

Facility Name & ID Number Wilson Care Inc.

0029975 Report Period Beginning: 01/01/04 Ending: 12/31/04

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	72,468	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	198	TOTALS	198	72,468	7

B. Census-For the entire report period.

	1 Level of Care	3 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		2 Public Aid Recipient	Private Pay	4 Other		
8	SNF					8
9	SNF/PED					9
10	ICF	64,780	1,168		65,948	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	64,780	1,168		65,948	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.00%

D. How many bed-hold days during this year were paid by Public Aid? 642 (Do not include bed-hold days in Section B.)

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 09/01/98

J. Was the facility purchased or leased after January 1, 1978?
YES Date 08/31/85 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: 12/31/04 Fiscal Year: 12/31/04

* 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: 01/01/04 Ending: 12/31/04

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	191,237	28,287	32,196	251,720		251,720	(18,652)	233,068		1
2	Food Purchase		247,772		247,772	(18,941)	228,832	(44)	228,788		2
3	Housekeeping	142,489	38,715		181,204		181,204	653	181,857		3
4	Laundry		14,752	6,121	20,873		20,873		20,873		4
5	Heat and Other Utilities			119,464	119,464		119,464	2,207	121,671		5
6	Maintenance	43,141	23,580	160,842	227,563		227,563	(52,342)	175,221		6
7	Other (specify):*							8,875	8,875		7
8	TOTAL General Services	376,867	353,106	318,623	1,048,596	(18,941)	1,029,656	(59,303)	970,352		8
B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600		3,600		9
10	Nursing and Medical Records	916,737	12,953	145,853	1,075,543		1,075,543	(23,709)	1,051,834		10
10a	Therapy			17,580	17,580		17,580	(7,197)	10,383		10a
11	Activities	96,528	6,606		103,134		103,134		103,134		11
12	Social Services	282,105	7,952	5,400	295,457		295,457		295,457		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*							5,451	5,451		15
16	TOTAL Health Care and Programs	1,295,370	27,511	172,433	1,495,314		1,495,314	(25,455)	1,469,859		16
C. General Administration											
17	Administrative	91,485		307,217	398,702		398,702	(75,605)	323,097		17
18	Directors Fees										18
19	Professional Services			150,414	150,414	(8,098)	142,316	(105,814)	36,502		19
20	Dues, Fees, Subscriptions & Promotions			19,263	19,263		19,263	(5,302)	13,961		20
21	Clerical & General Office Expenses	141,661	26,782	166,104	334,547		334,547	(83,144)	251,403		21
22	Employee Benefits & Payroll Taxes			287,112	287,112	18,941	306,053	(297)	305,756		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,520	3,520		3,520	459	3,979		24
25	Other Admin. Staff Transportation			4,377	4,377		4,377	2,633	7,010		25
26	Insurance-Prop.Liab.Malpractice			152,855	152,855		152,855	1,367	154,222		26
27	Other (specify):*							34,294	34,294		27
28	TOTAL General Administration	233,146	26,782	1,090,862	1,350,790	10,843	1,361,633	(231,409)	1,130,224		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,905,383	407,399	1,581,918	3,894,700	(8,098)	3,886,602	(316,167)	3,570,435		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:

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Ending:

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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			83,925	83,925		83,925	73,298	157,223			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							414,559	414,559			32
33	Real Estate Taxes			61,851	61,851	8,098	69,949	6,110	76,059			33
34	Rent-Facility & Grounds			614,280	614,280		614,280	(614,280)				34
35	Rent-Equipment & Vehicles			12,411	12,411		12,411	8,590	21,001			35
36	Other (specify):*							10,991	10,991			36
37	TOTAL Ownership			772,467	772,467	8,098	780,565	(100,733)	679,832			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			108,702	108,702		108,702		108,702			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			108,702	108,702		108,702		108,702			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,905,383	407,399	2,463,087	4,775,869		4,775,869	(416,899)	4,358,970			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.

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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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	19,269	30		9
10	Interest and Other Investment Income	(46,126)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(44)	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	(1,300)	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	(118,327)	21		24
25	Fund Raising, Advertising and Promotional	(2,304)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(14,179)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(36,953)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (199,964)		\$	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)	(216,935)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (216,935)		36
37	TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)	\$ (416,899)		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
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 Ending: 12/31/04

Sch. V Line

NON-ALLOWABLE EXPENSES	Amount	Sch. V Line
1 Misc. Income - Jury Duty	10	1
2 Il. Council on LTC - COPE	(3,604)	2
3 Misc. Income - Telephone	(7)	3
4 Capitalized RRM	(28,775)	4
5 Non-Allowable Legal	(3,270)	5
6 Cable TV	(1,745)	6
7		7
8		8
9		9
10		10
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94		94
95		95
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97		97
98		98
99		99
100		100
101 Total	(36,953)	101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Wilson Care Inc.# 0029975 Report Period Beginning:01/01/04

Ending:

12/31/04

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					(13,961)	(4,691)						(18,652)	1
2	Food Purchase	(44)											(44)	2
3	Housekeeping			653									653	3
4	Laundry													4
5	Heat and Other Utilities	(7)		856	1,358								2,207	5
6	Maintenance	(30,520)		623	(11,641)	305	(8,417)		(2,692)				(52,342)	6
7	Other (specify):*				921	1,307	6,647						8,875	7
8	TOTAL General Services	(30,571)		2,132	(9,362)	(12,349)	(6,461)		(2,692)				(59,303)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(52)			(21,912)				(1,745)				(23,709)	10
10a	Therapy						(7,197)						(7,197)	10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*				3,275		2,176						5,451	15
16	TOTAL Health Care and Programs	(52)			(18,637)		(5,021)		(1,745)				(25,455)	16
	C. General Administration													
17	Administrative			16,779	(60,238)	(10,546)	(21,600)						(75,605)	17
18	Directors Fees													18
19	Professional Services	(2,970)		(100,420)	315	13,305	(16,044)						(105,814)	19
20	Fees, Subscriptions & Promotions	(5,708)		206	200								(5,302)	20
21	Clerical & General Office Expenses	(133,806)	121	57,885	(7,758)	414							(83,144)	21
22	Employee Benefits & Payroll Taxes							(297)					(297)	22
23	Inservice Training & Education													23
24	Travel and Seminar			164	295								459	24
25	Other Admin. Staff Transportation			564	2,069								2,633	25
26	Insurance-Prop.Liab.Malpractice			409	654	304							1,367	26
27	Other (specify):*			9,918	3,860	20,516							34,294	27
28	TOTAL General Administration	(142,484)	121	(14,495)	(60,603)	23,993	(37,644)	(297)					(231,409)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(173,107)	121	(12,363)	(88,602)	11,644	(49,126)	(297)	(4,437)				(316,167)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Wilson Care Inc.# 0029975 Report Period Beginning:01/01/04 Ending:12/31/04

