

		FOR BHF USE					

LL1

2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

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

I. IDPH Facility ID Number: 0029975

Facility Name: Wilson Care

Address: 4544 North Hazel Street Chicago 60640
 Number City Zip Code

County: Cook

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

HFS ID Number: 363379568001

Date of Initial License for Current Owners: 09/01/85

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input checked="" type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) _____	
	(Title) _____	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) <u>Cary C. Buxbaum, C.P.A.</u>	
	(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>	
	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>	

MAIL TO: BUREAU OF HEALTH FINANCE
 ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
 201 S. Grand Avenue East
 Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care

0029975 Report Period Beginning: 01/01/05 Ending: 12/31/05

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	<u>198</u>	Intermediate (ICF)	<u>198</u>	<u>72,270</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>198</u>	TOTALS	<u>198</u>	<u>72,270</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF	<u>63,127</u>	<u>1,135</u>		<u>64,262</u>
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	<u>63,127</u>	<u>1,135</u>		<u>64,262</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.92%

D. How many bed-hold days during this year were paid by the Department?

1,715 (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: 12/31/05 Fiscal Year: 12/31/05

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

Facility Name & ID Number

Wilson Care

0029975

Report Period Beginning:

01/01/05

Ending:

12/31/05

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	201,586	26,208	32,196	259,990		259,990	(18,407)	241,583			1
2	Food Purchase		262,283		262,283	(20,531)	241,752	(46)	241,706			2
3	Housekeeping	135,814	42,268		178,082		178,082	(867)	177,215			3
4	Laundry		14,830	6,314	21,144		21,144		21,144			4
5	Heat and Other Utilities			119,218	119,218		119,218	2,386	121,604			5
6	Maintenance	47,157	31,844	119,686	198,687		198,687	(35,640)	163,047			6
7	Other (specify):*							4,738	4,738			7
8	TOTAL General Services	384,557	377,433	277,414	1,039,404	(20,531)	1,018,873	(47,836)	971,037			8
	B. Health Care and Programs											
9	Medical Director			3,300	3,300		3,300		3,300			9
10	Nursing and Medical Records	925,309	22,881	142,217	1,090,407		1,090,407	(20,422)	1,069,985			10
10a	Therapy			17,580	17,580		17,580	(6,956)	10,624			10a
11	Activities	122,779	6,327		129,106		129,106		129,106			11
12	Social Services	294,993	9,772		304,765		304,765		304,765			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							6,300	6,300			15
16	TOTAL Health Care and Programs	1,343,081	38,980	163,097	1,545,158		1,545,158	(21,078)	1,524,080			16
	C. General Administration											
17	Administrative	85,216		307,217	392,433		392,433	(130,190)	262,243			17
18	Directors Fees											18
19	Professional Services			143,820	143,820	(1,028)	142,792	(102,844)	39,948			19
20	Dues, Fees, Subscriptions & Promotions			46,024	46,024		46,024	(14,999)	31,025			20
21	Clerical & General Office Expenses	143,076	26,522	80,141	249,739		249,739	9,164	258,903			21
22	Employee Benefits & Payroll Taxes			300,849	300,849	20,531	321,380		321,380			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,541	1,541		1,541	346	1,887			24
25	Other Admin. Staff Transportation			4,744	4,744		4,744	2,871	7,615			25
26	Insurance-Prop.Liab.Malpractice			151,264	151,264		151,264	1,306	152,570			26
27	Other (specify):*							32,696	32,696			27
28	TOTAL General Administration	228,292	26,522	1,035,600	1,290,414	19,503	1,309,917	(201,650)	1,108,268			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,955,930	442,935	1,476,111	3,874,976	(1,028)	3,873,948	(270,564)	3,603,384			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 #0029975 Report Period Beginning: 01/01/05 Ending: 12/31/05

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			89,565	89,565		89,565	68,781	158,346			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							401,383	401,383			32
33	Real Estate Taxes			70,545	70,545	1,028	71,573	6,598	78,171			33
34	Rent-Facility & Grounds			614,280	614,280		614,280	(614,280)				34
35	Rent-Equipment & Vehicles			10,830	10,830		10,830	6,470	17,300			35
36	Other (specify):*							10,991	10,991			36
37	TOTAL Ownership			785,220	785,220	1,028	786,248	(120,057)	666,191			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			108,405	108,405		108,405		108,405			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			108,405	108,405		108,405		108,405			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,955,930	442,935	2,369,736	4,768,601		4,768,601	(390,621)	4,377,980			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

0029975

Report Period Beginning: 01/01/05

Ending: 12/31/05

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	63,494	30		9
10	Interest and Other Investment Income	(44,074)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(46)	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	(8,770)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(28,767)	21		24
25	Fund Raising, Advertising and Promotional	(4,000)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(18,100)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(28,046)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (68,309)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(322,311)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (322,311)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (390,621)		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

OHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Wilson Care ID# 0029975
 Report Period Beginning: 01/01/05
 Ending: 12/31/05

NON-ALLOWABLE EXPENSES	Amount	Sch. V Line	Reference
1 Copy Dues	\$ (2,400)	20	1
2 Theft and Damage	(117)	21	2
3 Capitalized REEM	(21,556)	06	3
4 Non Allowable Legal	(1,830)	19	4
5 Cable TV	(1,962)	08	5
6 Office Expense - Bldg. Co	(156)	21	6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
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96			96
97			97
98			98
99			99
100			100
101 Total	(28,048)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Wilson Care# 0029975

Report Period Beginning:

01/01/05

Ending:

