84)	459
16	S.I.R. Properties - S.I.R. Management - Allocation	1997		104	10	20	5	(5)	39
17	S.I.R. Properties - S.I.R. Management - Allocation	1994		262	7	20	13	6	125
18	S.I.R. Properties - S.I.R. Management - Allocation	1993		447	7	20	22	15	235
19									
20	S.I.R. Properties - Preferred Bookkeeping - Allocation	2002		61	-	20	3	3	5
21	S.I.R. Properties - Preferred Bookkeeping - Allocation	1999		1,963	196	20	98	(98)	442
22	S.I.R. Properties - Preferred Bookkeeping - Allocation	1998		938	94	20	47	(47)	258
23	S.I.R. Properties - Preferred Bookkeeping - Allocation	1997		58	6	20	3	(3)	22
24	S.I.R. Properties - Preferred Bookkeeping - Allocation	1994		148	4	20	7	3	70
25	S.I.R. Properties - Preferred Bookkeeping - Allocation	1993		251	4	20	13	9	132
26									
27	S.I.R. Management - Allocation	1993		11,837	330	20	596	266	6,456
28	S.I.R. Management - Allocation	1994		37	-	20	4	4	35
29	S.I.R. Management - Allocation	1995		271	-	20	14	14	114
30	S.I.R. Management - Allocation	1999		1,286	-	20	64	64	271
31	S.I.R. Management - Allocation	2000		776	-	20	39	39	143
32									
33									
34									
35									
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-REP, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37			\$	\$		\$	\$	\$		37
38										38
39										39
40										40
41										41
42										42
43										43
44										44
45										45
46										46
47										47
48										48
49										49
50										50
51										51
52										52
53										53
54										54
55										55
56										56
57										57
58										58
59										59
60										60
61										61
62										62
63										63
64										64
65										65
66										66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 87,222	\$ 2,974		\$ 3,444	\$ 470	\$ 29,300		70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 430,212	\$ 2,056	\$ 28,858	\$ 26,802	10	\$ 305,522	71
72	Current Year Purchases	20,377	488	1,226	738	10	1,226	72
73	Fully Depreciated Assets	423,948				10	423,947	73
74								74
75	TOTALS	\$ 874,537	\$ 2,544	\$ 30,084	\$ 27,540		\$ 730,695	75

D. Vehicle Depreciation (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										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,419,892	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 174,560	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 180,867	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 6,307	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,068,575	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Date of Lease	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

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.	<u>/2004</u>	\$ _____
13.	<u>/2005</u>	\$ _____
14.	<u>/2006</u>	\$ _____

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: \$ 14,033 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Facility</u>	<u>1999 Dodge</u>	\$ <u>422.24</u>	\$ <u>4,672</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>422.24</u>	\$ <u>4,672</u>	21

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF AIDES TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost						
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist	N/A	hrs	\$		\$	\$			\$				1
2	Licensed Speech and Language Development Therapist		hrs											2
3	Licensed Recreational Therapist		hrs											3
4	Licensed Physical Therapist		hrs											4
5	Physician Care		visits											5
6	Dental Care		visits											6
7	Work Related Program		hrs											7
8	Habilitation		hrs											8
9	Pharmacy		# of prescrpts											9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs											10
11	Academic Education		hrs											11
12	Exceptional Care Program													12
13	Other (specify): See Supplemental													13
14	TOTAL			\$		\$	\$			\$		\$		14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Wilson Care Inc.

0029975

Report Period Beginning: 01/01/03

Ending:

12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/03

(last day of reporting year)

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

	1	2	
	Operating	After Consolidation*	
A. Current Assets			
1 Cash on Hand and in Banks	\$ 30,244	\$ 33,026	1
2 Cash-Patient Deposits	17,227	17,227	2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance)	793,307	793,307	3
4 Supply Inventory (priced at)			4
5 Short-Term Investments			5
6 Prepaid Insurance	17,834	17,834	6
7 Other Prepaid Expenses	6,293	6,293	7
8 Accounts Receivable (owners or related parties)	850,000	850,000	8
9 Other(specify): See Attached Schedule	23,392	23,392	9
10 TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,738,297	\$ 1,741,079	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		1,571,291	14
15 Leasehold Improvements, at Historical Cost	1,196,701	1,196,701	15
16 Equipment, at Historical Cost	1,118,517	1,148,517	16
17 Accumulated Depreciation (book methods)	(1,471,476)	(3,022,188)	17
18 Deferred Charges			18
19 Organization & Pre-Operating Costs			19
20 Accumulated Amortization - Organization & Pre-Operating Costs			20
21 Restricted Funds			21
22 Other Long-Term Assets (specify):			22
23 Other(specify): See Attached Schedule	4,125	49,459	23
24 TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 847,867	\$ 968,980	24
25 TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,586,164	\$ 2,710,059	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26 Accounts Payable	\$ 93,108	\$ 93,108	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits	21,578	21,578	28
29 Short-Term Notes Payable			29
30 Accrued Salaries Payable	160,762	160,762	30
31 Accrued Taxes Payable (excluding real estate taxes)	10,652	10,652	31
32 Accrued Real Estate Taxes(Sch.IX-B)	74,400	74,400	32
33 Accrued Interest Payable		26,697	33
34 Deferred Compensation			34
35 Federal and State Income Taxes	23,500	23,500	35
Other Current Liabilities(specify):			
36 See Attached Schedule	28,056	28,056	36
37			37
38 TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 412,056	\$ 438,753	38
D. Long-Term Liabilities			
39 Long-Term Notes Payable			39
40 Mortgage Payable		5,266,585	40
41 Bonds Payable			41
42 Deferred Compensation			42
Other Long-Term Liabilities(specify):			
43 See Attached Schedule			43
44			44
45 TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 5,266,585	45
46 TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 412,056	\$ 5,705,338	46
47 TOTAL EQUITY(page 18, line 24)	\$ 2,174,108	\$ (2,995,279)	47
48 TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,586,164	\$ 2,710,059	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,193,806	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,193,806	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	979,302	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	(999,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (19,698)	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)	\$ 2,174,108	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care Inc.