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	19,269	49,398	2,021	2,610								73,298	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(46,126)	459,446	366	873								414,559	32
33	Real Estate Taxes			2,203	3,907								6,110	33
34	Rent-Facility & Grounds		(614,280)										(614,280)	34
35	Rent-Equipment & Vehicles			2,124	1,593	4,873							8,590	35
36	Other (specify):*		10,991										10,991	36
37	TOTAL Ownership	(26,857)	(94,445)	6,714	8,983	4,873							(100,733)	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)	(199,964)	(94,324)	(5,649)	(79,619)	16,517	(49,126)	(297)	(4,437)				(416,899)	45

Facility Name & ID Number Wilson Care Inc.

0029975

Report Period Beginning:

01/01/04

Ending:

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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	100.00%	\$	\$ (614,280) 1
2	V	36 Amortization		Wilson Care LLC	100.00%	10,991	10,991 2
3	V	30 Depreciation		Wilson Care LLC	100.00%	49,398	49,398 3
4	V	32 Interest Expense		Wilson Care LLC	100.00%	459,811	459,811 4
5	V	21 Office Expense		Wilson Care LLC	100.00%	121	121 5
6	V	32 Interest Income	365	Wilson Care LLC	100.00%		(365) 6
7	V						7
8	V						8
9	V						9
10	V						10
11	V						11
12	V						12
13	V						13
14	Total		\$ 614,645			\$ 520,321	\$ * (94,324) 14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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%	\$ 653	\$ 653
16	V	5 UTILITIES		PREFERRED BOOKKEEPING	100.00%	856	856
17	V	6 REPAIRS AND MAINT.		PREFERRED BOOKKEEPING	100.00%	623	623
18	V	17 ADMIN. FINANCIAL SAL.		PREFERRED BOOKKEEPING	100.00%	16,779	16,779
19	V	19 PROFESSIONAL FEES		PREFERRED BOOKKEEPING	100.00%	1,356	1,356
20	V	20 DUES,SUBSCRIPTIONS		PREFERRED BOOKKEEPING	100.00%	206	206
21	V	21 CLERICAL		PREFERRED BOOKKEEPING	100.00%	57,885	57,885
22	V	24 SEMINARS		PREFERRED BOOKKEEPING	100.00%	164	164
23	V	25 ADMIN. STAFF TRAVEL		PREFERRED BOOKKEEPING	100.00%	564	564
24	V	26 INSURANCE		PREFERRED BOOKKEEPING	100.00%	409	409
25	V	27 EMPLOYEE BENEFITS		PREFERRED BOOKKEEPING	100.00%	9,918	9,918
26	V	30 DEPRECIATION		PREFERRED BOOKKEEPING	100.00%	2,021	2,021
27	V	32 INTEREST		PREFERRED BOOKKEEPING	100.00%	366	366
28	V	33 REAL ESTATE TAXES		PREFERRED BOOKKEEPING	100.00%	2,203	2,203
29	V	35 EQUIPMENT RENTAL		PREFERRED BOOKKEEPING	100.00%	2,124	2,124
30	V						
31	V						
32	V	19 ACCOUNT./BOOKKEEPING	101,776	PREFERRED BOOKKEEPING	100.00%		(101,776)
33	V	19 COMPUTER	4,752	PREFERRED BOOKKEEPING	100.00%	4,752	
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 106,528			\$ 100,879	\$ * (5,649)

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

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/04 Ending: 12/31/04

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%	\$ 1,358	\$ 1,358
16	V	6 REPAIRS AND MAINT.	17,820	S.I.R. MANAGEMENT, INC.	100.00%	6,179	(11,641)
17	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	921	921
18	V	10 NURSING	39,204	S.I.R. MANAGEMENT, INC.	100.00%	17,292	(21,912)
19	V	15 EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	3,275	3,275
20	V	17 ADMINISTRATIVE	69,492	S.I.R. MANAGEMENT, INC.	100.00%	9,254	(60,238)
21	V	19 PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	315	315
22	V	20 FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	200	200
23	V	21 CLERICAL & GENERAL	20,196	S.I.R. MANAGEMENT, INC.	100.00%	12,438	(7,758)
24	V	24 EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	295	295
25	V	25 OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	2,069	2,069
26	V	26 INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	654	654
27	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	3,860	3,860
28	V	30 DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	2,610	2,610
29	V	32 INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	873	873
30	V	33 REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	3,907	3,907
31	V	35 EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	1,593	1,593
32	V						
33	V	39 LEASED EQUIPMENT		S.I.R. MANAGEMENT, INC.	100.00%		
34	V	30 DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%		
35	V	32 INTEREST		S.I.R. MANAGEMENT, INC.	100.00%		
36	V						
37	V						
38	V						
39	Total		\$ 146,712			\$ 67,093	\$ * (79,619)