12/31/05**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					(13,539)	(4,868)						(18,407)	1
2	Food Purchase	(46)											(46)	2
3	Housekeeping			693					(1,560)				(867)	3
4	Laundry													4
5	Heat and Other Utilities			962	1,424								2,386	5
6	Maintenance	(23,538)		1,144	(10,911)	163	(2,498)						(35,640)	6
7	Other (specify):*				970	1,362	2,406						4,738	7
8	TOTAL General Services	(23,584)		2,799	(8,517)	(12,014)	(4,960)		(1,560)				(47,836)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records				(18,528)				(1,894)				(20,422)	10
10a	Therapy						(6,956)						(6,956)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				4,126		2,174						6,300	15
16	TOTAL Health Care and Programs				(14,402)		(4,782)		(1,894)				(21,078)	16
	C. General Administration													
17	Administrative			17,698	(59,971)	(66,317)	(21,600)						(130,190)	17
18	Directors Fees													18
19	Professional Services	(1,830)		(100,958)	921	15,067	(16,044)						(102,844)	19
20	Fees, Subscriptions & Promotions	(15,175)		75	101								(14,999)	20
21	Clerical & General Office Expenses	(47,140)	156	62,273	(6,556)	431							9,164	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			114	232								346	24
25	Other Admin. Staff Transportation			663	2,208								2,871	25
26	Insurance-Prop.Liab.Malpractice			379	491	436							1,306	26
27	Other (specify):*			11,378	3,856	17,462							32,696	27
28	TOTAL General Administration	(64,145)	156	(8,378)	(58,718)	(32,921)	(37,644)						(201,650)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(87,729)	156	(5,579)	(81,637)	(44,934)	(47,386)		(3,454)				(270,564)	29

STATE OF ILLINOIS

Facility Name & ID Number Wilson Care

0029975

Report Period Beginning:

01/01/05 Ending:

Summary B

12/31/05

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	63,494	1,181	1,685	2,421								68,781	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(44,074)	445,932	(312)	(163)								401,383	32
33	Real Estate Taxes			2,405	4,193								6,598	33
34	Rent-Facility & Grounds		(614,280)										(614,280)	34
35	Rent-Equipment & Vehicles			2,565	1,702	2,203							6,470	35
36	Other (specify):*		10,991										10,991	36
37	TOTAL Ownership	19,420	(156,176)	6,343	8,153	2,203							(120,057)	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)	(68,309)	(156,020)	764	(73,484)	(42,732)	(47,386)		(3,454)				(390,621)	45

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rental Income	\$ 614,280	Wilson Care LLC	100.00%	\$	\$ (614,280)	1
2	V	33 Rent Real Estate Tax	69,825	Wilson Care LLC	100.00%		(69,825)	2
3	V	36 Amortization Of Loan Fees		Wilson Care LLC	100.00%	10,991	10,991	3
4	V	30 Depreciation		Wilson Care LLC	100.00%	1,181	1,181	4
5	V	32 Mortgage Interest		Wilson Care LLC	100.00%	447,174	447,174	5
6	V	21 Office Expenses		Wilson Care LLC	100.00%	156	156	6
7	V	33 Real Estate Taxes		Wilson Care LLC	100.00%	69,825	69,825	7
8	V	32 Interest Income	1,242	Wilson Care LLC	100.00%		(1,242)	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 685,347			\$ 529,327	\$ * (156,020)	14

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

Facility Name & ID Number Wilson Care# 0029975Report Period Beginning: 01/01/05Ending: 12/31/05

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%	\$ 693	\$ 693	15	
16	V	5 UTILITIES		PREFERRED BOOKKEEPING	100.00%	962	962	16	
17	V	6 REPAIRS AND MAINT.		PREFERRED BOOKKEEPING	100.00%	1,144	1,144	17	
18	V	17 ADMIN. FINANCIAL SAL.		PREFERRED BOOKKEEPING	100.00%	17,698	17,698	18	
19	V	19 PROFESSIONAL FEES		PREFERRED BOOKKEEPING	100.00%	1,618	1,618	19	
20	V	20 DUES,SUBSCRIPTIONS		PREFERRED BOOKKEEPING	100.00%	75	75	20	
21	V	21 CLERICAL		PREFERRED BOOKKEEPING	100.00%	62,273	62,273	21	
22	V	24 SEMINARS		PREFERRED BOOKKEEPING	100.00%	114	114	22	
23	V	25 ADMIN. STAFF TRAVEL		PREFERRED BOOKKEEPING	100.00%	663	663	23	
24	V	26 INSURANCE		PREFERRED BOOKKEEPING	100.00%	379	379	24	
25	V	27 EMPLOYEE BENEFITS		PREFERRED BOOKKEEPING	100.00%	11,378	11,378	25	
26	V	30 DEPRECIATION		PREFERRED BOOKKEEPING	100.00%	1,685	1,685	26	
27	V	32 INTEREST		PREFERRED BOOKKEEPING	100.00%	(312)	(312)	27	
28	V	33 REAL ESTATE TAXES		PREFERRED BOOKKEEPING	100.00%	2,405	2,405	28	
29	V	35 EQUIPMENT RENTAL		PREFERRED BOOKKEEPING	100.00%	2,565	2,565	29	
30	V							30	
31	V							31	
32	V	19 ACCOUNT./BOOKKEEPING	102,576	PREFERRED BOOKKEEPING	100.00%		(102,576)	32	
33	V	19 COMPUTER	4,752	PREFERRED BOOKKEEPING	100.00%	4,752		33	
34	V							34	
35	V							35	
36	V							36	
37	V							37	
38	V							38	
39	Total		\$ 107,328			\$ 108,092	\$ *	764	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care# 0029975Report Period Beginning: 01/01/05Ending: 12/31/05

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%	\$ 1,424	\$ 1,424	15
16	V	6 REPAIRS AND MAINT.	17,820	S.I.R. MANAGEMENT, INC.	100.00%	6,909	(10,911)	16
17	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	970	970	17
18	V	10 NURSING	39,204	S.I.R. MANAGEMENT, INC.	100.00%	20,676	(18,528)	18
19	V	15 EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	4,126	4,126	19
20	V	17 ADMINISTRATIVE	69,492	S.I.R. MANAGEMENT, INC.	100.00%	9,521	(59,971)	20
21	V	19 PROFESSIONAL FEES	0	S.I.R. MANAGEMENT, INC.	100.00%	921	921	21
22	V	20 FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	101	101	22
23	V	21 CLERICAL & GENERAL	20,196	S.I.R. MANAGEMENT, INC.	100.00%	13,640	(6,556)	23
24	V	24 EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	232	232	24
25	V	25 OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	2,208	2,208	25
26	V	26 INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	491	491	26
27	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	3,856	3,856	27
28	V	30 DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	2,421	2,421	28
29	V	32 INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(163)	(163)	29
30	V	33 REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	4,193	4,193	30
31	V	35 EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	1,702	1,702	31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 146,712			\$ 73,228	\$ * (73,484)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care# 0029975Report Period Beginning: 01/01/05Ending: 12/31/05

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%	\$ 6,657	\$ (13,539)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	1,362	1,362	16
17	V	17	ADMIN./LEGAL SALARIES	120,000	S.I.R. MANAGEMENT, INC.	100.00%	48,292	(71,708)	17
18	V	19	FINANCIAL CONSULTANT		S.I.R. MANAGEMENT, INC.	100.00%	15,067	15,067	18
19	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	7,560	7,560	19
20	V								20
21	V	17	ADMIN. SALARY-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	3,314	3,314	21
22	V	6	REPAIRS & MAINT.-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	163	163	22
23	V	21	CLERICAL & GEN.-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	337	337	23
24	V	26	AUTO INSURANCE-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	299	299	24
25	V	27	EMP. BENEFITS-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	5,013	5,013	25
26	V	35	AUTO LEASE-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	1,118	1,118	26
27	V								27
28	V	17	ADMIN. SALARY-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	2,077	2,077	28
29	V	21	CLERICAL & GEN.-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	95	95	29
30	V	26	AUTO INSURANCE-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	137	137	30
31	V	27	EMP. BENEFITS-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	4,890	4,890	31
32	V	35	AUTO LEASE-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	1,085	1,085	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 140,196				\$ 97,464	\$ * (42,732)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care# 0029975Report Period Beginning: 01/01/05Ending: 12/31/05

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%	10,624	\$ (6,956)	15
16	V	15 EMP. BEN.-H. CARE & PROG.		S.I.R. MANAGEMENT, INC.	100.00%	2,174	2,174	16
17	V							17
18	V	6 REPAIRS AND MAINT.	7,128	S.I.R. MANAGEMENT, INC.	100.00%	4,630	(2,498)	18
19	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	947	947	19
20	V							20
21	V							21
22	V	1 DIETICIAN SALARIES	12,000	S.I.R. MANAGEMENT, INC.	100.00%	7,132	(4,868)	22
23	V	7 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	1,459	1,459	23
24	V							24
25	V	19 LEGAL FEES	16,044	S.I.R. MANAGEMENT, INC.	100.00%		(16,044)	25
26	V							26
27	V	17 FEES	21,600	S.I.R. MANAGEMENT, INC.	100.00%		(21,600)	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		\$ 74,352			\$ 26,966	\$ * (47,386)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care

0029975

Report Period Beginning: 01/01/05

Ending: 12/31/05

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%	\$ 48,855	\$ 48,855	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INSURANCE	48,855	CCS EMPLOYEE BENEFIT GROUP	100.00%		(48,855)	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			\$ 48,855			\$ 48,855	\$ *	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	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	\$ 0	XCEL MEDICAL SUPPLY, LLC	100.00%	\$ 0		15
16	V	02 FOOD	0	XCEL MEDICAL SUPPLY, LLC	100.00%	0		16
17	V	03 HOUSEKEEPING	15,737	XCEL MEDICAL SUPPLY, LLC	100.00%	14,177	(1,560)	17
18	V	04 LAUNDRY	0	XCEL MEDICAL SUPPLY, LLC	100.00%	0		18
19	V	06 REPAIRS & MAINTENANCE	0	XCEL MEDICAL SUPPLY, LLC	100.00%	0		19
20	V	10 NURSING	19,101	XCEL MEDICAL SUPPLY, LLC	100.00%	17,208	(1,894)	20
21	V	11 ACTIVITIES	0	XCEL MEDICAL SUPPLY, LLC	100.00%	0		21
22	V	20 DUES, FEES, SUBSCRIPTIONS & PROM	0	XCEL MEDICAL SUPPLY, LLC	100.00%	0		22
23	V	21 CLERICAL & GENERAL OFFICE	0	XCEL MEDICAL SUPPLY, LLC	100.00%	0		23
24	V	22 EMPLOYEE BENEFITS	0	XCEL MEDICAL SUPPLY, LLC	100.00%	0		24
25	V	39 ANCILLARY	0	XCEL MEDICAL SUPPLY, LLC	100.00%	0		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		\$ 34,839			\$ 31,385	\$ * (3,454)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care

0029975

Report Period Beginning: 01/01/05

Ending: 12/31/05

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care

0029975

Report Period Beginning: 01/01/05

Ending: 12/31/05

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care

0029975

Report Period Beginning: 01/01/05

Ending: 12/31/05

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/05 Ending: 12/31/05

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	Nenita Guzman	Relative	Dietary		See Attached	5.05	10.10%	Alloc. Salary	\$ 6,657	1-7	1
2	Adam Vales	Relative	Clerical		See Attached	0.32	0.80%	Alloc. Salary	398	22-7	2
3	Byran Barrish	Owner	Administrative	4.86%	See Attached	4.14	10.35%	Alloc. Salary	3,314	17-7	3
4	Howard Geller	Owner	Administrative	4.44%	See Attached	2.00	3.33%	Mgmt Fees	48,000	17-3	4
5	Kim Rudolph	Relative	Clerical		See Attached	0.24	0.69%	Alloc. Salary	241	22-7	5
6	Noah Wolff	Owner	Administrative	5.56%	See Attached	3.00	7.69%	Mgmt Fees	48,000	17-3	6
7	Eric Rothner	Owner	Administrative	20.00%	See Attached	0.73	1.58%	Alloc. Salary	9,450	17-7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 116,060		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

0029975 Report Period Beginning: 01/01/05 Ending: 12/31/05

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care

0029975

Report Period Beginning:

01/01/05

Ending: 12/31/05

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	BOOK./ACCNT.INCOME 936,008	10	\$ 6,321	\$	102,576	\$ 693	1
2	5	UTILITIES	BOOK./ACCNT.INCOME 936,008	10	8,775		102,576	962	2
3	6	REPAIRS AND MAINT.	BOOK./ACCNT.INCOME 936,008	10	10,437		102,576	1,144	3
4	17	ADMIN. FINANCIAL SAL.	BOOK./ACCNT.INCOME 936,008	10	161,494	161,494	102,576	17,698	4
5	19	PROFESSIONAL FEES	BOOK./ACCNT.INCOME 936,008	10	14,763		102,576	1,618	5
6	20	DUES,SUBSCRIPTIONS	BOOK./ACCNT.INCOME 936,008	10	685		102,576	75	6
7	21	CLERICAL	BOOK./ACCNT.INCOME 936,008	10	568,241	511,444	102,576	62,273	7
8	24	SEMINARS	BOOK./ACCNT.INCOME 936,008	10	1,042		102,576	114	8
9	25	ADMIN. STAFF TRAVEL	BOOK./ACCNT.INCOME 936,008	10	6,051		102,576	663	9
10	26	INSURANCE	BOOK./ACCNT.INCOME 936,008	10	3,462		102,576	379	10
11	27	EMPLOYEE BENEFITS	BOOK./ACCNT.INCOME 936,008	10	103,823		102,576	11,378	11
12	30	DEPRECIATION	BOOK./ACCNT.INCOME 936,008	10	15,373		102,576	1,685	12
13	32	INTEREST	BOOK./ACCNT.INCOME 936,008	10	(2,849)		102,576	(312)	13
14	33	REAL ESTATE TAXES	BOOK./ACCNT.INCOME 936,008	10	21,946		102,576	2,405	14
15	35	EQUIPMENT RENTAL	BOOK./ACCNT.INCOME 936,008	10	23,404		102,576	2,565	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				\$ 942,968	\$ 672,937		\$ 108,092	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care

0029975

Report Period Beginning:

01/01/05

Ending: 12/31/05

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	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	5	UTILITIES	PATIENT DAYS	636,443	10	\$ 14,105	\$ 64,262	\$ 1,424	1	
2	6	REPAIRS AND MAINT.	PATIENT DAYS	636,443	10	68,426	46,969	64,262	6,909	2
3	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	636,443	10	9,610		64,262	970	3
4	10	NURSING	PATIENT DAYS	636,443	10	204,773	204,773	64,262	20,676	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	636,443	10	40,863		64,262	4,126	5
6	17	ADMINISTRATIVE	PATIENT DAYS	636,443	10	94,293	94,293	64,262	9,521	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	636,443	10	9,125		64,262	921	7
8	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	636,443	10	999		64,262	101	8
9	21	CLERICAL & GENERAL	PATIENT DAYS	636,443	10	135,090	96,485	64,262	13,640	9
10	24	EDUCATION & SEMINAR	PATIENT DAYS	636,443	10	2,293		64,262	232	10
11	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	636,443	10	21,870		64,262	2,208	11
12	26	INSURANCE	PATIENT DAYS	636,443	10	4,867		64,262	491	12
13	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	636,443	10	38,192		64,262	3,856	13
14	30	DEPRECIATION	PATIENT DAYS	636,443	10	23,979		64,262	2,421	14
15	32	INTEREST	PATIENT DAYS	636,443	10	(1,613)		64,262	(163)	15
16	33	REAL ESTATE TAXES	PATIENT DAYS	636,443	10	41,530		64,262	4,193	16
17	35	EQUIPMENT RENTAL	PATIENT DAYS	636,443	10	16,852		64,262	1,702	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 725,254	\$ 442,521		\$ 73,228	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care

0029975

Report Period Beginning:

01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	DIETARY SALARIES	PATIENT DAYS	636,443	10	\$ 65,932	\$ 65,932	64,262	\$ 6,657	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	636,443	10	13,490		64,262	1,362	2
3	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	636,443	10	478,274	478,274	64,262	48,292	3
4	19	FINANCIAL CONSULTANT	PATIENT DAYS	636,443	10	149,224		64,262	15,067	4
5	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	636,443	10	74,875		64,262	7,560	5
6										6
7	17	ADMIN. SALARY-B. BARRISH	AVG HRS WKD	20	4	16,008	16,008	4	3,314	7
8	6	REPAIRS & MAINT.-B. BARRIS	AVG HRS WKD	20	4	789		4	163	8
9	21	CLERICAL & GEN.-B. BARRIS	AVG HRS WKD	20	4	1,626		4	337	9
10	26	AUTO INSURANCE-B. BARRIS	AVG HRS WKD	20	4	1,444		4	299	10
11	27	EMP. BENEFITS-B. BARRISH	AVG HRS WKD	20	4	24,215		4	5,013	11
12	35	AUTO LEASE-B. BARRISH	AVG HRS WKD	20	4	5,400		4	1,118	12
13										13
14	17	ADMIN. SALARY-M. GIANNINI	AVG HRS WKD	30	4	10,035	10,035	6	2,077	14
15	21	CLERICAL & GEN.-M. GIANNI	AVG HRS WKD	30	4	457		6	95	15
16	26	AUTO INSURANCE-M. GIANNI	AVG HRS WKD	30	4	662		6	137	16
17	27	EMP. BENEFITS-M. GIANNINI	AVG HRS WKD	30	4	23,622		6	4,890	17
18	35	AUTO LEASE-M. GIANNINI	AVG HRS WKD	30	4	5,242		6	1,085	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 871,295	\$ 570,249		\$ 97,464	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care

0029975

Report Period Beginning: 01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	10A	SPECIAL REHAB	SPECIAL REHAB INC.	107,736	7	\$ 65,110	\$ 65,110	17,580	\$ 10,624	1
2	15	EMP. BEN.-H. CARE & PROG.	SPECIAL REHAB INC.	107,736	7	13,322	17,580	2,174		2
3										3
4	6	REPAIRS AND MAINT.	MAINTENANCE INC.	144,648	10	93,966	93,966	7,128	4,630	4
5	7	EMP. BEN.-GEN. SERV.	MAINTENANCE INC.	144,648	10	19,226	7,128	947		5
6										6
7										7
8	1	DIETICIAN SALARIES	DIETICIAN SERVICE INC.	125,400	10	74,533	74,533	12,000	7,132	8
9	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN SERVICE INC.	125,400	10	15,250	12,000	1,459		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					\$ 281,405	\$ 233,608		\$ 26,966	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care

0029975

Report Period Beginning:

01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization 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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	<u>22</u>	<u>EMPLOYEE HEALTH INSURANCE</u>	<u>DIRECT ALLOCATION</u>		\$	\$		\$ 48,855	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				\$	\$		\$ 48,855	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care

0029975

Report Period Beginning: 01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	01	DIETARY	Direct Allocation		\$	\$		\$	1
2	02	FOOD	Direct Allocation						2
3	03	HOUSEKEEPING	Direct Allocation					14,177	3
4	04	LAUNDRY	Direct Allocation						4
5	06	REPAIRS & MAINTENANCE	Direct Allocation						5
6	10	NURSING	Direct Allocation					17,208	6
7	11	ACTIVITIES	Direct Allocation						7
8	20	DUES, FEES, SUBSCRIPTIONS	Direct Allocation						8
9	21	CLERICAL & GENERAL OFFICE	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				\$	\$		\$ 31,385	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care

0029975 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care

0029975 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care

0029975 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	Noruma		X	Mortgage	\$48,561.00	03/01/95	\$ 5,817,265	\$ 5,009,416	02/21/08		\$ 447,174	1								
2												2								
3												3								
4												4								
5	See Supplemental Schedule											5								
Working Capital																				
6	Allocate Preferred		X								(312)	6								
7	Allocate SIR		X								(163)	7								
8	See Supplemental Schedule											8								
9	TOTAL Facility Related				\$48,561.00		\$ 5,817,265	\$ 5,009,416			\$ 446,699	9								
B. Non-Facility Related*																				
10	Interest Income		X								(44,074)	10								
11	Interest Income - Bldg Co.		X								(1,242)	11								
12												12								
13	See Supplemental Schedule											13								
14	TOTAL Non-Facility Related						\$	\$			(45,316)	14								
15	TOTALS (line 9+line14)						\$ 5,817,265	\$ 5,009,416			\$ 401,383	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.)

Facility Name & ID Number

Wilson Care

0029975

Report Period Beginning:

01/01/05

Ending:

12/31/05

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																		
	Working Capital																		
8							\$	\$			\$	8							
9												9							
10												10							
11												11							
12												12							
13												13							
14	TOTAL Working Capital																		
	B. Non-Facility Related*																		
15							\$	\$			\$	15							
16												16							
17												17							
18												18							
19												19							
20	TOTAL Non-Facility Related																		

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

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

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2004 report.		\$ 69,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ 75,343	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 6,343	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 70,800	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.)		\$ 1,028	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.		\$ 78,171	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2000	<u>70,014</u>	<u>8</u>
	2001	<u>71,835</u>	<u>9</u>
	2002	<u>72,641</u>	<u>10</u>
	2003	<u>67,251</u>	<u>11</u>
	2004	<u>68,745</u>	<u>12</u>
Accrual For 2005 \$68,745 x 1.03= \$70,808			
Allocation from SIR - \$4,193			
Allocation from Preferred - \$2,405			

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 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 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 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 Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Wilson Care 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 2004 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 2004.

(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>68,745.00</u>	\$ <u>68,745.00</u>
2. <u>See Attached</u>	<u>See Attached</u>	\$ <u>61,128.74</u>	\$ <u>6,354.35</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>129,873.74</u>	\$ <u>75,099.35</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 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 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 2004 real estate tax costs, as well as copies of your real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 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 Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Wilson Care 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 2004 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 2004.

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2005.

Facility Name & ID Number Wilson Care

0029975 Report Period Beginning:

01/01/05 Ending:

12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 42,020 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 5

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

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

Facility Name & ID Number Wilson Care

0029975

Report Period Beginning:

01/01/05

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XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
Improvement Type**											
9	Various			1985	65,366		20			65,340	9
10	Various			1986	161,365		20	3,740	3,740	161,346	10
11	Various			1987	49,380		20	2,593	2,593	48,578	11
12	Various			1989	49,210		20	2,461	2,461	40,748	12
13	Various			1990	105,470		20	5,274	5,274	79,556	13
14	Various			1991	29,903		20	1,494	1,494	21,767	14
15	Various			1992	69,669		20	3,484	3,484	47,228	15
16	Various			1993	61,688		20	3,087	3,087	38,529	16
17	Various			1994	55,691		20	2,654	2,654	32,925	17
18	Various			1995	87,144		20	4,360	4,360	45,768	18
19	Various			1996	303,393		20	15,172	15,172	143,172	19
20	Various			1997	145,411		20	7,348	7,348	57,100	20
21	Various			1998	34,959		20	1,748	1,748	13,193	21
22	Various			1999	64,557		20	3,229	3,229	21,044	22
23	Various			2000	342,218		20	17,110	17,110	90,709	23
24	Various			2001	102,633		20	5,132	5,132	23,933	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

0029975

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		1,539,800	1,181		19,088	17,907	1,558,888	67
68		86,182	2,929		3,393	464	35,719	68
69			89,565			(89,565)		69
70		\$ 3,354,039	\$ 93,675		\$ 101,367	\$ 7,692	\$ 2,525,543	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

0029975

Report Period Beginning:

01/01/05

Ending:

12/31/05

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		\$ 3,354,039	\$ 93,675		\$ 101,367	\$ 7,692	\$ 2,525,543	1
2	Plumbing	2002	24,086		20	2,409	2,409	8,029	2
3	Module & Cable	2002	9,897		20	1,979	1,979	6,433	3
4	Plumbing Repair	2002	1,076		20	108	108	430	4
5	Freezer Motor	2002	1,151		20	230	230	902	5
6	Repair Walk In Freezer	2002	1,007		20	201	201	789	6
7	Strainer Basket On Sinks	2002	1,150		20	115	115	441	7
8	Wall Repair	2002	2,950		20	295	295	1,106	8
9	Hot Water Heater	2002	1,120		20	112	112	420	9
10	Blinds	2002	1,194		20	119	119	418	10
11	Bathtub Liner	2002	716		20	72	72	263	11
12	Door	2002	1,608		20	161	161	549	12
13	Window Treatments	2002	2,493		20	249	249	852	13
14	Paint	2002	814		20			814	14
15	Heater	2002	1,698		20	170	170	566	15
16	Dry Wall	2002	3,000		20	300	300	1,000	16
17	Bathtub Liner	2002	631		20	63	63	205	17
18	Boiler	2002	2,004		20	200	200	651	18
19	Paint	2002	512		20			512	19
20	Bathtub Liner	2002	1,848		20	185	185	601	20
21	Wall Cover	2002	5,031		20			5,031	21
22	Dry Wall	2002	4,000		20	400	400	1,300	22
23	Elevator Door Lock	2003	2,341		20	234	234	644	23
24	Roofing Work	2003	2,475		20	124	124	299	24
25	Plumbing	2003	13,800		20	690	690	1,668	25
26	Sewer Pipe Work	2003	4,300		20	215	215	502	26
27	Sewer Pipe Work	2003	3,000		20	150	150	350	27
28	Steam Pipes	2003	4,279		20	214	214	642	28
29	Fire Alarm Wiring	2003	2,935		20	147	147	416	29
30	Elevator Work	2003	2,020		20	101	101	278	30
31	Elevator Work	2003	3,239		20	162	162	445	31
32	Fire Proof Door	2003	17,075		20	1,708	1,708	3,842	32
33	New Windows	2003	3,300		20	165	165	344	33
34	TOTAL (lines 1 thru 33)		\$ 3,480,789	\$ 93,675		\$ 112,645	\$ 18,970	\$ 2,566,285	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

0029975

Report Period Beginning:

01/01/05

Ending:

12/31/05

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		\$ 3,480,789	\$ 93,675		\$ 112,645	\$ 18,970	\$ 2,566,285	1
2	Handrails	2003	3,906		20	391	391	814	2
3	Elevator Work	2003	3,429		20	171	171	357	3
4	Elevator Work	2003	3,547		20	177	177	369	4
5	Upgrade Kitchen System	2003	1,785		20	89	89	245	5
6	Sprinkler System	2003	5,130		20	257	257	577	6
7	Cubicle Curtains	2003	2,123		20	106	106	318	7
8	Exit Devices	2003	1,470		20	74	74	202	8
9	Doors	2003	921		20	46	46	127	9
10	Blinds	2003	1,305		20	65	65	179	10
11	Bathtub Liner	2003	1,250		20	63	63	172	11
12	Electrical Work	2003	1,673		20	84	84	230	12
13	Bath Tub Wall Panel	2003	1,013		20	51	51	139	13
14	Ten Windows	2003	1,417		20	71	71	195	14
15	Wall Tiles	2003	2,875		20	144	144	323	15
16	A/C Window Supports	2003	2,349		20	117	117	254	16
17	Emt Installation	2003	1,458		20	73	73	152	17
18	Courtyard Fence Work	2003	2,772		20	139	139	347	18
19	Bathroom Work	2004			20				19
20	Bathroom Work	2004	3,380		20	169	169	296	20
21	New Windows	2004	19,936		20	997	997	1,578	21
22	Stairwell Gate	2004	1,119		20	112	112	177	22
23	Walk-In-Freezer Work	2004			20				23
24	Walk-In-Freezer Work	2004	2,357		20	118	118	187	24
25	Cubicle Dividers	2004			20				25
26	Cubicle Dividers	2004	3,655		20	183	183	274	26
27	Doors	2004			20				27
28	Doors	2004	7,200		20	360	360	420	28
29	Wall Surround And Bath Tub Liner	2004	1,300		20	130	130	260	29
30	Bath Tub Liner #204	2004	625		20	63	63	104	30
31	Wall Surround #517	2004	725		20	73	73	103	31
32	Wall Surround #405	2004	725		20	73	73	103	32
33	Wall Surround #217	2004	725		20	73	73	103	33
34	TOTAL (lines 1 thru 33)		\$ 3,560,959	\$ 93,675		\$ 117,114	\$ 23,439	\$ 2,574,890	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

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		\$ 3,560,959	\$ 93,675		\$ 117,114	\$ 23,439	\$ 2,574,890	1
2	Wall Surround #417	2004	725		20	73	73	103	2
3	Bathroom Repair Work	2004	2,475		20	248	248	351	3
4	Replace Drywall And Build Retaining Wall	2004	1,600		20	160	160	213	4
5	Bathroom Repair Work	2004	2,800		20	280	280	327	5
6	Repipe Bathroom Radiator	2004	1,802		20	180	180	210	6
7	Boiler Repair And Boiler Reset Control	2004	1,745		20	174	174	189	7
8	Reline Elevator Brake Shoes	2004	2,189		20	219	219	347	8
9	Replace 44 Smoke Detectors	2004	5,770		20	577	577	1,106	9
10	Elevator Work	2004	1,480		20	74	74	148	10
11	Elevator Work*	2005	5,670		20	473	473	473	11
12	Plumbing Work*	2005	12,800		20	427	427	427	12
13	Walk - In Freezer*	2005	42,000		20	1,225	1,225	1,225	13
14	Roof Work*	2005	6,500		20	190	190	190	14
15	Roof Work*	2005	48,750		20	2,844	2,844	2,844	15
16	Roof Work*	2005	5,200		20	152	152	152	16
17	Wall Repair	2005	2,800		20	58	58	58	17
18	Plumbing Work	2005	6,350		20	132	132	132	18
19	Cubicle Tracks	2005	4,615		20	96	96	96	19
20	Hvac Work	2005	2,269		20	47	47	47	20
21	Flooring - Tile*	2005	10,317		20	43	43	43	21
22	Sprinkler System	2005	4,785		20	60	60	60	22
23	Boiler Work	2005	4,699		20	59	59	59	23
24	Alarm System	2005	3,031		20	25	25	25	24
25	Carpeting	2005	1,787		20	89	89	89	25
26	Blinds	2005	3,233		20	162	162	162	26
27	Wall Panels	2005	2,053		20	103	103	103	27
28	Replacement Well	2005	1,644		20	82	82	82	28
29	Railing	2005	1,780		20	89	89	89	29
30	Radiator Repiping*	2005	1,444		20	72	72	72	30
31	Radiator Repiping*	2005	1,455		20	73	73	73	31
32	Radiator Repiping*	2005	908		20	45	45	45	32
33	Masonry*	2005	32,650		20	1,633	1,633	1,633	33
34	TOTAL (lines 1 thru 33)		\$ 3,788,285	\$ 93,675		\$ 127,278	\$ 33,603	\$ 2,586,063	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

0029975

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 3,788,285	\$ 93,675		\$ 127,278	\$ 33,603	\$ 2,586,063	1
2	Masonry	2005	9,870		20	987	987	987	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,798,155	\$ 93,675		\$ 128,265	\$ 34,590	\$ 2,587,050	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

0029975

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 3,798,155	\$ 93,675		\$ 128,265	\$ 34,590	\$ 2,587,050	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 3,798,155	\$ 93,675		\$ 128,265	\$ 34,590	\$ 2,587,050	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

0029975

Report Period Beginning:

01/01/05

Ending:

12/31/05

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	\$ 3,798,155	\$ 93,675		\$ 128,265	\$ 34,590	\$ 2,587,050		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
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20									20
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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)	\$ 3,798,155	\$ 93,675		\$ 128,265	\$ 34,590	\$ 2,587,050		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

0029975

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12G, Carried Forward	\$ 3,798,155	\$ 93,675		\$ 128,265	\$ 34,590	\$ 2,587,050		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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24									24
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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)	\$ 3,798,155	\$ 93,675		\$ 128,265	\$ 34,590	\$ 2,587,050		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

0029975

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 3,798,155	\$ 93,675		\$ 128,265	\$ 34,590	\$ 2,587,050	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 3,798,155	\$ 93,675		\$ 128,265	\$ 34,590	\$ 2,587,050	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

0029975

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 3,798,155	\$ 93,675		\$ 128,265	\$ 34,590	\$ 2,587,050	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
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21								21
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24								24
25								25
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27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 3,798,155	\$ 93,675		\$ 128,265	\$ 34,590	\$ 2,587,050	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

0029975

Report Period Beginning:

01/01/05

Ending:

12/31/05

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	\$ 3,798,155	\$ 93,675		\$ 128,265	\$ 34,590	\$ 2,587,050		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 3,798,155	\$ 93,675		\$ 128,265	\$ 34,590	\$ 2,587,050		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

0029975

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	198		1985		\$ 1,539,800	\$ 1,181		\$ 19,088	\$ 17,907	\$ 1,558,888	4
5											5
6											6
7											7
8											8
Improvement Type**											
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

0029975

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 1,539,800	\$ 1,181		\$ 19,088	\$ 17,907	\$ 1,558,888	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

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Alloc SIR		1993	1993	\$ 15,475	\$ 491	35	\$ 442	\$ (49)	\$ 5,527	4
5	Alloc SIR		1993	1993	26,980	857	35	771	(86)	9,636	5
6											6
7											7
8											8
	Improvement Type**										
9	Preferred Bookkeeping - Allocation			1993	19,325	433	20	966	533	8,512	9
10	Preferred Bookkeeping - Allocation			1999	153	-	20	8	8	50	10
11	Preferred Bookkeeping - Allocation			2000	969	-	20	48	48	262	11
12											
13	SIR Properties - Preferred Bookkeeping - Allocation			2002	61	-	20	3	3	11	13
14	SIR Properties - Preferred Bookkeeping - Allocation			1999	1,961	196	20	98	(98)	637	14
15	SIR Properties - Preferred Bookkeeping - Allocation			1998	937	94	20	47	(47)	351	15
16	SIR Properties - Preferred Bookkeeping - Allocation			1997	58	6	20	3	(3)	28	16
17	SIR Properties - Preferred Bookkeeping - Allocation			1994	147	4	20	7	3	85	17
18	SIR Properties - Preferred Bookkeeping - Allocation			1993	251	1	20	13	12	157	18
19											
20	SIR Management - Allocation			1993	11,588	323	20	575	252	7,469	20
21	SIR Management - Allocation			1994	36	-	20	-	-	36	21
22	SIR Management - Allocation			1995	265	-	20	13	13	138	22
23	SIR Management - Allocation			1999	1,259	-	20	63	63	391	23
24	SIR Management - Allocation			2000	760	-	20	38	38	216	24
25											
26	SIR Properties - SIR Management			2002	107	-	20	5	5	19	26
27	SIR Properties - SIR Management			1999	3,419	342	20	171	(171)	1,111	27
28	SIR Properties - SIR Management			1998	1,634	163	20	82	(81)	613	28
29	SIR Properties - SIR Management			1997	102	10	20	5	(5)	48	29
30	SIR Properties - SIR Management			1994	257	7	20	13	6	148	30
31	SIR Properties - SIR Management			1993	438	2	20	22	20	274	31
32											
33											
34											
35											
36											

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

0029975

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70
		86,182	2,929		3,393	464	35,719	

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 # 0029975 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 450,786	\$ 1,002	\$ 28,398	\$ 27,396	10	\$ 350,110	71
72	Current Year Purchases	30,220	176	1,684	1,508	10	1,684	72
73	Fully Depreciated Assets	440,168				10	440,168	73
74								74
75	TOTALS	\$ 921,174	\$ 1,178	\$ 30,082	\$ 28,904		\$ 791,962	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)	\$ 4,732,629	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 94,853	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 158,347	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 63,494	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,379,012	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care

0029975

Report Period Beginning: 01/01/05

Ending: 12/31/05

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.	_____ /2006	\$ _____
13.	_____ /2007	\$ _____
14.	_____ /2008	\$ _____

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: \$ 11,736

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>422.00</u>	\$ <u>3,361</u>	17
18	<u>Allocate SIR</u>			<u>2,203</u>	18
19					19
20					20
21	TOTAL		\$ 422.00	\$ 5,564	21

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5 Units Cost					
					Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist	N/A	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 CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care# 0029975Report Period Beginning: 01/01/05

Ending:

12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/05

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 20,036	\$ 22,451	1
2	Cash-Patient Deposits	17,939	17,939	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,138,955	1,138,955	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	6,466	6,466	6
7	Other Prepaid Expenses	3,465	3,465	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	739,072	739,072	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,925,933	\$ 1,928,348	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	1,351,874	1,351,874	15
16	Equipment, at Historical Cost	1,237,835	1,267,835	16
17	Accumulated Depreciation (book methods)	(1,644,966)	(3,246,257)	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): <u>See Attached Schedule</u>		23,352	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 944,743	\$ 993,295	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,870,676	\$ 2,921,643	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 73,103	\$ 73,103	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	18,178	18,178	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	132,750	132,750	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,998	9,998	31
32	Accrued Real Estate Taxes(Sch.IX-B)	70,800	70,800	32
33	Accrued Interest Payable		25,394	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	20,500	20,500	35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	909	909	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 326,238	\$ 351,632	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,009,416	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 5,009,416	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 326,238	\$ 5,361,048	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,544,438	\$ (2,439,405)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,870,676	\$ 2,921,643	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,241,592	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,241,592	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,166,846	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)	\$ 302,846	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)	\$ 2,544,438	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care

0029975

Report Period Beginning: 01/01/05

Ending: 12/31/05

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	\$ 5,890,142	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,890,142	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	44,074	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 44,074	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	1,231	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,231	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,935,447	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,039,404	31
32	Health Care	1,545,158	32
33	General Administration	1,290,414	33
B. Capital Expense			
34	Ownership	785,220	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	108,405	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,768,601	40
41	Income before Income Taxes (line 30 minus line 40)**	1,166,846	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,166,846	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

0029975

Report Period Beginning:

01/01/05

Ending:

12/31/05

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	1,641	1,974	\$ 64,144	\$ 32.49	1
2	Assistant Director of Nursing	1,431	1,743	46,754	26.82	2
3	Registered Nurses	2,334	2,463	59,182	24.03	3
4	Licensed Practical Nurses	8,956	9,352	198,418	21.22	4
5	CNAs & Orderlies	52,298	55,780	497,416	8.92	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,952	2,084	29,657	14.23	9
10	Activity Assistants	8,723	9,538	77,553	8.13	10
11	Social Service Workers	19,494	20,728	294,993	14.23	11
12	Dietician					12
13	Food Service Supervisor	1,989	2,086	37,031	17.75	13
14	Head Cook	3,100	3,419	33,270	9.73	14
15	Cook Helpers/Assistants	16,838	17,902	131,285	7.33	15
16	Dishwashers					16
17	Maintenance Workers	3,915	4,145	47,157	11.38	17
18	Housekeepers	15,906	17,240	135,814	7.88	18
19	Laundry					19
20	Administrator	1,925	2,126	85,216	40.08	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,209	12,717	143,076	11.25	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,914	2,569	59,395	23.12	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	4,802	4,802	15,569	3.24	33
34	TOTAL (lines 1 - 33)	159,427	170,668	\$ 1,955,930 *	\$ 11.46	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	\$ 32,196	01-03	35
36	Medical Director	Monthly	3,300	09-03	36
37	Medical Records Consultant	98	4,224	10-03	37
38	Nurse Consultant	1,079	39,204	10-03	38
39	Pharmacist Consultant	47	3,207	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	<u>Rehab Consultant</u>	Monthly	17,580	10a-03	47
48	<u>Psychiatric Director</u>	Monthly	4,950	10-03	48
49	TOTAL (lines 35 - 48)	1,224	\$ 104,661		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	30	\$ 1,578	10-03	50
51	Licensed Practical Nurses	2,498	89,054	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	2,528	\$ 90,632		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care

Report Period Beginning: 01/01/05 Ending:

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2002	6 FY2003	7 FY2004	8 FY2005	9 FY2006	10 FY2007	11 FY2008	12 FY2009	13 FY2010
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

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IL Council - \$10,157
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 8,675 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 during this cost report period. \$ 108,405
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, 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. \$ 20,531 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