

		FOR BHF USE				

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**2007**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2007)**

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

**I. IDPH License ID Number:** 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:** 9/1/1985

**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
<b>IRS Exemption Code</b> _____	<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 01/01/07 to 12/31/07 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) _____
Paid Preparer	(Type or Print Name) _____
	(Title) _____
Paid Preparer	(Signed) _____
	(Date) _____
	(Print Name and Title) <u>Steven N. Lavenda, C.P.A.</u>
	(Firm Name & Address) <u>Frost, Ruttenberg &amp; 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: 01/01/07 Ending: 12/31/07

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>64,303</u>	<u>1,307</u>		<u>65,610</u>
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	<u>64,303</u>	<u>1,307</u>		<u>65,610</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.78%

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

1,911 (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: 12/31/07 Fiscal Year: 12/31/07

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

Facility Name & ID Number      Wilson Care      #      0029975      Report Period Beginning:      01/01/07      Ending:      12/31/07

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	193,667	27,453	31,785	252,905		252,905	(12,530)	240,375		1
2	Food Purchase		251,936		251,936	(19,382)	232,555	(50)	232,505		2
3	Housekeeping	155,016	40,224		195,240		195,240	(1,117)	194,123		3
4	Laundry		19,926	9,953	29,879		29,879		29,879		4
5	Heat and Other Utilities			132,349	132,349		132,349	2,931	135,280		5
6	Maintenance	41,581	26,624	108,218	176,423		176,423	(25,686)	150,737		6
7	Other (specify):*							3,190	3,190		7
8	<b>TOTAL General Services</b>	<b>390,264</b>	<b>366,163</b>	<b>282,305</b>	<b>1,038,732</b>	<b>(19,382)</b>	<b>1,019,351</b>	<b>(33,262)</b>	<b>986,089</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			3,600	3,600		3,600		3,600		9
10	Nursing and Medical Records	986,190	26,911	179,686	1,192,787		1,192,787	(23,522)	1,169,265		10
10a	Therapy			17,580	17,580		17,580	(10,585)	6,995		10a
11	Activities	108,591	7,258	2,138	117,987		117,987		117,987		11
12	Social Services	293,801	8,829		302,630		302,630		302,630		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							4,760	4,760		15
16	<b>TOTAL Health Care and Programs</b>	<b>1,388,582</b>	<b>42,998</b>	<b>203,004</b>	<b>1,634,584</b>		<b>1,634,584</b>	<b>(29,347)</b>	<b>1,605,237</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	135,261		311,177	446,438		446,438	(124,572)	321,866		17
18	Directors Fees										18
19	Professional Services			187,090	187,090	(139)	186,951	(145,492)	41,459		19
20	Dues, Fees, Subscriptions & Promotions			49,458	49,458		49,458	(10,247)	39,211		20
21	Clerical & General Office Expenses	188,941	33,042	77,781	299,764		299,764	31,303	331,067		21
22	Employee Benefits & Payroll Taxes			362,595	362,595	19,382	381,977		381,977		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,619	2,619		2,619	316	2,935		24
25	Other Admin. Staff Transportation			6,042	6,042		6,042	4,777	10,819		25
26	Insurance-Prop.Liab.Malpractice			155,185	155,185		155,185	570	155,755		26
27	Other (specify):*							38,949	38,949		27
28	<b>TOTAL General Administration</b>	<b>324,202</b>	<b>33,042</b>	<b>1,151,947</b>	<b>1,509,191</b>	<b>19,243</b>	<b>1,528,434</b>	<b>(204,396)</b>	<b>1,324,037</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,103,048</b>	<b>442,203</b>	<b>1,637,256</b>	<b>4,182,507</b>	<b>(139)</b>	<b>4,182,368</b>	<b>(267,005)</b>	<b>3,915,363</b>		<b>29</b>

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Wilson Care #0029975 Report Period Beginning: 01/01/07 Ending: 12/31/07

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>D. Ownership</b>										
30	Depreciation			82,401	82,401		82,401	80,421	162,822		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			13,983	13,983		13,983	396,602	410,585		32
33	Real Estate Taxes			270,758	270,758	139	270,897	8,238	279,135		33
34	Rent-Facility & Grounds			614,280	614,280		614,280	(614,280)			34
35	Rent-Equipment & Vehicles			7,018	7,018		7,018	7,305	14,323		35
36	Other (specify):*							10,991	10,991		36
37	<b>TOTAL Ownership</b>			988,440	988,440	139	988,579	(110,723)	877,856		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
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	<b>TOTAL Special Cost Centers</b>			108,405	108,405		108,405		108,405		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,103,048	442,203	2,734,101	5,279,352		5,279,352	(377,728)	4,901,624		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:

01/01/07

Ending:

12/31/07

**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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	74,119	30		9
10	Interest and Other Investment Income	(25,415)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(50)	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	(4,058)	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	(27,283)	21		24
25	Fund Raising, Advertising and Promotional	(6,242)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(16,283)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(74,473)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (79,685)		\$	30

BHF USE ONLY						
48		49		50		51
						52

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

		1	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)	(298,043)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (298,043)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (377,728)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Wilson Care ID# 0029975  
 Report Period Beginning: 01/01/07  
 Ending: 12/31/07

NON-ALLOWABLE EXPENSES	Amount	Sch. V Line	Reference
1 Miscellaneous Income	\$ (467)	21	1
2 Theft & Damage	(230)	21	2
3 Building Company - Replacement Tax	(553)	21	3
4 Building Company - Office Expense	(150)	21	4
5 C&PF Dues	(2,396)	20	5
6 Insurance Expense	(654)	26	6
7 Cable TV	(2,714)	06	7
8 Non Allowable Legal - Collections	(623)	19	8
9 Capitalized R&M	(14,240)	09	9
10 Building Company - Professional Fees	(25,452)	19	10
11 PPA - Legal Fees	(26,792)	19	11
12 Non Allowable Legal	(200)	19	12
13			13
14			14
15			15
16			16
17			17
18			18
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95			95
96			96
97			97
98			98
99			99
100			100
101 Total	(74,473)		101

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Wilson Care# 0029975

Report Period Beginning:

01/01/07

Ending:

12/31/07**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)	
	<b>A. General Services</b>													
1	Dietary					(12,530)							(12,530)	1
2	Food Purchase	(50)											(50)	2
3	Housekeeping			865					(1,982)				(1,117)	3
4	Laundry													4
5	Heat and Other Utilities			1,370	1,561								2,931	5
6	Maintenance	(16,954)		1,202	(8,344)		(1,590)						(25,686)	6
7	Other (specify):*				997	1,532	661						3,190	7
8	<b>TOTAL General Services</b>	<b>(17,004)</b>		<b>3,437</b>	<b>(5,786)</b>	<b>(10,998)</b>	<b>(929)</b>		<b>(1,982)</b>				<b>(33,262)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records				(21,775)				(1,747)				(23,522)	10
10a	Therapy						(10,585)						(10,585)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				3,362		1,398						4,760	15
16	<b>TOTAL Health Care and Programs</b>				<b>(18,413)</b>		<b>(9,187)</b>		<b>(1,747)</b>				<b>(29,347)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			20,448	(61,831)	(61,589)	(21,600)						(124,572)	17
18	Directors Fees													18
19	Professional Services	(53,067)	25,452	(118,455)	528	16,094	(16,044)						(145,492)	19
20	Fees, Subscriptions & Promotions	(12,698)		286	2,165								(10,247)	20
21	Clerical & General Office Expenses	(44,966)	703	67,640	7,663	263							31,303	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			27	289								316	24
25	Other Admin. Staff Transportation			1,010	3,767								4,777	25
26	Insurance-Prop.Liab.Malpractice	(654)		376	572	276							570	26
27	Other (specify):*			12,994	6,089	19,866							38,949	27
28	<b>TOTAL General Administration</b>	<b>(111,385)</b>	<b>26,155</b>	<b>(15,674)</b>	<b>(40,758)</b>	<b>(25,090)</b>	<b>(37,644)</b>						<b>(204,396)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(128,389)</b>	<b>26,155</b>	<b>(12,237)</b>	<b>(64,957)</b>	<b>(36,088)</b>	<b>(47,760)</b>		<b>(3,729)</b>				<b>(267,005)</b>	<b>29</b>

STATE OF ILLINOIS

Facility Name & ID Number Wilson Care

# 0029975

Report Period Beginning:

01/01/07

Ending:

Summary B

12/31/07

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	74,119		1,721	4,581								80,421	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(25,415)	418,892	(66)	3,191								396,602	32
33	Real Estate Taxes			2,955	5,283								8,238	33
34	Rent-Facility & Grounds		(614,280)										(614,280)	34
35	Rent-Equipment & Vehicles			2,405	1,895	3,005							7,305	35
36	Other (specify):*		10,991										10,991	36
37	<b>TOTAL Ownership</b>	<b>48,704</b>	<b>(184,397)</b>	<b>7,015</b>	<b>14,950</b>	<b>3,005</b>							<b>(110,723)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>													<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(79,685)</b>	<b>(158,242)</b>	<b>(5,222)</b>	<b>(50,007)</b>	<b>(33,083)</b>	<b>(47,760)</b>		<b>(3,729)</b>				<b>(377,728)</b>	<b>45</b>

**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		
				Wilson Care, LLC		Building Co.

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rental Income	\$ 614,280	Wilson Care, LLC	100.00%	\$	\$ (614,280)	1
2	V	33 Rent Real Estate Tax	270,758	Wilson Care, LLC	100.00%		(270,758)	2
3	V	36 Amortization of Loan Fees		Wilson Care, LLC	100.00%	10,991	10,991	3
4	V	32 Mortgage Interest		Wilson Care, LLC	100.00%	421,156	421,156	4
5	V	21 Office Expense		Wilson Care, LLC	100.00%	150	150	5
6	V	19 Professional Fees		Wilson Care, LLC	100.00%	25,452	25,452	6
7	V	33 Real Estate Taxes		Wilson Care, LLC	100.00%	270,758	270,758	7
8	V	32 Interest Income	2,264	Wilson Care, LLC	100.00%		(2,264)	8
9	V	21 Replacement Tax		Wilson Care, LLC	100.00%	553	553	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 887,302			\$ 729,060	\$ * (158,242)	14

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

Facility Name & ID Number Wilson Care# 0029975Report Period Beginning: 01/01/07Ending: 12/31/07

## 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%	\$ 865	\$ 865	15
16	V	5 UTILITIES		PREFERRED BOOKKEEPING	100.00%	1,370	1,370	16
17	V	6 REPAIRS AND MAINT.		PREFERRED BOOKKEEPING	100.00%	1,202	1,202	17
18	V	17 ADMIN. FINANCIAL SAL.		PREFERRED BOOKKEEPING	100.00%	20,448	20,448	18
19	V	19 PROFESSIONAL FEES		PREFERRED BOOKKEEPING	100.00%	974	974	19
20	V	20 DUES,SUBSCRIPTIONS		PREFERRED BOOKKEEPING	100.00%	286	286	20
21	V	21 CLERICAL		PREFERRED BOOKKEEPING	100.00%	67,640	67,640	21
22	V	24 SEMINARS		PREFERRED BOOKKEEPING	100.00%	27	27	22
23	V	25 ADMIN. STAFF TRAVEL		PREFERRED BOOKKEEPING	100.00%	1,010	1,010	23
24	V	26 INSURANCE		PREFERRED BOOKKEEPING	100.00%	376	376	24
25	V	27 EMPLOYEE BENEFITS		PREFERRED BOOKKEEPING	100.00%	12,994	12,994	25
26	V	30 DEPRECIATION		PREFERRED BOOKKEEPING	100.00%	1,721	1,721	26
27	V	32 INTEREST		PREFERRED BOOKKEEPING	100.00%	(66)	(66)	27
28	V	33 REAL ESTATE TAXES		PREFERRED BOOKKEEPING	100.00%	2,955	2,955	28
29	V	35 EQUIPMENT RENTAL		PREFERRED BOOKKEEPING	100.00%	2,405	2,405	29
30	V							30
31	V							31
32	V	19 ACCOUNT./BOOKKEEPING	119,429	PREFERRED BOOKKEEPING	100.00%		(119,429)	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		\$ 124,181			\$ 118,959	\$ * (5,222)	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: 01/01/07Ending: 12/31/07

## VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5 UTILITIES	\$	S.I.R. MANAGEMENT, INC.	100.00%	\$ 1,561	\$ 1,561	15
16	V	6 REPAIRS AND MAINT.	17,820	S.I.R. MANAGEMENT, INC.	100.00%	9,476	(8,344)	16
17	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	997	997	17
18	V	10 NURSING	39,204	S.I.R. MANAGEMENT, INC.	100.00%	17,429	(21,775)	18
19	V	15 EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	3,362	3,362	19
20	V	17 ADMINISTRATIVE	73,452	S.I.R. MANAGEMENT, INC.	100.00%	11,621	(61,831)	20
21	V	19 PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	528	528	21
22	V	20 FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	2,165	2,165	22
23	V	21 CLERICAL & GENERAL	20,196	S.I.R. MANAGEMENT, INC.	100.00%	27,859	7,663	23
24	V	24 EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	289	289	24
25	V	25 OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	3,767	3,767	25
26	V	26 INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	572	572	26
27	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	6,089	6,089	27
28	V	30 DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	4,581	4,581	28
29	V	32 INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	3,191	3,191	29
30	V	33 REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	5,283	5,283	30
31	V	35 EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	1,895	1,895	31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 150,672			\$ 100,665	\$ * (50,007)	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: 01/01/07Ending: 12/31/07

## 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%	\$ 7,666	\$ (12,530)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	1,532	1,532	16
17	V	17	ADMIN./LEGAL SALARIES	120,000	S.I.R. MANAGEMENT, INC.	100.00%	53,469	(66,531)	17
18	V	19	FINANCIAL CONSULTANT		S.I.R. MANAGEMENT, INC.	100.00%	16,094	16,094	18
19	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	10,779	10,779	19
20	V								20
21	V	17	ADMIN. SALARY-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	3,441	3,441	21
22	V	6	REPAIRS & MAINT.-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%			22
23	V	21	CLERICAL & GEN.-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	197	197	23
24	V	26	AUTO INSURANCE-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	128	128	24
25	V	27	EMP. BENEFITS-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	4,605	4,605	25
26	V	35	AUTO LEASE-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	1,745	1,745	26
27	V								27
28	V	17	ADMIN. SALARY-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	1,501	1,501	28
29	V	21	CLERICAL & GEN.-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	66	66	29
30	V	26	AUTO INSURANCE-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	148	148	30
31	V	27	EMP. BENEFITS-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	4,482	4,482	31
32	V	35	AUTO LEASE-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	1,260	1,260	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 140,196				\$ 107,113	\$ * (33,083)	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: 01/01/07Ending: 12/31/07

## 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%	6,995	\$	(10,585)	15
16	V	15 EMP. BEN.-H. CARE & PROG.		S.I.R. MANAGEMENT, INC.	100.00%	1,398		1,398	16
17	V								17
18	V	6 REPAIRS AND MAINT.	4,896	S.I.R. MANAGEMENT, INC.	100.00%	3,306		(1,590)	18
19	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	661		661	19
20	V								20
21	V								21
22	V								22
23	V								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		\$ 60,120			\$ 12,360	\$ *	(47,760)	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%	\$ 80,470	\$ 80,470	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	80,470	CCS Employee Benefit Group	100.00%		(80,470)	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			\$ 80,470			\$ 80,470	\$ *	39

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary	\$	Xcel Supply, LLC	100.00%	\$		15
16	V	3 Housekeeping	24,572	Xcel Supply, LLC	100.00%	22,590	(1,982)	16
17	V	4 Laundry		Xcel Supply, LLC	100.00%			17
18	V	6 Repairs & Maintenance		Xcel Supply, LLC	100.00%			18
19	V	10 Nursing	21,664	Xcel Supply, LLC	100.00%	19,917	(1,747)	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 And Subscriptions		Xcel Supply, LLC	100.00%			22
23	V	21 Office And Clerical		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		\$ 46,236			\$ 42,507	\$ * (3,729)	39

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

Facility Name & ID Number Wilson Care

# 0029975

Report Period Beginning: 01/01/07

Ending: 12/31/07

**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: 01/01/07

Ending: 12/31/07

**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: 01/01/07

Ending: 12/31/07

**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: 01/01/07 Ending: 12/31/07

## 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	Owner	Administrative	4.86%	See Attached	3.61	9.03%	Alloc. Salary	\$ 3,441	17-7	1
2	Eric Rothner	Owner	Administrative	20.00%	See Attached	0.75	1.63%	Alloc. Salary	10,410	17-7	2
3	Nenita Guzman	Relative	Dietary	0.00%	See Attached	0.43	0.86%	Alloc. Salary	7,666	1-7	3
4	Noah Wolff	Owner	Administrative	5.56%	See Attached	3.00	8.33%	Mgmt. Fee	48,000	17-3	4
5	Howard Geller	Owner	Administrative	4.44%	See Attached	8.00	13.33%	Mgmt. Fee	48,000	17-3	5
6	Kim Rudolph	Relative	Clerical	0.00%	See Attached	0.43	1.23%	Alloc. Salary	381	22-7	6
7	Adam Vales	Relative	Clerical	0.00%	See Attached	0.50	1.25%	Alloc. Salary	693	22-7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 118,591		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: 01/01/07 Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care

# 0029975

Report Period Beginning:

01/01/07

Ending: 12/31/07

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 1,051,322	10	\$ 7,611	\$	119,429	\$ 865	1
2	5	UTILITIES	BOOK./ACCNT.INCOME 1,051,322	10	12,056		119,429	1,370	2
3	6	REPAIRS AND MAINT.	BOOK./ACCNT.INCOME 1,051,322	10	10,582		119,429	1,202	3
4	17	ADMIN. FINANCIAL SAL.	BOOK./ACCNT.INCOME 1,051,322	10	180,000	180,000	119,429	20,448	4
5	19	PROFESSIONAL FEES	BOOK./ACCNT.INCOME 1,051,322	10	8,570		119,429	974	5
6	20	DUES,SUBSCRIPTIONS	BOOK./ACCNT.INCOME 1,051,322	10	2,521		119,429	286	6
7	21	CLERICAL	BOOK./ACCNT.INCOME 1,051,322	10	595,432	519,081	119,429	67,640	7
8	24	SEMINARS	BOOK./ACCNT.INCOME 1,051,322	10	240		119,429	27	8
9	25	ADMIN. STAFF TRAVEL	BOOK./ACCNT.INCOME 1,051,322	10	8,887		119,429	1,010	9
10	26	INSURANCE	BOOK./ACCNT.INCOME 1,051,322	10	3,314		119,429	376	10
11	27	EMPLOYEE BENEFITS	BOOK./ACCNT.INCOME 1,051,322	10	114,384		119,429	12,994	11
12	30	DEPRECIATION	BOOK./ACCNT.INCOME 1,051,322	10	15,147		119,429	1,721	12
13	32	INTEREST	BOOK./ACCNT.INCOME 1,051,322	10	(585)		119,429	(66)	13
14	33	REAL ESTATE TAXES	BOOK./ACCNT.INCOME 1,051,322	10	26,015		119,429	2,955	14
15	35	EQUIPMENT RENTAL	BOOK./ACCNT.INCOME 1,051,322	10	21,168		119,429	2,405	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				\$ 1,005,342	\$ 699,081		\$ 118,959	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care

# 0029975

Report Period Beginning:

01/01/07

Ending: 12/31/07

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	611,427	10	\$ 14,547	\$ 65,610	\$ 1,561	1	
2	6	REPAIRS AND MAINT.	PATIENT DAYS	611,427	10	88,312	52,015	65,610	9,476	2
3	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	611,427	10	9,289	65,610	997	3	
4	10	NURSING	PATIENT DAYS	611,427	10	162,421	162,421	65,610	17,429	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	611,427	10	31,333	65,610	3,362	5	
6	17	ADMINISTRATIVE	PATIENT DAYS	611,427	10	108,301	108,301	65,610	11,621	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	611,427	10	4,925	65,610	528	7	
8	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	611,427	10	20,178	65,610	2,165	8	
9	21	CLERICAL & GENERAL	PATIENT DAYS/DIRECT	611,427	10	259,625	203,511	65,610	27,859	9
10	24	EDUCATION & SEMINAR	PATIENT DAYS	611,427	10	2,693	65,610	289	10	
11	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	611,427	10	35,101	65,610	3,767	11	
12	26	INSURANCE	PATIENT DAYS	611,427	10	5,328	65,610	572	12	
13	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS/DIRECT	611,427	10	56,748	65,610	6,089	13	
14	30	DEPRECIATION	PATIENT DAYS	611,427	10	42,694	65,610	4,581	14	
15	32	INTEREST	PATIENT DAYS	611,427	10	29,739	65,610	3,191	15	
16	33	REAL ESTATE TAXES	PATIENT DAYS	611,427	10	49,229	65,610	5,283	16	
17	35	EQUIPMENT RENTAL	PATIENT DAYS	611,427	10	17,659	65,610	1,895	17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 938,122	\$ 526,247	\$ 100,665	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care

# 0029975 Report Period Beginning: 01/01/07

Ending: 12/31/07

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	611,427	10	\$ 71,444	\$ 71,444	65,610	\$ 7,666	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	611,427	10	14,275		65,610	1,532	2
3	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	611,427	10	498,282	498,282	65,610	53,469	3
4	19	FINANCIAL CONSULTANT	PATIENT DAYS	611,427	10	149,980		65,610	16,094	4
5	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	611,427	10	100,448		65,610	10,779	5
6										6
7	17	ADMIN. SALARY-B. BARRISH	AVG HRS WKD	23	10	22,231	22,231	3	3,441	7
8	6	REPAIRS & MAINT.-B. BARRIS	AVG HRS WKD	23	10			3		8
9	21	CLERICAL & GEN.-B. BARRIS	AVG HRS WKD	23	10	1,275		3	197	9
10	26	AUTO INSURANCE-B. BARRIS	AVG HRS WKD	23	10	824		3	128	10
11	27	EMP. BENEFITS-B. BARRISH	AVG HRS WKD	23	10	29,750		3	4,605	11
12	35	AUTO LEASE-B. BARRISH	AVG HRS WKD	23	10	11,272		3	1,745	12
13										13
14	17	ADMIN. SALARY-M. GIANNINI	AVG HRS WKD	30	10	9,702	9,702	5	1,501	14
15	21	CLERICAL & GEN.-M. GIANNI	AVG HRS WKD	30	10	425		5	66	15
16	26	AUTO INSURANCE-M. GIANNI	AVG HRS WKD	30	10	959		5	148	16
17	27	EMP. BENEFITS-M. GIANNINI	AVG HRS WKD	30	10	28,968		5	4,482	17
18	35	AUTO LEASE-M. GIANNINI	AVG HRS WKD	30	10	8,144		5	1,260	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 947,979	\$ 601,659		\$ 107,113	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care

# 0029975

Report Period Beginning: 01/01/07

Ending: 12/31/07

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	\$ 42,868	\$ 42,868	17,580	\$ 6,995	1
2	15	EMP. BEN.-H. CARE & PROG.	SPECIAL REHAB INC.	107,736	7	8,566	17,580	1,398		2
3										3
4	6	REPAIRS AND MAINT.	MAINTENANCE INC.	116,640	8	78,758	78,758	4,896	3,306	4
5	7	EMP. BEN.-GEN. SERV.	MAINTENANCE INC.	116,640	8	15,737	4,896	661		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					\$ 145,929	\$ 121,626		\$ 12,360	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care

# 0029975

Report Period Beginning:

01/01/07

Ending: 12/31/07

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 West 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	22	Employee Health Insurance	Direct Allocation		\$	\$		\$ 80,470	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				\$	\$		\$ 80,470	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care

# 0029975

Report Period Beginning: 01/01/07

Ending: 12/31/07

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	1	Dietary	Direct Allocation			\$		\$	1
2	3	Housekeeping	Direct Allocation					22,590	2
3	4	Laundry	Direct Allocation						3
4	6	Repairs & Maintenance	Direct Allocation						4
5	10	Nursing	Direct Allocation					19,917	5
6	11	Activities	Direct Allocation						6
7	12	Social Service	Direct Allocation						7
8	20	Dues, Fees And Subscriptions	Direct Allocation						8
9	21	Office And Clerical	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					\$		\$	42,507

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care

# 0029975 Report Period Beginning: 01/01/07 Ending: 12/31/07

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: 01/01/07 Ending: 12/31/07

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care

# 0029975

Report Period Beginning:

01/01/07

Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Nomura		X	Mortgage	\$48,561.00		\$ 4,862,169	\$ 4,701,412		\$ 421,156	1									
2											2									
3											3									
4											4									
5	See Supplemental Schedule										5									
<b>Working Capital</b>																				
6	SIR Management		X	Line of Credit				990,000		13,983	6									
7											7									
8	See Supplemental Schedule									3,125	8									
9	<b>TOTAL Facility Related</b>				\$48,561.00		\$ 4,862,169	\$ 5,691,412		\$ 438,264	9									
<b>B. Non-Facility Related*</b>																				
10	Interest Income - Bldg Co.		X							(2,264)	10									
11	Interest Income		X							(25,415)	11									
12											12									
13	See Supplemental Schedule										13									
14	<b>TOTAL Non-Facility Related</b>						\$	\$		(27,679)	14									
15	<b>TOTALS (line 9+line14)</b>						\$ 4,862,169	\$ 5,691,412		\$ 410,585	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:

01/01/07

Ending:

12/31/07

**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
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1							\$	\$			\$	1								
2												2								
3												3								
4												4								
5												5								
6												6								
7	<b>TOTAL Long-Term</b>											7								
<b>Working Capital</b>																				
8	Alloc. - Preferred Book.		X				\$	\$			\$	(66)	8							
9	Alloc. - SIR Management		X									3,191	9							
10													10							
11													11							
12													12							
13													13							
14	<b>TOTAL Working Capital</b>											14								
<b>B. Non-Facility Related*</b>																				
15							\$	\$			\$		15							
16													16							
17													17							
18													18							
19													19							
20	<b>TOTAL Non-Facility Related</b>											20								

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

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

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

B. Real Estate Taxes

<p><b>Important</b>, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2006 report.		\$ 74,100	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ 177,896	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 103,796	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 175,200	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$ 139	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$ _____	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 279,135	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2002	72,641	8
	2003	67,251	9
	2004	68,745	10
	2005	71,860	11
	2006	169,658	12
<u>Accrual for 2006 = \$169,658 x 1.03 = \$175,200</u>			
<u>Property Appraisal, S.I.R. Properties = \$139.25</u>			
<u>Alloc. - Preferred Bookkeeping = \$2,955</u>			
<u>Alloc. - S.I.R. Management = \$5,283</u>			
		<b>FOR BHF USE ONLY</b>	
	13	FROM R. E. TAX STATEMENT FOR 2006 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

**2006 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 2006 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 2006.

	(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	<u>14-17-220-009-0000</u>	<u>Long Term Care Property</u>	<u>\$ 169,658.00</u>	<u>\$ 169,658.00</u>
2.	<u>See Attached</u>	<u>See Attached</u>	<u>\$ 94,525.44</u>	<u>\$ 7,312.48</u>
3.	<u>                    </u>	<u>                    </u>	<u>\$</u>	<u>\$</u>
4.	<u>                    </u>	<u>                    </u>	<u>\$</u>	<u>\$</u>
5.	<u>                    </u>	<u>                    </u>	<u>\$</u>	<u>\$</u>
6.	<u>                    </u>	<u>                    </u>	<u>\$</u>	<u>\$</u>
7.	<u>                    </u>	<u>                    </u>	<u>\$</u>	<u>\$</u>
8.	<u>                    </u>	<u>                    </u>	<u>\$</u>	<u>\$</u>
9.	<u>                    </u>	<u>                    </u>	<u>\$</u>	<u>\$</u>
10.	<u>                    </u>	<u>                    </u>	<u>\$</u>	<u>\$</u>
		<b>TOTALS</b>	<u>\$ 264,183.44</u>	<u>\$ 176,970.48</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

**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.

**IMPORTANT NOTICE**

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

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

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

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

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

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

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

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

Facility Name & ID Number Wilson Care

# 0029975 Report Period Beginning:

01/01/07 Ending:

12/31/07

**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	<b>TOTALS</b>			\$ <b>13,300</b>	3

SEE ACCOUNTANTS' COMPILATION REPORT

**XI. OWNERSHIP COSTS (continued)**

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$		4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Various		1985		65,366		20			65,340	9
10	Various		1986		161,365		20			161,346	10
11	Various		1987		49,380		20			49,348	11
12	Various		1989		49,210		20	2,461	2,461	45,670	12
13	Various		1990		105,470		20	5,274	5,274	90,103	13
14	Various		1991		29,903		20	1,494	1,494	24,758	14
15	Various		1992		69,669		20	3,484	3,484	54,194	15
16	Various		1993		61,688		20	3,087	3,087	44,700	16
17	Various		1994		55,691		20	2,654	2,654	38,232	17
18	Various		1995		87,144		20	4,360	4,360	54,482	18
19	Various		1996		303,393		20	15,172	15,172	173,513	19
20	Various		1997		145,411		20	7,348	7,348	71,793	20
21	Various		1998		34,959		20	1,748	1,748	16,691	21
22	Various		1999		64,557		20	3,229	3,229	27,499	22
23	Various		2000		342,218		20	17,110	17,110	124,932	23
24	Various		2001		102,633		20	5,132	5,132	34,198	24
25	Various		2002		67,986		20	6,479	6,479	45,158	25
26	Various		2003		97,187		20	6,028	6,028	26,484	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		1,539,800			19,088	19,088	1,597,064	67
68		96,988	3,641		3,657	16	44,768	68
69			82,401			(82,401)		69
70		\$ 3,530,018	\$ 86,042		\$ 107,805	\$ 21,763	\$ 2,790,273	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Wilson Care

# 0029975

Report Period Beginning:

01/01/07

Ending:

12/31/07

## 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	<b>Totals from Page 12A, Carried Forward</b>		\$ 3,530,018	\$ 86,042		\$ 107,805	\$ 21,763	\$ 2,790,273	1
2	Bathroom Work	2004			20				2
3	Bathroom Work	2004	3,380		20	169	169	634	3
4	New Windows	2004	19,936		20	997	997	3,572	4
5	Stairwell Gate	2004	1,119		20	112	112	401	5
6	Walk-In-Freezer Work	2004			20				6
7	Walk-In-Freezer Work	2004	2,357		20	118	118	422	7
8	Cubicle Dividers	2004			20				8
9	Cubicle Dividers	2004	3,655		20	183	183	640	9
10	Doors	2004			20				10
11	Doors	2004	7,200		20	360	360	1,140	11
12	Wall Surround And Bath Tub Liner	2004	1,300		20	130	130	520	12
13	Pump Valve	2004			20				13
14	Hallway Carpeting	2004			20				14
15	Bath Tub Liner #204	2004	625		20	63	63	229	15
16	Wall Surround #517	2004	725		20	73	73	248	16
17	Wall Surround #405	2004	725		20	73	73	248	17
18	Wall Surround #217	2004	725		20	73	73	248	18
19	Wall Surround #417	2004	725		20	73	73	248	19
20	Bathroom Repair Work	2004	2,475		20	248	248	846	20
21	Replace Drywall And Build Retaining Wall	2004	1,600		20	160	160	533	21
22	Bathroom Repair Work	2004	2,800		20	280	280	887	22
23	Replace Light Fixtures And Wiring	2004			20				23
24	Repipe Bathroom Radiator	2004	1,802		20	180	180	571	24
25	Boiler Repair And Boiler Reset Control	2004	1,745		20	174	174	538	25
26	Reline Elevator Brake Shoes	2004	2,189		20	219	219	784	26
27	Replace 44 Smoke Detectors	2004	5,770		20	577	577	2,260	27
28	Elevator Work	2004	1,480		20	74	74	228	28
29	Elevator Work	2005	5,670		20	567	567	1,607	29
30	Plumbing Work	2005	12,800		20	640	640	1,707	30
31	Walk - In Freezer	2005	42,000		20	2,100	2,100	5,425	31
32	Roof Work	2005	6,500		20	325	325	840	32
33	Roof Work	2005	48,750		20	4,875	4,875	12,594	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,708,071	\$ 86,042		\$ 120,648	\$ 34,606	\$ 2,827,643	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; 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	<b>Totals from Page 12B, Carried Forward</b>		\$ 3,708,071	\$ 86,042		\$ 120,648	\$ 34,606	\$ 2,827,643	1
2	Roof Work	2005	5,200		20	260	260	672	2
3	Masonry	2005			20				3
4	Wall Repair	2005	2,800		20	140	140	338	4
5	Plumbing Work	2005	6,350		20	318	318	767	5
6	Cubicle Tracks	2005	4,615		20	231	231	558	6
7	Hvac Work	2005	2,269		20	113	113	274	7
8	Flooring - Tile	2005	10,317		20	516	516	1,075	8
9	Sprinkler System	2005	4,785		20	239	239	538	9
10	Boiler Work	2005	4,699		20	235	235	529	10
11	Alarm System	2005	3,031		20	152	152	328	11
12	Masonry	2005	32,650		20	1,633	1,633	4,217	12
13	Masonry	2005	9,870		20	494	494	1,275	13
14	Radiator Repiping	2005	1,444		20	72	72	150	14
15	Radiator Repiping	2005	1,455		20	73	73	152	15
16	Radiator Repiping	2005	908		20	45	45	95	16
17	Carpeting	2005	1,787		20	89	89	231	17
18	Blinds	2005	3,233		20	162	162	418	18
19	Wall Panels	2005	2,053		20	103	103	265	19
20	Replacement Well	2005	1,644		20	82	82	192	20
21	Railing	2005	1,780		20	89	89	223	21
22	Stairs And Flooring	2006	10,338		20	517	517	560	22
23	Locks	2006	2,950		20	295	295	492	23
24	Rewiring Fire Pump	2006	4,640		20	232	232	367	24
25	Sheet Flooring	2006	11,662		20	583	583	923	25
26	Fire Doors	2006	7,475		20	374	374	623	26
27	Fire Alarm Equipment	2006	2,298		20	230	230	345	27
28	Fire Doors	2006	2,800		20	140	140	198	28
29	Bathroom Remodel	2006	5,850		20	293	293	341	29
30	Electrical Work	2006	7,848		20	392	392	491	30
31	Electrical Work	2006	2,656		20	133	133	155	31
32	Reception Station	2007	12,557		20	1,046	1,046	1,046	32
33	Security System Work	2007	2,525		20	210	210	210	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,882,560	\$ 86,042		\$ 130,139	\$ 44,097	\$ 2,845,691	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Wilson Care

# 0029975

Report Period Beginning:

01/01/07

Ending:

12/31/07

## 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	<b>Totals from Page 12C, Carried Forward</b>		\$ 3,882,560	\$ 86,042		\$ 130,139	\$ 44,097	\$ 2,845,691	1
2	Camera	2007	1,303		20	109	109	109	2
3	Bathroom Remodeling	2007	11,700		20	439	439	439	3
4	Bathroom Remodeling	2007	12,085		20	453	453	453	4
5	Bathroom Remodeling	2007	11,700		20	390	390	390	5
6	Bathroom Remodeling	2007	10,980		20	320	320	320	6
7	Cameras	2007	2,970		20	198	198	198	7
8	Bathroom Remodeling	2007	11,700		20	341	341	341	8
9	Bathroom Remodeling	2007	12,085		20	352	352	352	9
10	Tile Flooring	2007	39,410		20	1,149	1,149	1,149	10
11	Bathroom Remodeling	2007	12,085		20	352	352	352	11
12	Bathroom Remodeling	2007	11,700		20	293	293	293	12
13	Hot Water Heater	2007	6,211		20	259	259	259	13
14	Bathroom Remodeling	2007	11,700		20	244	244	244	14
15	Bathroom Remodeling	2007	12,160		20	253	253	253	15
16	Fire Doors	2007	6,850		20	114	114	114	16
17	Security System	2007	4,110		20	103	103	103	17
18	Security System	2007	8,310		20	208	208	208	18
19	Tile Flooring	2007	29,171		20	365	365	365	19
20	Bathroom Work	2007	2,080		20	26	26	26	20
21	Boiler Work	2007	5,323		20	67	67	67	21
22	Bathroom Remodeling	2007	11,700		20	146	146	146	22
23	Bathroom Remodeling	2007	11,700		20	146	146	146	23
24	Tile Flooring	2007	68,581		20	572	572	572	24
25	Fire Doors	2007	7,975		20	66	66	66	25
26	Handrails	2007	10,930		20	46	46	46	26
27	Bathroom Work	2007	11,700		20	195	195	195	27
28	Bathroom Work	2007	11,700		20	98	98	98	28
29	Ceiling Panels	2007	2,550		20	128	128	128	29
30	Boiler Work	2007	2,660		20	133	133	133	30
31	Roof Work	2007	3,565		20	178	178	178	31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,249,254	\$ 86,042		\$ 137,882	\$ 51,840	\$ 2,853,434	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 4,249,254	\$ 86,042		\$ 137,882	\$ 51,840	\$ 2,853,434	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,249,254	\$ 86,042		\$ 137,882	\$ 51,840	\$ 2,853,434	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 4,249,254	\$ 86,042		\$ 137,882	\$ 51,840	\$ 2,853,434	1
2									2
3									3
4									4
5									5
6									6
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,249,254	\$ 86,042		\$ 137,882	\$ 51,840	\$ 2,853,434	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 4,249,254	\$ 86,042		\$ 137,882	\$ 51,840	\$ 2,853,434	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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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,249,254	\$ 86,042		\$ 137,882	\$ 51,840	\$ 2,853,434	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 4,249,254	\$ 86,042		\$ 137,882	\$ 51,840	\$ 2,853,434	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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32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,249,254	\$ 86,042		\$ 137,882	\$ 51,840	\$ 2,853,434	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 4,249,254	\$ 86,042		\$ 137,882	\$ 51,840	\$ 2,853,434	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)		\$ 4,249,254	\$ 86,042		\$ 137,882	\$ 51,840	\$ 2,853,434	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 4,249,254	\$ 86,042		\$ 137,882	\$ 51,840	\$ 2,853,434	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
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19									19
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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)		\$ 4,249,254	\$ 86,042		\$ 137,882	\$ 51,840	\$ 2,853,434	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 4,249,254	\$ 86,042		\$ 137,882	\$ 51,840	\$ 2,853,434	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)		\$ 4,249,254	\$ 86,042		\$ 137,882	\$ 51,840	\$ 2,853,434	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12K, Carried Forward		\$ 4,249,254	\$ 86,042		\$ 137,882	\$ 51,840	\$ 2,853,434	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)		\$ 4,249,254	\$ 86,042		\$ 137,882	\$ 51,840	\$ 2,853,434	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12L, Carried Forward		\$ 4,249,254	\$ 86,042		\$ 137,882	\$ 51,840	\$ 2,853,434	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)		\$ 4,249,254	\$ 86,042		\$ 137,882	\$ 51,840	\$ 2,853,434	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12M, Carried Forward		\$ 4,249,254	\$ 86,042		\$ 137,882	\$ 51,840	\$ 2,853,434	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)		\$ 4,249,254	\$ 86,042		\$ 137,882	\$ 51,840	\$ 2,853,434	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12N, Carried Forward		\$ 4,249,254	\$ 86,042		\$ 137,882	\$ 51,840	\$ 2,853,434	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)		\$ 4,249,254	\$ 86,042		\$ 137,882	\$ 51,840	\$ 2,853,434	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12O, Carried Forward		\$ 4,249,254	\$ 86,042		\$ 137,882	\$ 51,840	\$ 2,853,434	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)		\$ 4,249,254	\$ 86,042		\$ 137,882	\$ 51,840	\$ 2,853,434	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12P, Carried Forward		\$ 4,249,254	\$ 86,042		\$ 137,882	\$ 51,840	\$ 2,853,434	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)		\$ 4,249,254	\$ 86,042		\$ 137,882	\$ 51,840	\$ 2,853,434	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:

01/01/07

Ending:

12/31/07

**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	1967	\$ 1,539,800	\$		\$ 19,088	\$ 19,088	\$ 1,597,064	4
5											5
6											6
7											7
8											8
<b>Improvement Type**</b>											
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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9			
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation			
37		\$	\$		\$	\$	\$	37		
38								38		
39								39		
40								40		
41								41		
42								42		
43								43		
44								44		
45								45		
46								46		
47								47		
48								48		
49								49		
50								50		
51								51		
52								52		
53								53		
54								54		
55								55		
56								56		
57								57		
58								58		
59								59		
60								60		
61								61		
62								62		
63								63		
64								64		
65								65		
66								66		
67								67		
68								68		
69								69		
70	TOTAL (lines 4 thru 69)	\$	1,539,800	\$	19,088	\$	19,088	\$	1,597,064	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Wilson Care

# 0029975

Report Period Beginning:

01/01/07

Ending:

12/31/07

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	SIR - SIR		1993	1993	\$ 28,673	\$ 910	35	\$ 819	\$ (91)	\$ 11,879	4
5	SIR - Pref		1993	1993	16,041	509	35	458	(51)	6,645	5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Preferred Bookkeeping - Allocation		1997		20,033	449	20	1,002	553	10,827	9
10	Preferred Bookkeeping - Allocation		1999		159	-	20	8	8	68	10
11	Preferred Bookkeeping - Allocation		2000		1,005	-	20	50	50	372	11
12											12
13	S.I.R. Properties - Preferred Bookkeeping - Allocation		2007		281	14	20	14		14	13
14	S.I.R. Properties - Preferred Bookkeeping - Allocation		2002		64	-	20	3	3	18	14
15	S.I.R. Properties - Preferred Bookkeeping - Allocation		1999		2,033	203	20	102	(101)	864	15
16	S.I.R. Properties - Preferred Bookkeeping - Allocation		1998		971	97	20	49	(48)	461	16
17	S.I.R. Properties - Preferred Bookkeeping - Allocation		1997		60	3	20	3		35	17
18	S.I.R. Properties - Preferred Bookkeeping - Allocation		1994		153	4	20	8	4	103	18
19	S.I.R. Properties - Preferred Bookkeeping - Allocation		1993		260	1	20	13	12	189	19
20											20
21	S.I.R. Properties - S.I.R. Management - Allocation		2007		502	25	20	25		25	21
22	S.I.R. Properties - S.I.R. Management - Allocation		2002		114	-	20	6	6	31	22
23	S.I.R. Properties - S.I.R. Management - Allocation		1999		3,633	363	20	182	(181)	1,544	23
24	S.I.R. Properties - S.I.R. Management - Allocation		1998		1,736	174	20	87	(87)	825	24
25	S.I.R. Properties - S.I.R. Management - Allocation		1997		108	5	20	5		62	25
26	S.I.R. Properties - S.I.R. Management - Allocation		1994		273	7	20	14	7	184	26
27	S.I.R. Properties - S.I.R. Management - Allocation		1993		465	2		23	21	337	27
28											28
29	S.I.R. Management - Allocation		1993		12,315	343	20	610	267	9,158	29
30	S.I.R. Management - Allocation		1994		38	-	20	-		38	30
31	S.I.R. Management - Allocation		1995		281	-	20	14	14	175	31
32	S.I.R. Management - Allocation		1999		1,338	-	20	67	67	549	32
33	S.I.R. Management - Allocation		2000		808	-	20	40	40	310	33
34	S.I.R. Management - Allocation		2007		5,644	532	20	55	(477)	55	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:

01/01/07

Ending:

12/31/07

**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	<b>TOTAL (lines 4 thru 69)</b>	\$	\$ 96,988		\$ 3,657	\$ 16	\$ 44,768	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: 01/01/07 Ending: 12/31/07

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	\$ 423,381	\$ 702	\$ 23,722	\$ 23,020	10	\$ 339,209	71
72	Current Year Purchases	28,900	1,956	1,216	(741)	10	1,216	72
73	Fully Depreciated Assets	506,241				10	506,241	73
74								74
75	TOTALS	\$ 958,522	\$ 2,658	\$ 24,938	\$ 22,280		\$ 846,666	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)	\$ 5,221,076	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 88,700	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 162,819	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 74,119	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,700,100	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: 01/01/07

Ending: 12/31/07

**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	<b>TOTAL</b>				\$			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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized  
by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 11,318

Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Alloc. - S.I.R. Management</u>		\$	\$ <u>3,005</u>	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$ <u>3,005</u>	21

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

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

**XIII. EXPENSES RELATING TO 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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

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

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

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5 Units Cost					
					Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist	N/A	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <a href="#">See Supplemental</a>									13
14	<b>TOTAL</b>			\$		\$	\$		\$	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: 01/01/07

Ending:

12/31/07**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/07

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 267	\$ 10,328	1
2	Cash-Patient Deposits	32,197	32,197	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	1,676,239	1,676,239	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	22,699	22,699	6
7	Other Prepaid Expenses	3,833	3,833	7
8	Accounts Receivable (owners or related parties)	240,000	240,000	8
9	Other(specify): <u>See Attached Schedule</u>	56,043	56,043	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 2,031,278	\$ 2,041,339	10
	<b>B. Long-Term Assets</b>			
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	1,688,300	1,688,300	15
16	Equipment, at Historical Cost	1,329,485	1,359,485	16
17	Accumulated Depreciation (book methods)	(1,811,187)	(3,570,718)	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>	35,873	37,243	23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 1,242,471	\$ 1,110,801	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 3,273,749	\$ 3,152,140	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 175,934	\$ 175,934	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	32,407	32,407	28
29	Short-Term Notes Payable	990,000	990,000	29
30	Accrued Salaries Payable	147,511	147,511	30
31	Accrued Taxes Payable (excluding real estate taxes)	28,725	28,725	31
32	Accrued Real Estate Taxes(Sch.IX-B)	175,200	175,200	32
33	Accrued Interest Payable		23,832	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	14,500	14,500	35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Attached Schedule</u>	3,716	3,716	36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 1,567,993	\$ 1,591,825	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,701,412	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>See Attached Schedule</u>			43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$	\$ 4,701,412	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 1,567,993	\$ 6,293,237	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 1,705,756	\$ (3,141,097)	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 3,273,749	\$ 3,152,140	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,263,039	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,263,039	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	1,026,717	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	(1,584,000)	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)	\$ (557,283)	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,705,756	24 *

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Wilson Care

# 0029975

Report Period Beginning: 01/01/07

Ending: 12/31/07

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 6,279,087	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 6,279,087	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	25,415	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 25,415	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	1,567	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,567	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 6,306,069	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,038,732	31
32	Health Care	1,634,584	32
33	General Administration	1,509,191	33
<b>B. Capital Expense</b>			
34	Ownership	988,440	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	108,405	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,279,352	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	1,026,717	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 1,026,717	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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:

01/01/07

Ending:

12/31/07

**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	2,004	2,109	\$ 73,081	\$ 34.65	1
2	Assistant Director of Nursing	613	613	19,584	31.95	2
3	Registered Nurses	2,163	2,396	59,262	24.73	3
4	Licensed Practical Nurses	9,265	9,937	216,460	21.78	4
5	CNAs & Orderlies	54,061	57,856	547,103	9.46	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,898	2,062	27,980	13.57	9
10	Activity Assistants	7,610	8,159	71,829	8.80	10
11	Social Service Workers	17,212	18,615	293,801	15.78	11
12	Dietician					12
13	Food Service Supervisor	1,817	2,121	36,910	17.40	13
14	Head Cook	4,704	5,010	42,914	8.57	14
15	Cook Helpers/Assistants	11,851	12,830	113,843	8.87	15
16	Dishwashers					16
17	Maintenance Workers	4,571	4,772	41,581	8.71	17
18	Housekeepers	16,347	17,375	155,016	8.92	18
19	Laundry					19
20	Administrator	3,918	4,158	93,604	22.51	20
21	Assistant Administrator	1,522	1,522	41,657	27.37	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,326	16,618	188,941	11.37	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	3,533	3,742	70,700	18.89	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	2,556	2,556	8,782	3.44	33
34	TOTAL (lines 1 - 33)	159,971	172,451	\$ 2,103,048 *	\$ 12.20	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	\$ 31,785	01-03	35
36	Medical Director	Monthly	3,600	09-03	36
37	Medical Records Consultant	Monthly	4,224	10-03	37
38	Nurse Consultant	1,079	39,204	10-03	38
39	Pharmacist Consultant	Monthly	3,314	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	2,138	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Psychiatric Director	Monthly	8,100	10-03	47
48	Specialized Rehab Consultant	Monthly	17,580	10a-03	48
49	TOTAL (lines 35 - 48)	1,079	\$ 109,945		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	8	\$ 480	10-03	50
51	Licensed Practical Nurses	3,655	124,364	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	3,663	\$ 124,844		53

SEE ACCOUNTANTS' COMPILATION REPORT



Facility Name & ID Number Wilson Care

Report Period Beginning: 01/01/07 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 FY2004	6 FY2005	7 FY2006	8 FY2007	9 FY2008	10 FY2009	11 FY2010	12 FY2011	13 FY2012
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