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

SEE ACCOUNTANTS' COMPILATION REPORT

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%	\$ 6,235	\$ (13,961)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	1,307	1,307	16
17	V	17	ADMIN./LEGAL SALARIES	120,000	S.I.R. MANAGEMENT, INC.	100.00%	45,688	(74,312)	17
18	V	19	FINANCIAL CONSULTANT		S.I.R. MANAGEMENT, INC.	100.00%	13,305	13,305	18
19	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	7,170	7,170	19
20	V								20
21	V	17	ADMIN. SALARY-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	32,376	32,376	21
22	V	6	REPAIRS & MAINT.-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	305	305	22
23	V	21	CLERICAL & GEN.-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	297	297	23
24	V	26	AUTO INSURANCE-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	153	153	24
25	V	27	EMP. BENEFITS-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	6,691	6,691	25
26	V	35	AUTO LEASE-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	3,465	3,465	26
27	V								27
28	V	17	ADMIN. SALARY-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	31,390	31,390	28
29	V	21	CLERICAL & GEN.-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	117	117	29
30	V	26	AUTO INSURANCE-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	151	151	30
31	V	27	EMP. BENEFITS-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	6,655	6,655	31
32	V	35	AUTO LEASE-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	1,408	1,408	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 140,196			\$ 156,713	\$ *	16,517	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	10A SPECIAL REHAB	17,580	S.I.R. MANAGEMENT, INC.	100.00%	10,383	\$ (7,197)
16	V	15 EMP. BEN.-H. CARE & PROG.		S.I.R. MANAGEMENT, INC.	100.00%	2,176	2,176
17	V						
18	V	6 REPAIRS AND MAINT.	34,236	S.I.R. MANAGEMENT, INC.	100.00%	25,819	(8,417)
19	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	5,115	5,115
20	V						
21	V						
22	V	1 DIETICIAN SALARIES	12,000	S.I.R. MANAGEMENT, INC.	100.00%	7,309	(4,691)
23	V	7 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	1,532	1,532
24	V						
25	V	19 LEGAL FEES	16,044	S.I.R. MANAGEMENT, INC.	100.00%		(16,044)
26	V						
27	V	17 FEES	21,600	S.I.R. MANAGEMENT, INC.	100.00%		(21,600)
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 101,460			\$ 52,334	\$ * (49,126)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22 EMPLOYEE HEALTH INSURANCE	\$	CCS EMPLOYEE BENEFIT GROUP	100.00%	\$ 54,643	\$ 54,643	15
16	V							16
17	V							17
18	V							18
19	V	22 EMPLOYEE HEALTH INSURANCE	54,940	CCS EMPLOYEE BENEFIT GROUP	100.00%		(54,940)	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		\$ 54,940			\$ 54,643	\$ * (297)	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: 01/01/04

Ending: 12/31/04

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	01 DIETARY	\$	XCEL MEDICAL SUPPLY, LLC	100.00%	\$	\$
16	V	02 FOOD		XCEL MEDICAL SUPPLY, LLC	100.00%		
17	V	03 HOUSEKEEPING		XCEL MEDICAL SUPPLY, LLC	100.00%		
18	V	04 LAUNDRY		XCEL MEDICAL SUPPLY, LLC	100.00%		
19	V	06 REPAIRS & MAINTENANCE	18,145	XCEL MEDICAL SUPPLY, LLC	100.00%	15,453	(2,692)
20	V	10 NURSING	11,761	XCEL MEDICAL SUPPLY, LLC	100.00%	10,016	(1,745)
21	V	10A THERAPY		XCEL MEDICAL SUPPLY, LLC	100.00%		
22	V	12 SOCIAL SERVICE		XCEL MEDICAL SUPPLY, LLC	100.00%		
23	V	21 CLERICAL & GENERAL OFFICE		XCEL MEDICAL SUPPLY, LLC	100.00%		
24	V	22 EMPLOYEE BENEFITS		XCEL MEDICAL SUPPLY, LLC	100.00%		
25	V	39 ANCILLARY		XCEL MEDICAL SUPPLY, LLC	100.00%		
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 29,906			\$ 25,469	\$ * (4,437)

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

Facility Name & ID Number Wilson Care Inc.

0029975

Report Period Beginning: 01/01/04

Ending: 12/31/04

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: 01/01/04

Ending: 12/31/04

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

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: 01/01/04 Ending: 12/31/04

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	Eric Rothner	Owner	Administrative	20.00%	See Attached	0.75	1.63%	Alloc. Salary	\$ 9,137	17-7	1
2	Nenita Guzman	Relative	Dietary		See Attached	4.86	9.72%	Alloc. Salary	6,235	1-7	2
3	Howard Geller	Owner	Administrative	4.44%	See Attached	2.00	3.33%	Mgmt Fees	48,000	17-3	3
4	Adam Vales	Relative	Clerical		See Attached	0.36	0.90%	Alloc. Salary	369	22-7	4
5	Bryan Barrish	Owner	Administrative	4.86%	See Attached	6.25	15.63%	Alloc. Salary	32,376	17-7	5
6	Noah Wolff	Owner	Administrative	5.56%	See Attached	3.00	8.57%	Mgmt Fees	48,000	17-3	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 144,117		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: 01/01/04 Ending: 12/31/04

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: 01/01/04 Ending: 12/31/04

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	927,958	10	\$ 5,955	\$ 101,776	\$ 653	1
2	5	UTILITIES	BOOK./ACCNT.INCOME	927,958	10	7,801	101,776	856	2
3	6	REPAIRS AND MAINT.	BOOK./ACCNT.INCOME	927,958	10	5,680	101,776	623	3
4	17	ADMIN. FINANCIAL SAL.	BOOK./ACCNT.INCOME	927,958	10	152,983	152,983	16,779	4
5	19	PROFESSIONAL FEES	BOOK./ACCNT.INCOME	927,958	10	12,360	101,776	1,356	5
6	20	DUES,SUBSCRIPTIONS	BOOK./ACCNT.INCOME	927,958	10	1,874	101,776	206	6
7	21	CLERICAL	BOOK./ACCNT.INCOME	927,958	10	527,777	466,233	57,885	7
8	24	SEMINARS	BOOK./ACCNT.INCOME	927,958	10	1,493	101,776	164	8
9	25	ADMIN. STAFF TRAVEL	BOOK./ACCNT.INCOME	927,958	10	5,142	101,776	564	9
10	26	INSURANCE	BOOK./ACCNT.INCOME	927,958	10	3,729	101,776	409	10
11	27	EMPLOYEE BENEFITS	BOOK./ACCNT.INCOME	927,958	10	90,428	101,776	9,918	11
12	30	DEPRECIATION	BOOK./ACCNT.INCOME	927,958	10	18,431	101,776	2,021	12
13	32	INTEREST	BOOK./ACCNT.INCOME	927,958	10	3,338	101,776	366	13
14	33	REAL ESTATE TAXES	BOOK./ACCNT.INCOME	927,958	10	20,087	101,776	2,203	14
15	35	EQUIPMENT RENTAL	BOOK./ACCNT.INCOME	927,958	10	19,368	101,776	2,124	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					\$ 876,446	\$ 619,216	\$ 100,879	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/04 Ending: 12/31/04