0029975

Report Period Beginning: 01/01/03

Ending: 12/31/03

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	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,625,891	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,625,891	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	Nurses Aide 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***	32,431	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 32,431	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	1,217	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,217	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,659,539	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,022,559	31
32	Health Care	1,487,631	32
33	General Administration	1,276,239	33
B. Capital Expense			
34	Ownership	785,403	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	108,405	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,680,237	40
41	Income before Income Taxes (line 30 minus line 40)**	979,302	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 979,302	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Wilson Care Inc.

0029975

Report Period Beginning: 01/01/03

Ending:

12/31/03

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	1,891	2,086	\$ 66,721	\$ 31.99	1
2	Assistant Director of Nursing	1,821	2,086	52,604	25.22	2
3	Registered Nurses	1,025	1,069	23,744	22.21	3
4	Licensed Practical Nurses	10,290	11,078	225,911	20.39	4
5	Nurse Aides & Orderlies	51,885	55,821	497,040	8.90	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	664	714	6,358	8.90	8
9	Activity Director	1,885	2,054	28,825	14.03	9
10	Activity Assistants	7,200	7,722	60,364	7.82	10
11	Social Service Workers	18,907	20,803	294,409	14.15	11
12	Dietician					12
13	Food Service Supervisor	1,897	2,206	36,966	16.76	13
14	Head Cook	3,635	3,942	32,328	8.20	14
15	Cook Helpers/Assistants	13,919	14,842	105,092	7.08	15
16	Dishwashers					16
17	Maintenance Workers	3,248	3,416	37,347	10.93	17
18	Housekeepers	16,657	17,506	126,245	7.21	18
19	Laundry					19
20	Administrator	1,784	2,080	81,199	39.04	20
21	Assistant Administrator	1,880	2,056	36,039	17.53	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,958	12,019	127,435	10.60	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	2,273	2,407	47,835	19.87	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	4,248	4,248	10,927	2.57	33
34	TOTAL (lines 1 - 33)	156,067	168,155	\$ 1,897,389 *	\$ 11.28	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly	\$ 12,000	01-03	35
36	Medical Director	Monthly	2,700	09-03	36
37	Medical Records Consultant	96	4,128	10-03	37
38	Nurse Consultant	1,079	39,204	10-03	38
39	Pharmacist Consultant	30	2,033	10-03	39
40	Physical Therapy Consultant	55	17,580	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	6,600	12-03	45
46	Other(specify)				46
47	Director of Food Services	SIR Mgmt	20,196	01-03	47
48					48
49	TOTAL (lines 35 - 48)	1,260	\$ 104,441		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	2,071	\$ 76,427	10-03	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	2,071	\$ 76,427		53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Charlene Hill-Jeon	Administrator	0	\$ 81,199	Workers' Compensation Insurance	\$ 21,671	IDPH License Fee	\$ 8,343	
Ralei Evans	Asst. Admin.	0	36,039	Unemployment Compensation Insurance	11,444	Advertising: Employee Recruitment	8,343	
				FICA Taxes	142,894	Health Care Worker Background Check	252	
				Employee Health Insurance	40,495	(Indicate # of checks performed <u>21</u>)		
				Employee Meals	18,725	IL Council Due	7,459	
				Illinois Municipal Retirement Fund (IMRF)*		Permits	962	
				Chicago Head Tax	4,434	Licenses	1,252	
				Union Health & Welfare	49,953	City Sales Tax	744	
				401K Plan	6,600	Allocate Preferred	197	
				Other Employee Benefits	4,125	See Supplemental Schedule	80	
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
\$ 117,238				\$ 300,341		\$ 19,289		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description	Amount			Description	Line #	Amount	Description	Amount
S.I.R. Management - Dir. Of Admin Services	\$ 24,948						Out-of-State Travel	\$
S.I.R. Management -Ancillary Admin. Charges	44,544							
S.I.R. Management - Council Dues	21,600						In-State Travel	
See Supplemental Schedule	216,000							
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)							Seminar Expense	4,952
\$ 307,092							Allocate Preferred	165
							Allocate S.I.R.	332
C. Professional Services				TOTAL			Entertainment Expense ()	
Vendor/Payee	Type	Amount					(agree to Sch. V, line 24, col. 8)	
Accounting	FR&R	\$ 12,527		\$			\$ 5,449	
ICS Solutions	Website	1,200						
LTC Solutions	Computer Service	1,320						
Property Valuation Services	Real Estate Appraisal Fee	2,500						
Personnel Planners	Unemployment Consultant	1,392						
Preferred Bookkeeping	Accounting	40,850						
Preferred Bookkeeping	Bookkeeping	61,776						
SIR Management	Legal	4,752						
Preferred Bookkeeping	Computer Service	4,752						
Meyer Magence	Legal	200						
Akin, Gump, Strauss, Hauer & F	Legal	735						
See Supplemental Schedule		32,880						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)								
\$ 164,884								

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5										
				6										
1	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year									
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	
2														
3														
4														
5														
6														
7														
8														
9														
10														
11														
12														
13														
14														
15														
16														
17														
18														
19														
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care Inc.# 0029975Report Period Beginning: 01/01/03Ending: 12/31/03**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IL Council - \$10,157
- (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? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 8,935 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (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.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 108,405
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 of Public Aid, 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. \$ 18,725 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. \$ _____
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? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT