

		FOR BHF USE					

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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 01/01/06 to 12/31/06 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: 01/01/06 Ending: 12/31/06

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>61,481</u>	<u>1,823</u>		<u>63,304</u>
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	<u>61,481</u>	<u>1,823</u>		<u>63,304</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.59%

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

812 (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: 12/31/06 Fiscal Year: 12/31/06

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

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	205,928	28,456	31,409	265,793		265,793	(18,087)	247,706			1
2	Food Purchase		250,121		250,121	(19,874)	230,247	(72)	230,175			2
3	Housekeeping	132,655	46,848		179,503		179,503	(869)	178,634			3
4	Laundry		18,615	5,763	24,378		24,378		24,378			4
5	Heat and Other Utilities			146,250	146,250		146,250	2,576	148,826			5
6	Maintenance	47,344	32,721	150,542	230,607		230,607	(34,868)	195,739			6
7	Other (specify):*							6,690	6,690			7
8	TOTAL General Services	385,927	376,761	333,964	1,096,652	(19,874)	1,076,778	(44,630)	1,032,148			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	1,008,152	22,588	137,239	1,167,979		1,167,979	(21,906)	1,146,073			10
10a	Therapy			17,580	17,580		17,580	(6,279)	11,301			10a
11	Activities	102,780	6,997	980	110,757		110,757		110,757			11
12	Social Services	296,883	9,817		306,700		306,700		306,700			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							5,514	5,514			15
16	TOTAL Health Care and Programs	1,407,815	39,402	159,399	1,606,616		1,606,616	(22,671)	1,583,945			16
	C. General Administration											
17	Administrative	88,463		307,217	395,680		395,680	(130,377)	265,303			17
18	Directors Fees											18
19	Professional Services			167,444	167,444	(17,500)	149,944	(112,375)	37,569			19
20	Dues, Fees, Subscriptions & Promotions			54,891	54,891		54,891	(24,942)	29,949			20
21	Clerical & General Office Expenses	172,958	30,182	145,517	348,657		348,657	(49,198)	299,459			21
22	Employee Benefits & Payroll Taxes			322,205	322,205	19,874	342,079	(1,029)	341,050			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,390	2,390		2,390	384	2,774			24
25	Other Admin. Staff Transportation			5,583	5,583		5,583	3,141	8,724			25
26	Insurance-Prop.Liab.Malpractice			147,544	147,544		147,544	(686)	146,858			26
27	Other (specify):*							34,374	34,374			27
28	TOTAL General Administration	261,421	30,182	1,152,791	1,444,394	2,374	1,446,768	(280,707)	1,166,061			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,055,163	446,345	1,646,154	4,147,662	(17,500)	4,130,162	(348,008)	3,782,154			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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			83,820	83,820		83,820	71,884	155,704			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							379,653	379,653			32
33	Real Estate Taxes			75,160	75,160	17,500	92,660	7,104	99,764			33
34	Rent-Facility & Grounds			614,280	614,280		614,280	(614,280)				34
35	Rent-Equipment & Vehicles			6,797	6,797		6,797	6,337	13,134			35
36	Other (specify):*							10,991	10,991			36
37	TOTAL Ownership			780,057	780,057	17,500	797,557	(138,311)	659,246			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)	2,055,163	446,345	2,534,616	5,036,124		5,036,124	(486,319)	4,549,805			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: 01/01/06

Ending: 12/31/06

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	67,930	30		9
10	Interest and Other Investment Income	(53,443)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(72)	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	(12,980)	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	(98,023)	21		24
25	Fund Raising, Advertising and Promotional	(7,699)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(14,500)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(21,359)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (140,146)		\$	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)	(346,173)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (346,173)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (486,319)		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

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Wilson Care ID# 0029975
 Report Period Beginning: 01/01/06
 Ending: 12/31/06

NON-ALLOWABLE EXPENSES	Amount	Sch. V Line	Reference
1			1
2			2
3			3
4			4
5			5
6			6
7			7
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10			10
11			11
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96			96
97			97
98			98
99			99
100			100
101 Total	(21,359)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Wilson Care# 0029975

Report Period Beginning:

01/01/06

Ending:

12/31/06**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					(13,227)	(4,860)						(18,087)	1
2	Food Purchase	(72)											(72)	2
3	Housekeeping			850					(1,719)				(869)	3
4	Laundry													4
5	Heat and Other Utilities			1,124	1,452								2,576	5
6	Maintenance	(12,986)		1,012	(9,892)	77	(13,079)						(34,868)	6
7	Other (specify):*				969	1,322	4,399						6,690	7
8	TOTAL General Services	(13,058)		2,986	(7,471)	(11,828)	(13,540)		(1,719)				(44,630)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records				(20,391)				(1,515)				(21,906)	10
10a	Therapy						(6,279)						(6,279)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				3,369		2,145						5,514	15
16	TOTAL Health Care and Programs				(17,022)		(4,134)		(1,515)				(22,671)	16
	C. General Administration													
17	Administrative			18,514	(58,864)	(68,427)	(21,600)						(130,377)	17
18	Directors Fees													18
19	Professional Services	(918)		(110,948)	269	15,266	(16,044)						(112,375)	19
20	Fees, Subscriptions & Promotions	(25,644)		298	404								(24,942)	20
21	Clerical & General Office Expenses	(113,249)	706	64,379	(1,339)	305							(49,198)	21
22	Employee Benefits & Payroll Taxes							(1,029)					(1,029)	22
23	Inservice Training & Education													23
24	Travel and Seminar			101	283								384	24
25	Other Admin. Staff Transportation			643	2,498								3,141	25
26	Insurance-Prop.Liab.Malpractice	(1,764)		354	532	192							(686)	26
27	Other (specify):*			11,622	4,628	18,124							34,374	27
28	TOTAL General Administration	(141,575)	706	(15,037)	(51,589)	(34,539)	(37,644)	(1,029)					(280,707)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(154,633)	706	(12,051)	(76,082)	(46,367)	(55,318)	(1,029)	(3,234)				(348,008)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Wilson Care

0029975

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	67,930		1,819	2,135								71,884	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(53,443)	433,194	(582)	484								379,653	32
33	Real Estate Taxes			2,615	4,489								7,104	33
34	Rent-Facility & Grounds		(614,280)										(614,280)	34
35	Rent-Equipment & Vehicles			2,232	2,088	2,017							6,337	35
36	Other (specify):*		10,991										10,991	36
37	TOTAL Ownership	14,487	(170,095)	6,084	9,196	2,017							(138,311)	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)	(140,146)	(169,389)	(5,967)	(66,886)	(44,350)	(55,318)	(1,029)	(3,234)				(486,319)	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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rental Income	\$ 614,280	Wilson Care, LLC	100.00%	\$	\$ (614,280)	1
2	V	33 Rent Real Estate Tax	75,160	Wilson Care, LLC	100.00%		(75,160)	2
3	V	36 Amortization of Loan Fees		Wilson Care, LLC	100.00%	10,991	10,991	3
4	V	21 Replacement Tax		Wilson Care, LLC	100.00%	526	526	4
5	V	32 Mortgage Interest		Wilson Care, LLC	100.00%	434,735	434,735	5
6	V	21 Office Expenses		Wilson Care, LLC	100.00%	180	180	6
7	V	33 Real Estate Taxes		Wilson Care, LLC	100.00%	75,160	75,160	7
8	V	32 Interest Income	1,541	Wilson Care, LLC	100.00%		(1,541)	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 690,981			\$ 521,592	\$ * (169,389)	14

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

Facility Name & ID Number Wilson Care# 0029975Report Period Beginning: 01/01/06Ending: 12/31/06

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%	\$ 850	850	15
16	V	5 UTILITIES		PREFERRED BOOKKEEPING	100.00%	1,124	1,124	16
17	V	6 REPAIRS AND MAINT.		PREFERRED BOOKKEEPING	100.00%	1,012	1,012	17
18	V	17 ADMIN. FINANCIAL SAL.		PREFERRED BOOKKEEPING	100.00%	18,514	18,514	18
19	V	19 PROFESSIONAL FEES		PREFERRED BOOKKEEPING	100.00%	1,206	1,206	19
20	V	20 DUES,SUBSCRIPTIONS		PREFERRED BOOKKEEPING	100.00%	298	298	20
21	V	21 CLERICAL		PREFERRED BOOKKEEPING	100.00%	64,379	64,379	21
22	V	24 SEMINARS		PREFERRED BOOKKEEPING	100.00%	101	101	22
23	V	25 ADMIN. STAFF TRAVEL		PREFERRED BOOKKEEPING	100.00%	643	643	23
24	V	26 INSURANCE		PREFERRED BOOKKEEPING	100.00%	354	354	24
25	V	27 EMPLOYEE BENEFITS		PREFERRED BOOKKEEPING	100.00%	11,622	11,622	25
26	V	30 DEPRECIATION		PREFERRED BOOKKEEPING	100.00%	1,819	1,819	26
27	V	32 INTEREST		PREFERRED BOOKKEEPING	100.00%	(582)	(582)	27
28	V	33 REAL ESTATE TAXES		PREFERRED BOOKKEEPING	100.00%	2,615	2,615	28
29	V	35 EQUIPMENT RENTAL		PREFERRED BOOKKEEPING	100.00%	2,232	2,232	29
30	V							30
31	V							31
32	V	19 ACCOUNT./BOOKKEEPING	112,154	PREFERRED BOOKKEEPING	100.00%		(112,154)	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		\$ 116,906			\$ 110,939	\$ * (5,967)	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: 01/01/06Ending: 12/31/06

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%	\$ 1,452	1,452	15
16	V	6 REPAIRS AND MAINT.	17,820	S.I.R. MANAGEMENT, INC.	100.00%	7,928	(9,892)	16
17	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	969	969	17
18	V	10 NURSING	39,204	S.I.R. MANAGEMENT, INC.	100.00%	18,813	(20,391)	18
19	V	15 EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	3,369	3,369	19
20	V	17 ADMINISTRATIVE	69,492	S.I.R. MANAGEMENT, INC.	100.00%	10,628	(58,864)	20
21	V	19 PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	269	269	21
22	V	20 FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	404	404	22
23	V	21 CLERICAL & GENERAL	20,196	S.I.R. MANAGEMENT, INC.	100.00%	18,857	(1,339)	23
24	V	24 EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	283	283	24
25	V	25 OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	2,498	2,498	25
26	V	26 INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	532	532	26
27	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	4,628	4,628	27
28	V	30 DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	2,135	2,135	28
29	V	32 INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	484	484	29
30	V	33 REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	4,489	4,489	30
31	V	35 EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	2,088	2,088	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			\$ 79,826	\$ * (66,886)	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: 01/01/06Ending: 12/31/06

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%	\$ 6,969	(13,227)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	1,322	1,322	16
17	V	17	ADMIN./LEGAL SALARIES	120,000	S.I.R. MANAGEMENT, INC.	100.00%	46,479	(73,521)	17
18	V	19	FINANCIAL CONSULTANT		S.I.R. MANAGEMENT, INC.	100.00%	15,266	15,266	18
19	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	7,662	7,662	19
20	V								20
21	V	17	ADMIN. SALARY-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	3,086	3,086	21
22	V	6	REPAIRS & MAINT.-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	77	77	22
23	V	21	CLERICAL & GEN.-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	229	229	23
24	V	26	AUTO INSURANCE-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	67	67	24
25	V	27	EMP. BENEFITS-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	5,281	5,281	25
26	V	35	AUTO LEASE-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	1,068	1,068	26
27	V								27
28	V	17	ADMIN. SALARY-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	2,009	2,009	28
29	V	21	CLERICAL & GEN.-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	76	76	29
30	V	26	AUTO INSURANCE-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	125	125	30
31	V	27	EMP. BENEFITS-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	5,181	5,181	31
32	V	35	AUTO LEASE-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	948	948	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 140,196				\$ 95,846	\$ * (44,350)	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: 01/01/06Ending: 12/31/06

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%	11,301	\$	(6,279)	15
16	V	15 EMP. BEN.-H. CARE & PROG.		S.I.R. MANAGEMENT, INC.	100.00%	2,145		2,145	16
17	V								17
18	V	6 REPAIRS AND MAINT.	33,120	S.I.R. MANAGEMENT, INC.	100.00%	20,041		(13,079)	18
19	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	3,803		3,803	19
20	V								20
21	V								21
22	V	1 DIETICIAN SALARIES	8,000	S.I.R. MANAGEMENT, INC.	100.00%	3,140		(4,860)	22
23	V	7 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	596		596	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 COUNCIL DUES	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		\$ 96,344			\$ 41,026	\$ *	(55,318)	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	22	EMPLOYEE HEALTH INSURANCE	\$	CCS EMPLOYEE BENEFIT GROUP	100.00%	\$ 50,829	\$ 50,829	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INSURANCE	51,858	CCS EMPLOYEE BENEFIT GROUP	100.00%		(51,858)	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			\$ 51,858			\$ 50,829	\$ * (1,029)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01 Dietary	\$	Xcel Supply, LLC	100.00%	\$		15
16	V	03 Housekeeping	21,193	Xcel Supply, LLC	100.00%	19,475	(1,719)	16
17	V	04 Laundry		Xcel Supply, LLC	100.00%			17
18	V	06 Repairs & Maintenance		Xcel Supply, LLC	100.00%			18
19	V	10 Nursing	18,685	Xcel Supply, LLC	100.00%	17,170	(1,515)	19
20	V	11 Activities		Xcel Supply, LLC	100.00%			20
21	V	12 Social Service		Xcel Supply, LLC	100.00%			21
22	V	20 Dues, Fees, Subscriptions & Promotions		Xcel Supply, LLC	100.00%			22
23	V	21 Clerical & General Office		Xcel Supply, LLC	100.00%			23
24	V	22 Employee Benefits		Xcel Supply, LLC	100.00%			24
25	V	24 Seminars & Education		Xcel Supply, LLC	100.00%			25
26	V	39 Ancillary		Xcel Supply, LLC	100.00%			26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 39,878			\$ 36,644	\$ * (3,234)	39

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

Facility Name & ID Number Wilson Care

0029975

Report Period Beginning: 01/01/06

Ending: 12/31/06

VII. RELATED PARTIES (continued)

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

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

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

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

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			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care

0029975

Report Period Beginning: 01/01/06

Ending: 12/31/06

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/06 Ending: 12/31/06

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Bryan Barrish	Shareholder	Administrative	4.86%	See Attached	4.07	10.18%	Alloc. Salary	\$ 3,086	17-7	1
2	Eric Rothner	Shareholder	Administrative	20.00%	See Attached	0.71	1.54%	Alloc. Salary	9,079	17-7	2
3	Nenita Guzman	Relative	Dietary	0.00%	See Attached	5.09	10.18%	Alloc. Salary	6,969	1-7	3
4	Noah Wolff	Shareholder	Administrative	5.56%	See Attached	3.00	7.69%	Mgmt. Fee	48,000	17-3	4
5	Howard Geller	Shareholder	Administrative	4.44%	See Attached	2.67	44.50%	Mgmt. Fee	48,000	17-3	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 115,134		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: 01/01/06 Ending: 12/31/06

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:

01/01/06

Ending: 12/31/06

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 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

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 999,524	10	\$ 7,576	\$	112,154	\$ 850	1
2	5	UTILITIES	BOOK./ACCNT.INCOME 999,524	10	10,021		112,154	1,124	2
3	6	REPAIRS AND MAINT.	BOOK./ACCNT.INCOME 999,524	10	9,017		112,154	1,012	3
4	17	ADMIN. FINANCIAL SAL.	BOOK./ACCNT.INCOME 999,524	10	165,000	165,000	112,154	18,514	4
5	19	PROFESSIONAL FEES	BOOK./ACCNT.INCOME 999,524	10	10,747		112,154	1,206	5
6	20	DUES,SUBSCRIPTIONS	BOOK./ACCNT.INCOME 999,524	10	2,655		112,154	298	6
7	21	CLERICAL	BOOK./ACCNT.INCOME 999,524	10	573,753	512,109	112,154	64,379	7
8	24	SEMINARS	BOOK./ACCNT.INCOME 999,524	10	898		112,154	101	8
9	25	ADMIN. STAFF TRAVEL	BOOK./ACCNT.INCOME 999,524	10	5,727		112,154	643	9
10	26	INSURANCE	BOOK./ACCNT.INCOME 999,524	10	3,157		112,154	354	10
11	27	EMPLOYEE BENEFITS	BOOK./ACCNT.INCOME 999,524	10	103,576		112,154	11,622	11
12	30	DEPRECIATION	BOOK./ACCNT.INCOME 999,524	10	16,212		112,154	1,819	12
13	32	INTEREST	BOOK./ACCNT.INCOME 999,524	10	(5,190)		112,154	(582)	13
14	33	REAL ESTATE TAXES	BOOK./ACCNT.INCOME 999,524	10	23,306		112,154	2,615	14
15	35	EQUIPMENT RENTAL	BOOK./ACCNT.INCOME 999,524	10	19,888		112,154	2,232	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				\$ 946,343	\$ 677,109		\$ 110,939	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care

0029975

Report Period Beginning:

01/01/06

Ending: 12/31/06

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	5	UTILITIES	PATIENT DAYS	621,946	10	\$ 14,269	\$ 63,304	\$ 1,452	1	
2	6	REPAIRS AND MAINT.	PATIENT DAYS	621,946	10	77,891	51,158	63,304	7,928	2
3	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	621,946	10	9,520		63,304	969	3
4	10	NURSING	PATIENT DAYS	621,946	10	184,832	184,832	63,304	18,813	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	621,946	10	33,100		63,304	3,369	5
6	17	ADMINISTRATIVE	PATIENT DAYS	621,946	10	104,417	104,417	63,304	10,628	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	621,946	10	2,646		63,304	269	7
8	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	621,946	10	3,970		63,304	404	8
9	21	CLERICAL & GENERAL	PATIENT DAYS/DIRECT	621,946	10	163,095	125,172	63,304	18,857	9
10	24	EDUCATION & SEMINAR	PATIENT DAYS	621,946	10	2,778		63,304	283	10
11	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	621,946	10	24,542		63,304	2,498	11
12	26	INSURANCE	PATIENT DAYS	621,946	10	5,228		63,304	532	12
13	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS/DIRECT	621,946	10	41,464		63,304	4,628	13
14	30	DEPRECIATION	PATIENT DAYS	621,946	10	20,978		63,304	2,135	14
15	32	INTEREST	PATIENT DAYS	621,946	10	4,752		63,304	484	15
16	33	REAL ESTATE TAXES	PATIENT DAYS	621,946	10	44,103		63,304	4,489	16
17	35	EQUIPMENT RENTAL	PATIENT DAYS	621,946	10	20,518		63,304	2,088	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 758,103	\$ 465,579		\$ 79,826	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care

0029975

Report Period Beginning:

01/01/06

Ending: 12/31/06

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	621,946	10	\$ 68,465	\$ 68,465	63,304	\$ 6,969	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	621,946	10	12,992		63,304	1,322	2
3	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	621,946	10	456,644	456,644	63,304	46,479	3
4	19	FINANCIAL CONSULTANT	PATIENT DAYS	621,946	10	149,980		63,304	15,266	4
5	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	621,946	10	75,273		63,304	7,662	5
6										6
7	17	ADMIN. SALARY-B. BARRISH	AVG HRS WKD	20	4	15,163	15,163	4	3,086	7
8	6	REPAIRS & MAINT.-B. BARRIS	AVG HRS WKD	20	4	376		4	77	8
9	21	CLERICAL & GEN.-B. BARRIS	AVG HRS WKD	20	4	1,125		4	229	9
10	26	AUTO INSURANCE-B. BARRIS	AVG HRS WKD	20	4	330		4	67	10
11	27	EMP. BENEFITS-B. BARRISH	AVG HRS WKD	20	4	25,952		4	5,281	11
12	35	AUTO LEASE-B. BARRISH	AVG HRS WKD	20	4	5,250		4	1,068	12
13										13
14	17	ADMIN. SALARY-M. GIANNINI	AVG HRS WKD	30	4	9,863	9,863	6	2,009	14
15	21	CLERICAL & GEN.-M. GIANNI	AVG HRS WKD	30	4	375		6	76	15
16	26	AUTO INSURANCE-M. GIANNI	AVG HRS WKD	30	4	614		6	125	16
17	27	EMP. BENEFITS-M. GIANNINI	AVG HRS WKD	30	4	25,440		6	5,181	17
18	35	AUTO LEASE-M. GIANNINI	AVG HRS WKD	30	4	4,656		6	948	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 852,498	\$ 550,135		\$ 95,846	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care

0029975

Report Period Beginning:

01/01/06

Ending: 12/31/06

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	\$ 69,259	\$ 69,259	17,580	\$ 11,301	1
2	15	EMP. BEN.-H. CARE & PROG.	SPECIAL REHAB INC.	107,736	7	13,143		17,580	2,145	2
3										3
4	6	REPAIRS AND MAINT.	MAINTENANCE INC.	126,720	10	76,680	76,680	33,120	20,041	4
5	7	EMP. BEN.-GEN. SERV.	MAINTENANCE INC.	126,720	10	14,551		33,120	3,803	5
6										6
7										7
8	1	DIETICIAN SALARIES	DIETICIAN SERVICE INC.	83,600	10	32,808	32,808	8,000	3,140	8
9	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN SERVICE INC.	83,600	10	6,226		8,000	596	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					\$ 212,667	\$ 178,747		\$ 41,026	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care

0029975

Report Period Beginning:

01/01/06

Ending: 12/31/06

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 2201 MAIN STREET
 City / State / Zip Code EVANSTON, IL 60202
 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>		\$	\$		\$ <u>50,829</u>	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				\$	\$		\$ <u>50,829</u>	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care

0029975

Report Period Beginning:

01/01/06

Ending: 12/31/06

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 Supply, LLC
 Street Address 2201 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	03	Housekeeping	Direct Allocation					19,475	2
3	04	Laundry	Direct Allocation						3
4	06	Repairs & Maintenance	Direct Allocation						4
5	10	Nursing	Direct Allocation					17,170	5
6	11	Activities	Direct Allocation						6
7	12	Social Service	Direct Allocation						7
8	20	Dues, Fees, Subscriptions & Prom	Direct Allocation						8
9	21	Clerical & General Office	Direct Allocation						9
10	22	Employee Benefits	Direct Allocation						10
11	24	Seminars & Education	Direct Allocation						11
12	39	Ancillary	Direct Allocation						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				\$	\$		\$	36,644

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care

0029975 Report Period Beginning: 01/01/06 Ending: 12/31/06

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: 01/01/06 Ending: 12/31/06

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: 01/01/06 Ending: 12/31/06

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	Nomura		X	Mortgage	\$48,561.00	03/01/95	\$ 5,009,416	\$ 4,862,169	02/21/08	8.6900	\$ 434,735	1								
2												2								
3												3								
4												4								
5	See Supplemental Schedule											5								
Working Capital																				
6	Lake Forest Bank		X	Line of Credit				355,000		Prime		6								
7												7								
8	See Supplemental Schedule										(98)	8								
9	TOTAL Facility Related				\$48,561.00		\$ 5,009,416	\$ 5,217,169			\$ 434,637	9								
B. Non-Facility Related*																				
10	Interest Income - Bldg Co.		X								(1,541)	10								
11	Interest Income		X								(53,443)	11								
12												12								
13	See Supplemental Schedule											13								
14	TOTAL Non-Facility Related						\$	\$			\$ (54,984)	14								
15	TOTALS (line 9+line14)						\$ 5,009,416	\$ 5,217,169			\$ 379,653	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:

01/01/06

Ending:

12/31/06

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	Alloc. - Preferred Bookkeeping		X				\$	\$			\$ (582)	8								
9	Alloc. - S.I.R. Management		X								484	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.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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.

2005 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 2005 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 2005.

(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>71,860.29</u>	\$ <u>71,860.29</u>
2. <u>See Attached</u>	<u>See Attached</u>	\$ <u>89,494.10</u>	\$ <u>6,664.35</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>161,354.39</u>	\$ <u>78,524.64</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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

Facility Name & ID Number Wilson Care

0029975 Report Period Beginning:

01/01/06 Ending:

12/31/06

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:

01/01/06

Ending:

12/31/06

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			161,346	10
11	Various		1987		49,380		20	771	771	49,348	11
12	Various		1989		49,210		20	2,461	2,461	43,210	12
13	Various		1990		105,470		20	5,274	5,274	84,830	13
14	Various		1991		29,903		20	1,494	1,494	23,263	14
15	Various		1992		69,669		20	3,484	3,484	50,710	15
16	Various		1993		61,688		20	3,087	3,087	41,617	16
17	Various		1994		55,691		20	2,654	2,654	35,580	17
18	Various		1995		87,144		20	4,360	4,360	50,126	18
19	Various		1996		303,393		20	15,172	15,172	158,346	19
20	Various		1997		145,411		20	7,348	7,348	64,447	20
21	Various		1998		34,959		20	1,748	1,748	14,942	21
22	Various		1999		64,557		20	3,229	3,229	24,272	22
23	Various		2000		342,218		20	17,110	17,110	107,824	23
24	Various		2001		102,633		20	5,132	5,132	29,071	24
25	Various		2002		67,986		20	7,368	7,368	38,678	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:

01/01/06

Ending:

12/31/06

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
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51								51
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57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		1,539,800			19,088	19,088	1,577,976	67
68		87,498	2,972		3,445	473	39,696	68
69			83,820			(83,820)		69
70		\$ 3,423,341	\$ 86,792		\$ 103,225	\$ 16,433	\$ 2,660,622	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:

01/01/06

Ending:

12/31/06

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		\$ 3,423,341	\$ 86,792		\$ 103,225	\$ 16,433	\$ 2,660,622	1
2	Elevator Door Lock	2003	2,341		20	234	234	878	2
3	Roofing Work	2003	2,475		20	124	124	423	3
4	Plumbing	2003	13,800		20	690	690	2,358	4
5	Sewer Pipe Work	2003	4,300		20	215	215	717	5
6	Sewer Pipe Work	2003	3,000		20	150	150	500	6
7	Steam Pipes	2003	4,279		20	214	214	856	7
8	Fire Alarm Wiring	2003	2,935		20	147	147	563	8
9	Elevator Work	2003	2,020		20	101	101	379	9
10	Elevator Work	2003	3,239		20	162	162	607	10
11	Fire Proof Door	2003	17,075		20	1,708	1,708	5,549	11
12	New Windows	2003	3,300		20	165	165	509	12
13	Handrails	2003	3,906		20	391	391	1,204	13
14	Elevator Work	2003	3,429		20	171	171	529	14
15	Elevator Work	2003	3,547		20	177	177	547	15
16	Upgrade Kitchen System	2003	1,785		20	89	89	335	16
17	Sprinkler System	2003	5,130		20	257	257	834	17
18	Cubicle Curtains	2003	2,123		20	106	106	425	18
19	Exit Devices	2003	1,470		20	74	74	276	19
20	Doors	2003	921		20	46	46	173	20
21	Blinds	2003	1,305		20	65	65	245	21
22	Bathtub Liner	2003	1,250		20	63	63	234	22
23	Electrical Work	2003	1,673		20	84	84	314	23
24	Bath Tub Wall Panel	2003	1,013		20	51	51	190	24
25	Ten Windows	2003	1,417		20	71	71	266	25
26	Wall Tiles	2003	2,875		20	144	144	467	26
27	A/C Window Supports	2003	2,349		20	117	117	372	27
28	Emt Installation	2003	1,458		20	73	73	225	28
29	Courtyard Fence Work	2003	2,772		20	139	139	485	29
30	Bathroom Work	2004	3,380		20	169	169	465	30
31	New Windows	2004	19,936		20	997	997	2,575	31
32	Stairwell Gate	2004	1,119		20	112	112	289	32
33	Walk-In-Freezer Work	2004	2,357		20	118	118	304	33
34	TOTAL (lines 1 thru 33)		\$ 3,547,320	\$ 86,792		\$ 110,649	\$ 23,857	\$ 2,684,715	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 12B, Carried Forward		\$ 3,547,320	\$ 86,792		\$ 110,649	\$ 23,857	\$ 2,684,715	1
2	Cubicle Dividers	2004	3,655		20	183	183	457	2
3	Doors	2004	7,200		20	360	360	780	3
4	Wall Surround And Bath Tub Liner	2004	1,300		20	130	130	390	4
5	Bath Tub Liner #204	2004	625		20	63	63	167	5
6	Wall Surround #517	2004	725		20	73	73	175	6
7	Wall Surround #405	2004	725		20	73	73	175	7
8	Wall Surround #217	2004	725		20	73	73	175	8
9	Wall Surround #417	2004	725		20	73	73	175	9
10	Bathroom Repair Work	2004	2,475		20	248	248	598	10
11	Replace Drywall And Build Retaining Wall	2004	1,600		20	160	160	373	11
12	Bathroom Repair Work	2004	2,800		20	280	280	607	12
13	Repipe Bathroom Radiator	2004	1,802		20	180	180	391	13
14	Boiler Repair And Boiler Reset Control	2004	1,745		20	174	174	363	14
15	Reline Elevator Brake Shoes	2004	2,189		20	219	219	565	15
16	Replace 44 Smoke Detectors	2004	5,770		20	577	577	1,683	16
17	Elevator Work	2004	1,480		20	74	74	154	17
18	Elevator Work	2005	5,670		20	567	567	1,040	18
19	Plumbing Work	2005	12,800		20	640	640	1,067	19
20	Walk - In Freezer	2005	42,000		20	2,100	2,100	3,325	20
21	Roof Work	2005	6,500		20	325	325	515	21
22	Roof Work	2005	48,750		20	4,875	4,875	7,719	22
23	Roof Work	2005	5,200		20	260	260	412	23
24	Wall Repair	2005	2,800		20	140	140	198	24
25	Plumbing Work	2005	6,350		20	318	318	450	25
26	Cubicle Tracks	2005	4,615		20	231	231	327	26
27	Hvac Work	2005	2,269		20	113	113	161	27
28	Flooring - Tile	2005	10,317		20	516	516	559	28
29	Sprinkler System	2005	4,785		20	239	239	299	29
30	Boiler Work	2005	4,699		20	235	235	294	30
31	Alarm System	2005	3,031		20	152	152	177	31
32	Masonry	2005	32,650		20	1,633	1,633	2,585	32
33	Masonry	2005	9,870		20	494	494	781	33
34	TOTAL (lines 1 thru 33)		\$ 3,785,167	\$ 86,792		\$ 126,427	\$ 39,635	\$ 2,711,852	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:

01/01/06

Ending:

12/31/06

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		\$ 3,785,167	\$ 86,792		\$ 126,427	\$ 39,635	\$ 2,711,852	1
2	Radiator Repiping	2005	1,444		20	72	72	78	2
3	Radiator Repiping	2005	1,455		20	73	73	79	3
4	Radiator Repiping	2005	908		20	45	45	49	4
5	Carpeting	2005	1,787		20	89	89	141	5
6	Blinds	2005	3,233		20	162	162	256	6
7	Wall Panels	2005	2,053		20	103	103	163	7
8	Replacement Well	2005	1,644		20	82	82	110	8
9	Railing	2005	1,780		20	89	89	134	9
10	Stairs And Flooring	2006	10,338		20	47	47	47	10
11	Locks	2006	2,950		20	197	197	197	11
12	Rewiring Fire Pump	2006	4,640		20	135	135	135	12
13	Sheet Flooring	2006	11,662		20	340	340	340	13
14	Fire Doors	2006	7,475		20	249	249	249	14
15	Fire Alarm Equipment	2006	2,298		20	115	115	115	15
16	Fire Doors	2006	2,800		20	58	58	58	16
17	Bathroom Remodel	2006	5,850		20	49	49	49	17
18	Electrical Work	2006	7,848		20	392	392	392	18
19	Electrical Work	2006	2,656		20	133	133	133	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)		\$ 3,857,988	\$ 86,792		\$ 128,857	\$ 42,065	\$ 2,714,577	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:

01/01/06

Ending:

12/31/06

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		\$ 3,857,988	\$ 86,792		\$ 128,857	\$ 42,065	\$ 2,714,577	1
2								2
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24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 3,857,988	\$ 86,792		\$ 128,857	\$ 42,065	\$ 2,714,577	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:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12E, Carried Forward	\$ 3,857,988	\$ 86,792		\$ 128,857	\$ 42,065	\$ 2,714,577		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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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)	\$ 3,857,988	\$ 86,792		\$ 128,857	\$ 42,065	\$ 2,714,577		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:

01/01/06

Ending:

12/31/06

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	\$ 3,857,988	\$ 86,792		\$ 128,857	\$ 42,065	\$ 2,714,577		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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27									27
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 3,857,988	\$ 86,792		\$ 128,857	\$ 42,065	\$ 2,714,577		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:

01/01/06

Ending:

12/31/06

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		\$ 3,857,988	\$ 86,792		\$ 128,857	\$ 42,065	\$ 2,714,577	1
2								2
3								3
4								4
5								5
6								6
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9								9
10								10
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31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 3,857,988	\$ 86,792		\$ 128,857	\$ 42,065	\$ 2,714,577	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:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 3,857,988	\$ 86,792		\$ 128,857	\$ 42,065	\$ 2,714,577	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,857,988	\$ 86,792		\$ 128,857	\$ 42,065	\$ 2,714,577	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:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 3,857,988	\$ 86,792		\$ 128,857	\$ 42,065	\$ 2,714,577	1
2									2
3									3
4									4
5									5
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,857,988	\$ 86,792		\$ 128,857	\$ 42,065	\$ 2,714,577	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:

01/01/06

Ending:

12/31/06

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	\$ 3,857,988	\$ 86,792		\$ 128,857	\$ 42,065	\$ 2,714,577		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 3,857,988	\$ 86,792		\$ 128,857	\$ 42,065	\$ 2,714,577		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:

01/01/06

Ending:

12/31/06

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 12K, Carried Forward	\$ 3,857,988	\$ 86,792		\$ 128,857	\$ 42,065	\$ 2,714,577		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 3,857,988	\$ 86,792		\$ 128,857	\$ 42,065	\$ 2,714,577		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:

01/01/06

Ending:

12/31/06

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		\$ 3,857,988	\$ 86,792		\$ 128,857	\$ 42,065	\$ 2,714,577	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
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24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 3,857,988	\$ 86,792		\$ 128,857	\$ 42,065	\$ 2,714,577	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:

01/01/06

Ending:

12/31/06

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 12M, Carried Forward	\$ 3,857,988	\$ 86,792		\$ 128,857	\$ 42,065	\$ 2,714,577		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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28									28
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 3,857,988	\$ 86,792		\$ 128,857	\$ 42,065	\$ 2,714,577		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:

01/01/06

Ending:

12/31/06

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		\$ 3,857,988	\$ 86,792		\$ 128,857	\$ 42,065	\$ 2,714,577	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)	\$ 3,857,988	\$ 86,792		\$ 128,857	\$ 42,065	\$ 2,714,577	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:

01/01/06

Ending:

12/31/06

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 12O, Carried Forward	\$ 3,857,988	\$ 86,792		\$ 128,857	\$ 42,065	\$ 2,714,577		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)	\$ 3,857,988	\$ 86,792		\$ 128,857	\$ 42,065	\$ 2,714,577		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:

01/01/06

Ending:

12/31/06

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 12P, Carried Forward	\$ 3,857,988	\$ 86,792		\$ 128,857	\$ 42,065	\$ 2,714,577		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)	\$ 3,857,988	\$ 86,792		\$ 128,857	\$ 42,065	\$ 2,714,577		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 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	\$		\$ 19,088	\$ 19,088	\$ 1,577,976	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:

01/01/06

Ending:

12/31/06

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
		1,539,800			19,088	19,088	1,577,976	

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	SIR - SIR		1993	1993	\$ 27,198	\$ 864	35	\$ 777	\$ (87)	\$ 10,490	4
5	SIR - PREF		1993	1993	15,844	503	35	453	(50)	6,111	5
6											6
7											7
8											8
	Improvement Type**										
9	Preferred Bookkeeping - Allocation			1997	19,787	443	20	989	546	9,704	9
10	Preferred Bookkeeping - Allocation			1999	157	-	20	8	8	59	10
11	Preferred Bookkeeping - Allocation			2000	992	-	20	50	50	318	11
12											
13	S.I.R. Properties - Preferred Bookkeeping - Allocation			2002	63	-	20	3	3	14	13
14	S.I.R. Properties - Preferred Bookkeeping - Allocation			1999	2,008	201	20	100	(101)	753	14
15	S.I.R. Properties - Preferred Bookkeeping - Allocation			1998	959	96	20	48	(48)	408	15
16	S.I.R. Properties - Preferred Bookkeeping - Allocation			1997	60	6	20	3	(3)	31	16
17	S.I.R. Properties - Preferred Bookkeeping - Allocation			1994	151	4	20	8	4	94	17
18	S.I.R. Properties - Preferred Bookkeeping - Allocation			1993	257	1	20	13	12	174	18
19											
20	S.I.R. Properties - S.I.R. Management - Allocation			2002	108	-	20	5	5	24	20
21	S.I.R. Properties - S.I.R. Management - Allocation			1999	3,446	345	20	172	(173)	1,292	21
22	S.I.R. Properties - S.I.R. Management - Allocation			1998	1,647	165	20	82	(83)	700	22
23	S.I.R. Properties - S.I.R. Management - Allocation			1997	102	10	20	5	(5)	54	23
24	S.I.R. Properties - S.I.R. Management - Allocation			1994	259	7	20	13	6	162	24
25	S.I.R. Properties - S.I.R. Management - Allocation			1993	441	2	20	22	20	298	25
26											
27	S.I.R. Management - Allocation			1993	11,681	325	20	579	254	8,108	27
28	S.I.R. Management - Allocation			1994	36	-	20	-		36	28
29	S.I.R. Management - Allocation			1995	267	-	20	13	13	152	29
30	S.I.R. Management - Allocation			1999	1,269	-	20	64	64	458	30
31	S.I.R. Management - Allocation			2000	766	-	20	38	38	256	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:

01/01/06

Ending:

12/31/06

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)	\$ 87,498	\$ 2,972		\$ 3,445	\$ 473	\$ 39,696	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: 01/01/06 Ending: 12/31/06

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	\$ 445,361	\$ 828	\$ 26,774	\$ 25,946	10	\$ 342,573	71
72	Current Year Purchases	4,925	154	73	(81)	10	73	72
73	Fully Depreciated Assets	476,749				10	476,749	73
74								74
75	TOTALS	\$ 927,035	\$ 982	\$ 26,847	\$ 25,865		\$ 819,395	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)	\$ 4,798,323	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 87,774	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 155,704	83**
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 67,930	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,533,972	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: 01/01/06

Ending: 12/31/06

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.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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: \$ 13,134 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			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	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: 01/01/06

Ending:

12/31/06**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/06

(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	\$ 7,225	\$ 9,627	1
2	Cash-Patient Deposits	40,049	40,049	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,529,479	1,529,479	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	19,298	19,298	6
7	Other Prepaid Expenses	2,192	2,192	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	624,414	624,414	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,222,657	\$ 2,225,059	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	1,384,364	1,384,364	15
16	Equipment, at Historical Cost	1,257,224	1,287,224	16
17	Accumulated Depreciation (book methods)	(1,728,786)	(3,499,467)	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>		12,361	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 912,802	\$ 780,973	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,135,459	\$ 3,006,032	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 201,541	\$ 201,541	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	45,515	45,515	28
29	Short-Term Notes Payable	355,000	355,000	29
30	Accrued Salaries Payable	140,759	140,759	30
31	Accrued Taxes Payable (excluding real estate taxes)	16,546	16,546	31
32	Accrued Real Estate Taxes(Sch.IX-B)	74,100	74,100	32
33	Accrued Interest Payable		24,647	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	10,000	10,000	35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	28,959	28,959	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 872,420	\$ 897,067	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,862,169	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)	\$	\$ 4,862,169	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 872,420	\$ 5,759,236	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,263,039	\$ (2,753,204)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,135,459	\$ 3,006,032	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,544,439	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,544,439	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	942,600	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	(1,224,000)	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)	\$ (281,400)	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)	\$ 2,263,039	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care

0029975

Report Period Beginning: 01/01/06

Ending: 12/31/06

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	\$ 5,923,829	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,923,829	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***	53,443	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 53,443	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	1,452	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,452	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,978,724	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,096,652	31
32	Health Care	1,606,616	32
33	General Administration	1,444,394	33
B. Capital Expense			
34	Ownership	780,057	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)*	\$ 5,036,124	40
41	Income before Income Taxes (line 30 minus line 40)**	942,600	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 942,600	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:

01/01/06

Ending:

12/31/06

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	1,773	1,862	\$ 64,563	\$ 34.67	1
2	Assistant Director of Nursing	1,227	1,363	40,613	29.80	2
3	Registered Nurses	2,659	2,847	70,970	24.93	3
4	Licensed Practical Nurses	8,926	9,753	211,571	21.69	4
5	CNAs & Orderlies	57,104	61,057	565,607	9.26	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,003	2,138	27,563	12.89	9
10	Activity Assistants	7,272	7,947	63,428	7.98	10
11	Social Service Workers	18,146	19,762	296,883	15.02	11
12	Dietician					12
13	Food Service Supervisor	2,008	2,278	41,557	18.24	13
14	Head Cook	2,242	2,531	25,256	9.98	14
15	Cook Helpers/Assistants	14,998	16,249	139,115	8.56	15
16	Dishwashers					16
17	Maintenance Workers	4,005	4,691	47,344	10.09	17
18	Housekeepers	15,779	16,552	132,655	8.01	18
19	Laundry					19
20	Administrator	2,015	2,302	86,937	37.77	20
21	Assistant Administrator	56	56	1,526	27.25	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,315	14,550	172,958	11.89	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	2,834	3,264	54,828	16.80	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	3,628	3,628	11,789	3.25	33
34	TOTAL (lines 1 - 33)	159,990	172,830	\$ 2,055,163 *	\$ 11.89	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	\$ 31,409	01-03	35
36	Medical Director	Monthly	3,600	09-03	36
37	Medical Records Consultant	103	4,444	10-03	37
38	Nurse Consultant	1,079	39,204	10-03	38
39	Pharmacist Consultant	47	3,176	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	980	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Psychiatric Director	Monthly	5,400	10-03	47
48	Rehab Consultant	Monthly	17,580	10a-03	48
49	TOTAL (lines 35 - 48)	1,229	\$ 105,793		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	8	\$ 405	10-03	50
51	Licensed Practical Nurses	2,373	84,610	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	2,381	\$ 85,015		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care

0029975

Report Period Beginning: 01/01/06

Ending: 12/31/06

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
<u>Charlene Hill-Jeon (1/1/06-6/15/06)</u>	<u>Administrator</u>		\$ <u>38,899</u>	<u>Workers' Compensation Insurance</u>	\$ <u>23,868</u>	<u>IDPH License Fee</u>	\$ <u>5,274</u>	
<u>Augusto Beley (6/15/06-12/31/06)</u>	<u>Administrator</u>		<u>48,038</u>	<u>Unemployment Compensation Insurance</u>	<u>37,450</u>	<u>Advertising: Employee Recruitment</u>	<u>5,274</u>	
<u>Patrick Baalke</u>	<u>Asst Administrator</u>		<u>1,526</u>	<u>FICA Taxes</u>	<u>155,970</u>	<u>Health Care Worker Background Check</u>	<u>4,910</u>	
				<u>Employee Health Insurance</u>	<u>93,987</u>	(Indicate # of checks performed <u>217</u>)		
				<u>Employee Meals</u>	<u>19,874</u>	<u>Patient Background Checks</u>		
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Advertising & Promotions</u>	<u>7,699</u>	
				<u>City Head Tax</u>	<u>4,560</u>	<u>Dues & Subscriptions</u>	<u>12,320</u>	
				<u>401K Plan</u>	<u>3,993</u>	<u>Licenses & Permits</u>	<u>6,743</u>	
				<u>Other Employee Benefits</u>	<u>1,348</u>			
						<u>See Supplemental Schedule</u>	<u>702</u>	
						<u>Less: Public Relations Expense</u>	()	
						<u>Non-allowable advertising</u>	<u>(7,699)</u>	
						<u>Yellow page advertising</u>	()	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ <u>88,463</u>	TOTAL (agree to Schedule V,	\$ <u>341,050</u>	TOTAL (agree to Sch. V,	\$ <u>29,949</u>	
(List each licensed administrator separately.)				line 22, col.8)		line 20, col. 8)		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
<u>SIR Management - Dir. Of Admin Services</u>			\$ <u>24,948</u>			\$	<u>Out-of-State Travel</u>	\$
<u>SIR Management - Ancillary Admin Charges</u>			<u>44,544</u>					
<u>Management Fees - SIR Management</u>			<u>120,000</u>					
<u>See Supplemental Schedule</u>			<u>117,725</u>				<u>In-State Travel</u>	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ <u>307,217</u>					
(Attach a copy of any management service agreement)							<u>Seminar Expense</u>	<u>2,390</u>
							<u>Alloc. - Preferred Bookkeeping</u>	<u>101</u>
							<u>Alloc. - S.I.R. Management</u>	<u>283</u>
							<u>Entertainment Expense</u>	()
							(agree to Sch. V,	
							line 24, col. 8)	\$ <u>2,774</u>
C. Professional Services				TOTAL		\$		
Vendor/Payee	Type		Amount					
<u>FR&R</u>	<u>Accounting</u>		\$ <u>12,950</u>					
<u>Preferred</u>	<u>Accounting</u>		<u>43,250</u>					
<u>SIR Management</u>	<u>Loan Fees (Adj on Pg 5A)</u>		<u>734</u>					
<u>Personnel Planners</u>	<u>Unemployment Consultant</u>		<u>1,168</u>					
<u>Rieff Schram & Kanter</u>	<u>Real Estate Tax Legal</u>		<u>15,000</u>					
<u>Preferred Bookkeeping</u>	<u>Bookkeeping</u>		<u>68,904</u>					
<u>Preferred Bookkeeping</u>	<u>Computer Services</u>		<u>4,752</u>					
<u>Edwin Benn</u>	<u>Union Arbitrator</u>		<u>600</u>					
<u>LTC Solutions</u>	<u>Computer Services</u>		<u>1,320</u>					
<u>ICS Solutions</u>	<u>Website</u>		<u>38</u>					
<u>Stuart Sikes</u>	<u>Collections (Adj on Pg 5A)</u>		<u>184</u>					
<u>See Supplemental Schedule</u>			<u>18,544</u>					
TOTAL (agree to Schedule V, line 19, column 3)			\$ <u>167,444</u>					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Facility Name & ID Number Wilson Care

Report Period Beginning: 01/01/06 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 FY2003	6 FY2004	7 FY2005	8 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 FY2011
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care

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; IL Assoc. HC \$2,178
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 8,525 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. \$ 19,874 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