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	678,909	11	\$ 13,981	\$	65,948	\$ 1,358	1
2	6 REPAIRS AND MAINT.	PATIENT DAYS	678,909	11	63,606		65,948	6,179	2
3	7 EMP. BEN.-GEN. SERV.	PATIENT DAYS	678,909	11	9,483		65,948	921	3
4	10 NURSING	PATIENT DAYS	678,909	11	178,013	178,013	65,948	17,292	4
5	15 EMP. BEN.-H.C.	PATIENT DAYS	678,909	11	33,716		65,948	3,275	5
6	17 ADMINISTRATIVE	PATIENT DAYS	678,909	11	95,266	95,266	65,948	9,254	6
7	19 PROFESSIONAL FEES	PATIENT DAYS	678,909	11	3,242		65,948	315	7
8	20 FEES,SUBSCRIPTIONS	PATIENT DAYS	678,909	11	2,062		65,948	200	8
9	21 CLERICAL & GENERAL	PATIENT DAYS	678,909	11	128,049	90,910	65,948	12,438	9
10	24 EDUCATION & SEMINAR	PATIENT DAYS	678,909	11	3,040		65,948	295	10
11	25 OTHER ADMIN. STAFF TRANS	PATIENT DAYS	678,909	11	21,297		65,948	2,069	11
12	26 INSURANCE	PATIENT DAYS	678,909	11	6,736		65,948	654	12
13	27 EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	678,909	11	39,734		65,948	3,860	13
14	30 DEPRECIATION	PATIENT DAYS	678,909	11	26,873		65,948	2,610	14
15	32 INTEREST	PATIENT DAYS	678,909	11	8,988		65,948	873	15
16	33 REAL ESTATE TAXES	PATIENT DAYS	678,909	11	40,220		65,948	3,907	16
17	35 EQUIPMENT RENTAL	PATIENT DAYS	678,909	11	16,401		65,948	1,593	17
18									18
19	39 LEASED EQUIPMENT	LEASING INCOME	52,560	1					19
20	30 DEPRECIATION	LEASING INCOME	52,560	1	24,293				20
21	32 INTEREST	LEASING INCOME	52,560	1	6,298				21
22									22
23									23
24									24
25	TOTALS				\$ 721,298	\$ 410,443		\$ 67,093	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/04 Ending: 12/31/04

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	1	DIETARY SALARIES	PATIENT DAYS	678,909	11	\$ 64,183	\$ 65,948	\$ 6,235	1	
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	678,909	11	13,453	65,948	1,307	2	
3	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	678,909	11	470,339	65,948	45,688	3	
4	19	FINANCIAL CONSULTANT	PATIENT DAYS	678,909	11	136,972	65,948	13,305	4	
5	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	678,909	11	73,815	65,948	7,170	5	
6									6	
7	17	ADMIN. SALARY-B. BARRISH	AVG HRS WKD	30	4	155,406	155,406	6	32,376	7
8	6	REPAIRS & MAINT.-B. BARRIS	AVG HRS WKD	30	4	1,462	6	6	305	8
9	21	CLERICAL & GEN.-B. BARRIS	AVG HRS WKD	30	4	1,426	6	6	297	9
10	26	AUTO INSURANCE-B. BARRIS	AVG HRS WKD	30	4	733	6	6	153	10
11	27	EMP. BENEFITS-B. BARRISH	AVG HRS WKD	30	4	32,115	6	6	6,691	11
12	35	AUTO LEASE-B. BARRISH	AVG HRS WKD	30	4	16,634	6	6	3,465	12
13										13
14	17	ADMIN. SALARY-M. GIANNINI	AVG HRS WKD	30	4	150,673	150,673	6	31,390	14
15	21	CLERICAL & GEN.-M. GIANNI	AVG HRS WKD	30	4	560	6	6	117	15
16	26	AUTO INSURANCE-M. GIANNI	AVG HRS WKD	30	4	726	6	6	151	16
17	27	EMP. BENEFITS-M. GIANNINI	AVG HRS WKD	30	4	31,946	6	6	6,655	17
18	35	AUTO LEASE-M. GIANNINI	AVG HRS WKD	30	4	6,756	6	6	1,408	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,157,199	\$ 840,601	\$	156,713	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/04 Ending: 12/31/04

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	10A	SPECIAL REHAB	SPECIAL REHAB INC.	107,736	7	\$ 63,630	\$ 63,630	17,580	\$ 10,383	1
2	15	EMP. BEN.-H. CARE & PROG.	SPECIAL REHAB INC.	107,736	7	13,337		17,580	2,176	2
3										3
4	6	REPAIRS AND MAINT.	MAINTENANCE INC.	143,028	11	107,866	107,866	34,236	25,819	4
5	7	EMP. BEN.-GEN. SERV.	MAINTENANCE INC.	143,028	11	21,371		34,236	5,115	5
6										6
7										7
8	1	DIETICIAN SALARIES	DIETICIAN SERVICE INC.	125,400	10	76,377	76,377	12,000	7,309	8
9	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN SERVICE INC.	125,400	10	16,008		12,000	1,532	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					\$ 298,589	\$ 247,873		\$ 52,334	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/04 Ending: 12/31/04

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		\$	\$		54,643	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				\$	\$		54,643	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/04 Ending: 12/31/04

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 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	01	DIETARY	Direct Allocation		\$	\$		\$	1
2	02	FOOD	Direct Allocation						2
3	03	HOUSEKEEPING	Direct Allocation						3
4	04	LAUNDRY	Direct Allocation						4
5	06	REPAIRS & MAINTENANCE	Direct Allocation					15,453	5
6	10	NURSING	Direct Allocation					10,016	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				\$	\$		\$ 25,469	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care Inc. # 0029975 Report Period Beginning: 01/01/04 Ending: 12/31/04

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: 01/01/04 Ending: 12/31/04

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: 01/01/04 Ending: 12/31/04

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: 01/01/04 Ending: 12/31/04

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	\$ 5,144,288	02/21/08		\$ 459,811	1								
2												2								
3												3								
4												4								
5	See Supplemental Schedule											5								
	Working Capital																			
6												6								
7												7								
8	See Supplemental Schedule											8								
9	TOTAL Facility Related				\$48,561.00		\$ 5,817,265	\$ 5,144,288			\$ 459,811	9								
	B. Non-Facility Related*																			
10	Interest Income		X								(46,126)	10								
11	Interest Income - Bldg. Com.		X								(365)	11								
12	Allocate Preferred		X								366	12								
13	See Supplemental Schedule										873	13								
14	TOTAL Non-Facility Related						\$	\$			\$ (45,252)	14								
15	TOTALS (line 9+line14)						\$ 5,817,265	\$ 5,144,288			\$ 414,559	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	Allocate SIR		X			\$	\$			\$	873									
16											16									
17											17									
18											18									
19											19									
20	TOTAL Non-Facility Related										873									

* 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: **01/01/04** Ending: **12/31/04****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 2003 report.				\$	74,400	1																			
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$	73,361	2																			
3. Under or (over) accrual (line 2 minus line 1).				\$	(1,039)	3																			
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	69,000	4																			
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$	8,098	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.				\$	76,059	7																			
Real Estate Tax History:																									
Real Estate Tax Bill for Calendar Year:	1999	77,033	8	<table border="1"> <tr> <td colspan="3">FOR OHF USE ONLY</td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2003</td> <td>\$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td>\$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6</td> <td>\$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td>\$</td> <td>16</td> </tr> </table>			FOR OHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2003	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
FOR OHF USE ONLY																									
13	FROM R. E. TAX STATEMENT FOR 2003	\$	13																						
14	PLUS APPEAL COST FROM LINE 5	\$	14																						
15	LESS REFUND FROM LINE 6	\$	15																						
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																						
	2000	70,014	9																						
	2001	71,835	10																						
	2002	72,641	11																						
	2003	67,251	12																						
Accrual for 2004 \$67,251*1.026= \$69,000																									
Allocation from SIR - \$3,907																									
Allocation from Preferred - \$2,203																									

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:** 2003 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 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 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 2004 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.

2003 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 2003 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 2003.

(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>67,251.42</u>	\$ <u>67,251.42</u>
2. <u>See Attached</u>	<u>See Attached</u>	\$ <u>79,702.01</u>	\$ <u>5,714.73</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>146,953.43</u>	\$ <u>72,966.15</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 original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

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.

2003 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	\$ <u>_____</u>	\$ <u>_____</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? 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:01/01/04 Ending:12/31/04

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	<u>Facility</u>		<u>1985</u>	\$ <u>13,300</u>	1
2					2
3	TOTALS			\$ 13,300	3

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		
	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	2,851	2,851	65,340	9
10	Various		1986		161,365		20	8,488	8,488	157,605	10
11	Various		1987		49,380		20	2,598	2,598	45,981	11
12	Various		1989		49,210		20	2,461	(2,461)	38,288	12
13	Various		1990		105,470		20	5,274	5,274	74,283	13
14	Various		1991		29,903		20	1,494	1,494	20,272	14
15	Various		1992		69,669		20	3,484	3,484	43,744	15
16	Various		1993		61,688		20	3,087	3,087	35,450	16
17	Various		1994		55,691		20	2,760	2,760	30,272	17
18	Various		1995		87,144		20	4,360	4,360	41,414	18
19	Various		1996		303,393		20	15,172	15,172	128,005	19
20	Various		1997		145,411		20	7,348	7,348	49,754	20
21	Various		1998		34,959		20	1,748	1,748	11,446	21
22	Various		1999		64,557		20	3,229	3,229	17,815	22
23	Various		2000		342,218		20	17,110	17,110	73,600	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:

01/01/04

Ending:

12/31/04

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	2 Year Constructed	3 Cost	4 Current Book Depreciation	5 Life in Years	6 Straight Line Depreciation	7 Adjustments	8 Accumulated Depreciation	9
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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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	49,398		19,088	(30,310)	1,539,800	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		82,274	2,797		3,241	444	30,871	68
69	Financial Statement Depreciation			83,925			(83,925)		69
70	TOTAL (lines 4 thru 69)		\$ 3,247,498	\$ 136,120		\$ 103,793	\$ (37,249)	\$ 2,403,940	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:

01/01/04

Ending:

12/31/04

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		\$ 3,247,498	\$ 136,120		\$ 103,793	\$ (32,327)	\$ 2,403,940	1
2	Flooring	2001	24,235		20	1,212	1,212	4,847	2
3	Window Treatment	2001	6,946		20	347	347	1,389	3
4	Doors	2001	6,905		20	345	345	1,381	4
5	Elevator Work	2001	5,690		20	285	285	1,020	5
6	Security System	2001	8,340		20	417	417	1,460	6
7	Hvac System	2001	5,175		20	259	259	884	7
8	Hvac Work	2001	11,902		20	595	595	1,835	8
9	Paint	2001	718		20	36	36	144	9
10	Booster Heater	2001	1,523		20	76	76	241	10
11	Fire Door	2001	1,221		20	61	61	229	11
12	Doors	2001	1,851		20	93	93	340	12
13	Blinds	2001	1,187		20	59	59	217	13
14	Aquastat	2001	1,064		20	53	53	200	14
15	Fire Door	2001	1,227		20	61	61	215	15
16	Blinds	2001	1,194		20	60	60	209	16
17	Fire Door	2001	1,495		20	75	75	262	17
18	Blinds	2001	1,194		20	60	60	199	18
19	Camera	2001	951		20	48	48	155	19
20	Window Treatment	2001	6,946		20	347	347	1,389	20
21	Bathub Liner	2001	3,186		20	159	159	505	21
22	Refinish Tub	2001	2,610		20	131	131	425	22
23	Hot Water Heater	2001	1,789		20	89	89	357	23
24	Water Heater	2001	1,276		20	64	64	239	24
25	Lighting	2001	2,060		20	103	103	352	25
26	Plumbing Repair	2001	1,948		20	97	97	308	26
27	Recep.Furniture	2002	3,851		20	770	770	2,182	27
28	Plumbing	2002	24,086		20	2,409	2,409	5,620	28
29	Module & Cable	2002	9,897		20	1,979	1,979	4,454	29
30	Plumbing Repair	2002	1,076		20	108	108	323	30
31	Freezer Motor	2002	1,151		20	230	230	671	31
32	Repair Walk In Freezer	2002	1,007		20	201	201	587	32
33	Strainer Basket On Sinks	2002	1,150		20	115	115	326	33
34	TOTAL (lines 1 thru 33)		\$ 3,392,349	\$ 136,120		\$ 114,737	\$ (21,383)	\$ 2,436,905	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:

01/01/04

Ending:

12/31/04

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		\$ 3,392,349	\$ 136,120		\$ 114,737	\$ (21,383)	\$ 2,436,905	1
2	Wall Repair	2002	2,950		20	295	295	811	2
3	Hot Water Heater	2002	1,120		20	112	112	308	3
4	Wall Repair	2002	440		20	44	44	117	4
5	Blinds	2002	1,194		20	119	119	299	5
6	Install Tile	2002	992		20	99	99	240	6
7	Bathtub Liner	2002	716		20	72	72	191	7
8	Door	2002	1,608		20	161	161	389	8
9	Window Treatments	2002	2,493		20	249	249	602	9
10	Paint	2002	814		20			814	10
11	Paint	2002	949		20			949	11
12	Heater	2002	1,698		20	170	170	396	12
13	Dry Wall	2002	3,000		20	300	300	700	13
14	Bathtub Liner	2002	631		20	63	63	142	14
15	Curtain	2002	489		20	49	49	110	15
16	Boiler	2002	2,004		20	200	200	451	16
17	Paint	2002	512		20			512	17
18	Bathtub Liner	2002	1,848		20	185	185	416	18
19	Wall Cover	2002	5,031		20			5,031	19
20	Dry Wall	2002	4,000		20	400	400	900	20
21	Elevator Door Lock	2003	2,341		20	234	234	410	21
22	Roofing Work	2003	2,475		20	124	124	175	22
23	Plumbing	2003	13,800		20	690	690	978	23
24	Sewer Pipe Work	2003	4,300		20	215	215	287	24
25	Sewer Pipe Work	2003	3,000		20	150	150	200	25
26	Steam Pipes	2003	4,279		20	214	214	428	26
27	Fire Alarm Wiring	2003	2,935		20	147	147	269	27
28	Elevator Work	2003	2,020		20	101	101	177	28
29	Elevator Work	2003	3,239		20	162	162	283	29
30	Elevator Work	2003	3,547		20	177	177	222	30
31	Fire Proof Door	2003	17,075		20	1,708	1,708	2,134	31
32	New Windows	2003	3,300		20	165	165	179	32
33	Handrails	2003	3,906		20	391	391	423	33
34	TOTAL (lines 1 thru 33)		\$ 3,491,055	\$ 136,120		\$ 121,733	\$ (14,387)	\$ 2,456,448	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:

01/01/04

Ending:

12/31/04

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		\$ 3,491,055	\$ 136,120		\$ 121,733	\$ (14,387)	\$ 2,456,448	1
2	Elevator Work	2003	3,429		20	171	171	186	2
3	Elevator Work	2003	3,547		20	177	177	192	3
4	Upgrade Kitchen System	2003	1,785		20	89	89	156	4
5	Sprinkler System	2003	5,130		20	257	257	321	5
6	Cubicle Curtains	2003	2,123		20	106	106	212	6
7	Exit Devices	2003	1,470		20	74	74	129	7
8	Doors	2003	921		20	46	46	81	8
9	Blinds	2003	1,305		20	65	65	114	9
10	Bathub Liner	2003	1,250		20	63	63	109	10
11	Electrical Work	2003	1,673		20	84	84	146	11
12	Bath Tub Wall Panel	2003	1,013		20	51	51	89	12
13	Ten Windows	2003	1,417		20	71	71	124	13
14	Dining Room A/C Repair	2003	1,207		20	60	60	96	14
15	Wall Tiles	2003	2,875		20	144	144	180	15
16	A/C Window Supports	2003	2,349		20	117	117	137	16
17	Emt Installation	2003	1,458		20	73	73	79	17
18	Stair Risers	2003	329		20	16	16	18	18
19	Courtyard Fence Work	2003	2,772		20	139	139	208	19
20	Bathroom Work	2004			20				20
21	Bathroom Work	2004	3,380		20	127	127	127	21
22	New Windows	2004	19,936		20	581	581	581	22
23	Stairwell Gate	2004	1,119		20	65	65	65	23
24	Walk-In-Freezer Work	2004			20				24
25	Walk-In-Freezer Work	2004	2,357		20	69	69	69	25
26	Cubicle Dividers	2004			20				26
27	Cubicle Dividers	2004	3,655		20	91	91	91	27
28	Doors	2004			20				28
29	Doors	2004	7,200		20	60	60	60	29
30	Wall Surround And Bath Tub Liner	2004	1,300		20	130	130	130	30
31	Pump Valve	2004	1,224		20	122	122	122	31
32	Hallway Carpeting	2004	636		20	64	64	64	32
33	Bath Tub Liner #204	2004	625		20	63	63	63	33
34	TOTAL (lines 1 thru 33)		\$ 3,568,540	\$ 136,120		\$ 124,907	\$ (11,213)	\$ 2,460,396	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		\$ 3,568,540	\$ 136,120		\$ 124,907	\$ (11,213)	\$ 2,460,396	1
2	Wall Surround #517	2004	725		20	73	73	73	2
3	Wall Surround #405	2004	725		20	73	73	73	3
4	Wall Surround #217	2004	725		20	73	73	73	4
5	Wall Surround #417	2004	725		20	73	73	73	5
6	Bathroom Repair Work	2004	2,475		20	248	248	248	6
7	Replace Drywall & Build Retaining	2004	1,600		20	160	160	160	7
8	Bathroom Repair Work	2004	2,800		20	280	280	280	8
9	Replace Light Fixtures And Wiring	2004	1,416		20	142	142	142	9
10	Repipe Bathroom Radiator	2004	1,802		20	180	180	180	10
11	Boiler Repair And Boiler Reset Con	2004	1,745		20	174	174	174	11
12	Reine Elevator Brake Shoes	2004	2,189		20	219	219	219	12
13	Replace 44 Smoke Detectors	2004	5,770		20	577	577	577	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)		\$ 3,591,237	\$ 136,120		\$ 127,177	\$ (8,943)	\$ 2,462,666	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		\$ 3,591,237	\$ 136,120		\$ 127,177	\$ (8,943)	\$ 2,462,666	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)		\$ 3,591,237	\$ 136,120		\$ 127,177	\$ (8,943)	\$ 2,462,666	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		\$ 3,591,237	\$ 136,120		\$ 127,177	\$ (8,943)	\$ 2,462,666	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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20									20
21									21
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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)		\$ 3,591,237	\$ 136,120		\$ 127,177	\$ (8,943)	\$ 2,462,666	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	10
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12G, Carried Forward	\$ 3,591,237	\$ 136,120		\$ 127,177	\$ (8,943)	\$ 2,462,666		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 3,591,237	\$ 136,120		\$ 127,177	\$ (8,943)	\$ 2,462,666		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	10
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12H, Carried Forward	\$ 3,591,237	\$ 136,120		\$ 127,177	\$ (8,943)	\$ 2,462,666		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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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 3,591,237	\$ 136,120		\$ 127,177	\$ (8,943)	\$ 2,462,666		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		\$ 3,591,237	\$ 136,120		\$ 127,177	\$ (8,943)	\$ 2,462,666	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,591,237	\$ 136,120		\$ 127,177	\$ (8,943)	\$ 2,462,666	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		\$ 3,591,237	\$ 136,120		\$ 127,177	\$ (8,943)	\$ 2,462,666	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,591,237	\$ 136,120		\$ 127,177	\$ (8,943)	\$ 2,462,666	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:

01/01/04

Ending:

12/31/04

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	198			\$ 1,539,800	\$ 49,398		\$ 19,088	\$ (30,310)	\$ 1,539,800
5		1985							
6									
7									
8									
Improvement Type**									
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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		
37			\$	\$		\$	\$	\$		37
38										38
39										39
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65										65
66										66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 1,539,800	\$ 49,398		\$ 19,088	\$ (30,310)	\$ 1,539,800		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:

01/01/04

Ending:

12/31/04

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		\$ 25,956	\$ 824	35	\$ 742	\$ (82)	\$ 8,528	4
5	Alloc SIR	1993		14,637	465	35	418	(47)	4,809	5
6										6
7										7
8										8
Improvement Type**										
9	Preferred Bookkeeping - Allocation	1997		18,279	409	20	914	505	7,137	9
10	Preferred Bookkeeping - Allocation	1999		145	-	20	7	7	40	10
11	Preferred Bookkeeping - Allocation	2000		917	-	20	46	46	202	11
12										12
13	SIR Properties - SIR Management - Allocation	2002		103	-	20	5	5	13	13
14	SIR Properties - SIR Management - Allocation	1999		3,289	329	20	164	(165)	904	14
15	SIR Properties - SIR Management - Allocation	1998		1,572	157	20	79	(78)	511	15
16	SIR Properties - SIR Management - Allocation	1997		98	10	20	5	(5)	42	16
17	SIR Properties - SIR Management - Allocation	1994		247	6	20	12	6	130	17
18	SIR Properties - SIR Management - Allocation	1993		421	2	20	21	19	242	18
19										19
20	SIR Properties - Preferred Bookkeeping - Allocation	2002		58	-	20	3	3	7	20
21	SIR Properties - Preferred Bookkeeping - Allocation	1999		1,855	185	20	93	(92)	510	21
22	SIR Properties - Preferred Bookkeeping - Allocation	1998		886	89	20	44	(45)	288	22
23	SIR Properties - Preferred Bookkeeping - Allocation	1997		55	6	20	3	(3)	23	23
24	SIR Properties - Preferred Bookkeeping - Allocation	1994		139	4	20	7	3	73	24
25	SIR Properties - Preferred Bookkeeping - Allocation	1993		237	1	20	12	11	137	25
26										26
27	SIR Management - Allocation	1993		11,148	310	20	553	243	6,633	27
28	SIR Management - Allocation	1994		35	-	20	2	2	35	28
29	SIR Management - Allocation	1995		255	-	20	13	13	120	29
30	SIR Management - Allocation	1999		1,211	-	20	61	61	316	30
31	SIR Management - Allocation	2000		731	-	20	37	37	171	31
32										32
33										33
34										34
35										35
36										36

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		
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)		\$ 82,274	\$ 2,797		\$ 3,241	\$ 444	\$ 30,871		70

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	\$ 440,566	\$ 1,720	\$ 29,260	\$ 27,540	10	\$ 326,354	71
72	Current Year Purchases	13,452	114	785	671	10	785	72
73	Fully Depreciated Assets	430,208				10	430,208	73
74								74
75	TOTALS	\$ 884,226	\$ 1,834	\$ 30,045	\$ 28,211		\$ 757,347	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)	\$ 4,488,763	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 137,954	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 157,223	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 19,269	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,220,014	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 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

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. /2005 \$ _____

13. /2006 \$ _____

14. /2007 \$ _____

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: \$ 11,061 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>5,067</u>	17
18	<u>Allocate SIR</u>			<u>4,873</u>	18
19					19
20					20
21	TOTAL		\$ <u>422.24</u>	\$ <u>9,940</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.

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 prescripts										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

Facility Name & ID Number Wilson Care Inc.

0029975

Report Period Beginning: 01/01/04

Ending:

12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/04

(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	\$ 10,173	\$ 13,251	1
2 Cash-Patient Deposits	24,754	24,754	2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,273,440	1,273,440	3
4 Supply Inventory (priced at)			4
5 Short-Term Investments			5
6 Prepaid Insurance	3,254	3,254	6
7 Other Prepaid Expenses	4,432	4,432	7
8 Accounts Receivable (owners or related parties)	380,000	380,000	8
9 Other(specify): See Attached Schedule	37,940	37,940	9
10 TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,733,993	\$ 1,737,071	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	1,216,637	1,216,637	15
16 Equipment, at Historical Cost	1,147,197	1,177,197	16
17 Accumulated Depreciation (book methods)	(1,555,401)	(3,155,511)	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		34,343	23
24 TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 808,433	\$ 869,157	24
25 TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,542,426	\$ 2,606,228	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26 Accounts Payable	\$ 73,463	\$ 73,463	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits	26,104	26,104	28
29 Short-Term Notes Payable			29
30 Accrued Salaries Payable	118,909	118,909	30
31 Accrued Taxes Payable (excluding real estate taxes)	6,088	6,088	31
32 Accrued Real Estate Taxes(Sch.IX-B)	69,000	69,000	32
33 Accrued Interest Payable		26,077	33
34 Deferred Compensation			34
35 Federal and State Income Taxes	19,000	19,000	35
Other Current Liabilities(specify):			
36 See Attached Schedule	(11,731)	(11,731)	36
37			37
38 TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 300,833	\$ 326,910	38
D. Long-Term Liabilities			
39 Long-Term Notes Payable			39
40 Mortgage Payable		5,144,288	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)	\$	\$ 5,144,288	45
46 TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 300,833	\$ 5,471,198	46
47 TOTAL EQUITY(page 18, line 24)	\$ 2,241,593	\$ (2,864,970)	47
48 TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,542,426	\$ 2,606,228	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,174,108	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,174,108	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	931,485	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	(864,000)	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)	\$ 67,485	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)	\$ 2,241,593	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care Inc.

0029975

Report Period Beginning: 01/01/04

Ending: 12/31/04

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	\$ 5,659,969	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,659,969	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***	46,126	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 46,126	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	1,259	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,259	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,707,354	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,048,596	31
32	Health Care	1,495,314	32
33	General Administration	1,350,790	33
B. Capital Expense			
34	Ownership	772,467	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	108,702	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,775,869	40
41	Income before Income Taxes (line 30 minus line 40)**	931,485	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 931,485	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: 01/01/04

Ending:

12/31/04

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	1,869	2,091	\$ 68,495	\$ 32.76	1
2	Assistant Director of Nursing	1,871	2,106	54,418	25.84	2
3	Registered Nurses	1,617	1,719	38,478	22.38	3
4	Licensed Practical Nurses	9,354	10,003	232,688	23.26	4
5	Nurse Aides & Orderlies	47,778	50,491	441,289	8.74	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,120	1,234	17,357	14.07	9
10	Activity Assistants	7,646	8,343	66,007	7.91	10
11	Social Service Workers	18,082	19,933	282,105	14.15	11
12	Dietician					12
13	Food Service Supervisor	1,927	2,115	36,476	17.25	13
14	Head Cook	3,830	4,100	37,243	9.08	14
15	Cook Helpers/Assistants	14,384	15,496	117,518	7.58	15
16	Dishwashers					16
17	Maintenance Workers	3,821	4,022	43,141	10.73	17
18	Housekeepers	16,680	18,869	142,489	7.55	18
19	Laundry					19
20	Administrator	1,920	2,320	87,617	37.77	20
21	Assistant Administrator	288	324	3,868	11.94	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,166	12,252	141,661	11.56	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	4,408	4,773	81,369	17.05	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	4,781	4,781	13,164	2.75	33
34	TOTAL (lines 1 - 33)	152,542	164,972	\$ 1,905,383 *	\$ 11.55	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	3,600	09-03	36
37	Medical Records Consultant	96	4,120	10-03	37
38	Nurse Consultant	1,079	39,204	10-03	38
39	Pharmacist Consultant	49	3,335	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	5,400	12-03	45
46	Other(specify) Dir of Food Services	SIR Mgmt	20,196	01-03	46
47	Rehab Consultant	Monthly	17,580	10a-03	47
48					48
49	TOTAL (lines 35 - 48)	1,224	\$ 105,435		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	109	\$ 3,976	10-03	50
51	Licensed Practical Nurses	2,612	95,218	10-03	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	2,721	\$ 99,194		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care Inc.

0029975

Report Period Beginning: 01/01/04

Ending: 12/31/04

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	\$ 87,617	Workers' Compensation Insurance	\$ 15,622	IDPH License Fee	\$		
Ralei Evans	Asst. Admin.	0	3,868	Unemployment Compensation Insurance	16,222	Advertising: Employee Recruitment	4,202		
				FICA Taxes	142,220	Health Care Worker Background Check	382		
				Employee Health Insurance	101,060	(Indicate # of checks performed 31)			
				Employee Meals	18,941	IL Assoc of Health Care Facilities	990		
				Illinois Municipal Retirement Fund (IMRF)*		Licenses and Permits	5,428		
				Chicago Head Tax	3,774	IL Council Due	6,753		
				401K Plan	5,258	Allocate Preferred	206		
				Other Employee Benefits	2,659	Allocate SIR	200		
							(4,200)		
						Less: Public Relations Expense	()		
						Non-allowable advertising	()		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 91,485	TOTAL (agree to Schedule V, line 22, col.8)	\$ 305,756	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 13,961		
(List each licensed administrator separately.)									
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 - Fees			21,600				In-State Travel		
See Supplemental Schedule			216,125						
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 307,217				Seminar Expense	3,520	
(Attach a copy of any management service agreement)							Allocate Preferred	164	
C. Professional Services							Allocate SIR	295	
Vendor/Payee	Type		Amount				Entertainment Expense	()	
FR&R	Accounting		\$ 12,465	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	\$ 3,979	
Preferred Bookkeeping	Accounting		40,000						
Rieff, Schramm & Kanter	Legal - RE Tax		7,969						
LTC Solutions	Computer Service		1,320						
ICS Solutions	Website		1,229						
HDSI	Computer Service		770						
Personnel Planners	Unemployment Consultant		819						
Meyer Magence	Legal		300						
Micheal Best & Friedrich	Legal (Adj. on P. 5)		2,970						
Preferred Bookkeeping	Bookkeeping		61,776						
Preferred Bookkeeping	Computer Service		4,752						
See Supplemental Schedule			16,044						
TOTAL (agree to Schedule V, line 19, column 3)			\$ 150,414						
(If total legal fees exceed \$2500 attach copy of invoices.)									

* 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								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
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: 01/01/04Ending: 12/31/04**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 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 8,903 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. \$ 108,702
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. \$ 18,941 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? None
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? 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