

Facility Name & ID Number Wilson Care

0029975 Report Period Beginning: 01/01/08 Ending: 12/31/08

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>72,468</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>72,468</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>64,622</u>	<u>1,574</u>		<u>66,196</u>
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	<u>64,622</u>	<u>1,574</u>		<u>66,196</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.35%

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

2,108 (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 09/01/08

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: 12/31/08 Fiscal Year: 12/31/08

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

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/08 Ending: 12/31/08

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
	A. General Services										
1	Dietary	195,168	30,349	30,372	255,889		255,889	(15,292)	240,597		1
2	Food Purchase		273,261		273,261	(20,752)	252,509	(65)	252,444		2
3	Housekeeping	179,285	37,951		217,236		217,236	(2,118)	215,118		3
4	Laundry		14,389	13,879	28,268		28,268		28,268		4
5	Heat and Other Utilities			144,975	144,975		144,975	2,365	147,340		5
6	Maintenance	24,440	33,049	158,179	215,668		215,668	(57,192)	158,476		6
7	Other (specify):*							2,777	2,777		7
8	TOTAL General Services	398,893	388,999	347,405	1,135,297	(20,752)	1,114,545	(69,525)	1,045,020		8
	B. Health Care and Programs										
9	Medical Director			6,400	6,400		6,400		6,400		9
10	Nursing and Medical Records	1,063,766	26,082	140,322	1,230,170		1,230,170	(27,419)	1,202,751		10
10a	Therapy			21,384	21,384		21,384	(18,227)	3,157		10a
11	Activities	109,596	8,504	2,513	120,613		120,613		120,613		11
12	Social Services	270,515	9,975	616	281,106		281,106		281,106		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							3,435	3,435		15
16	TOTAL Health Care and Programs	1,443,877	44,561	171,235	1,659,673		1,659,673	(42,211)	1,617,462		16
	C. General Administration										
17	Administrative	136,701		313,416	450,117		450,117	(108,139)	341,978		17
18	Directors Fees										18
19	Professional Services			174,101	174,101		174,101	(107,955)	66,146		19
20	Dues, Fees, Subscriptions & Promotions			57,197	57,197		57,197	(31,745)	25,452		20
21	Clerical & General Office Expenses	168,019	28,787	127,377	324,183		324,183	(1,171)	323,012		21
22	Employee Benefits & Payroll Taxes			396,894	396,894	20,752	417,646		417,646		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,943	4,943		4,943	150	5,093		24
25	Other Admin. Staff Transportation			6,216	6,216		6,216	8,487	14,703		25
26	Insurance-Prop.Liab.Malpractice			179,273	179,273		179,273	927	180,200		26
27	Other (specify):*							37,769	37,769		27
28	TOTAL General Administration	304,720	28,787	1,259,417	1,592,924	20,752	1,613,676	(201,677)	1,411,999		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,147,490	462,347	1,778,057	4,387,894		4,387,894	(313,413)	4,074,481		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				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	
	D. Ownership											
30	Depreciation			87,751	87,751	87,751	112,249	200,000				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			84,627	84,627	84,627	738,239	822,866				32
33	Real Estate Taxes						173,761	173,761				33
34	Rent-Facility & Grounds			1,287,810	1,287,810	1,287,810	(1,287,810)					34
35	Rent-Equipment & Vehicles			7,387	7,387	7,387	6,816	14,203				35
36	Other (specify):*						63,093	63,093				36
37	TOTAL Ownership			1,467,575	1,467,575	1,467,575	(193,652)	1,273,923				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			108,702	108,702	108,702		108,702				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			108,702	108,702	108,702		108,702				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,147,490	462,347	3,354,334	5,964,171	5,964,171	(507,065)	5,457,106				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: 01/01/08

Ending: 12/31/08

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	(3,063)	06		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	79,212	30		9
10	Interest and Other Investment Income	(45,673)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(65)	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	(10,275)	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	(45,422)	21		24
25	Fund Raising, Advertising and Promotional	(11,358)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(17,620)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(59,854)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (114,118)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(392,947)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (392,947)		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (507,065)		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Wilson Care

ID# 0029975

Report Period Beginning: 01/01/08

Ending: 12/31/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Misc. Income	\$ (41)	10	1
2	Filing & Other Fees- Building Co.	(906)	20	2
3	Office Expense- Building Co.	(707)	21	3
4	Professional Fees- Building co.	(2,087)	19	4
5	Replacement Tax- Building Co.	(529)	21	5
6	Collections	(275)	21	6
7	Non-Allowable Seminar	(380)	24	7
8	Annual Report	(250)	20	8
9	Capitalized R&M	(43,114)	06	9
10	COPE Dues	(6,813)	20	10
11	Alliance for Living PAC Dues	(4,752)	20	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
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	Total	(59,854)		49

Wilson Care

ID# 0029975

Report Period Beginning: 01/01/08

Ending: 12/31/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
50	\$		1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
58			9
59			10
60			11
61			12
62			13
63			14
64			15
65			16
66			17
67			18
68			19
69			20
70			21
71			22
72			23
73			24
74			25
75			26
76			27
77			28
78			29
79			30
80			31
81			32
82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Wilson Care

0029975

Report Period Beginning:

01/01/08

Ending:

12/31/08

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary				(15,292)								(15,292)	1
2	Food Purchase	(65)											(65)	2
3	Housekeeping					(2,118)							(2,118)	3
4	Laundry													4
5	Heat and Other Utilities			2,365									2,365	5
6	Maintenance	(46,177)		(9,702)	(1,313)								(57,192)	6
7	Other (specify):*			823	1,954								2,777	7
8	TOTAL General Services	(46,242)		(6,514)	(14,651)	(2,118)							(69,525)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(41)		(32,766)	7,262	(1,874)							(27,419)	10
10a	Therapy				(18,227)								(18,227)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			1,683	1,752								3,435	15
16	TOTAL Health Care and Programs	(41)		(31,083)	(9,213)	(1,874)							(42,211)	16
	C. General Administration													
17	Administrative			(206,724)	98,585								(108,139)	17
18	Directors Fees													18
19	Professional Services	(2,087)	2,087	(121,862)	13,907								(107,955)	19
20	Fees, Subscriptions & Promotions	(34,354)	906	1,703									(31,745)	20
21	Clerical & General Office Expenses	(64,553)	1,236	57,469	4,677								(1,171)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(380)		530									150	24
25	Other Admin. Staff Transportation			8,487									8,487	25
26	Insurance-Prop.Liab.Malpractice			927									927	26
27	Other (specify):*			16,573	21,196								37,769	27
28	TOTAL General Administration	(101,374)	4,229	(242,897)	138,365								(201,677)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(147,657)	4,229	(280,494)	114,501	(3,992)							(313,413)	29

STATE OF ILLINOIS

Facility Name & ID Number Wilson Care

0029975

Report Period Beginning:

01/01/08

Ending:

Summary B

12/31/08

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	79,212	21,175	11,862									112,249	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(45,673)	778,558	5,354									738,239	32
33	Real Estate Taxes		167,930	5,831									173,761	33
34	Rent-Facility & Grounds		(1,287,810)										(1,287,810)	34
35	Rent-Equipment & Vehicles			6,816									6,816	35
36	Other (specify):*		63,093										63,093	36
37	TOTAL Ownership	33,539	(257,054)	29,863									(193,652)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers													44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(114,118)	(252,825)	(250,631)	114,501	(3,992)							(507,065)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				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 Rent- Base	\$ 1,192,380	Wilson Care, LLC.	100.00%	\$	\$ (1,192,380)	1
2	V	34 Rent- Tax	95,430	Wilson Care, LLC.	100.00%		(95,430)	2
3	V	36 Amortization		Wilson Care, LLC.	100.00%	63,093	63,093	3
4	V	30 Depreciation		Wilson Care, LLC.	100.00%	21,175	21,175	4
5	V	20 Filing & Other Fees		Wilson Care, LLC.	100.00%	906	906	5
6	V	32 Interest	210,480	Wilson Care, LLC.	100.00%	989,038	778,558	6
7	V	21 Office Expense		Wilson Care, LLC.	100.00%	707	707	7
8	V	19 Professional Fees		Wilson Care, LLC.	100.00%	2,087	2,087	8
9	V	33 Real Estate Taxes		Wilson Care, LLC.	100.00%	167,930	167,930	9
10	V	21 Replacement Tax		Wilson Care, LLC.	100.00%	529	529	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,498,290			\$ 1,245,465	\$ * (252,825)	14

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

Facility Name & ID Number Wilson Care# 0029975Report Period Beginning: 01/01/08Ending: 12/31/08

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5 UTILITIES	\$	S.I.R. MANAGEMENT, INC.	100.00%	\$ 2,365	\$ 2,365	15
16	V	6 REPAIRS AND MAINT.	21,384	S.I.R. MANAGEMENT, INC.	100.00%	11,682	(9,702)	16
17	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	823	823	17
18	V	10 NURSING	42,768	S.I.R. MANAGEMENT, INC.	100.00%	10,002	(32,766)	18
19	V	15 EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	1,683	1,683	19
20	V	17 ADMINISTRATIVE	206,724	S.I.R. MANAGEMENT, INC.	100.00%		(206,724)	20
21	V	19 PROFESSIONAL FEES	140,544	S.I.R. MANAGEMENT, INC.	100.00%	18,682	(121,862)	21
22	V	20 FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	1,703	1,703	22
23	V	21 CLERICAL & GENERAL	42,768	S.I.R. MANAGEMENT, INC.	100.00%	100,237	57,469	23
24	V	24 EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	530	530	24
25	V	25 OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	8,487	8,487	25
26	V	26 INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	927	927	26
27	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	16,573	16,573	27
28	V	30 DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	11,862	11,862	28
29	V	32 INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	5,354	5,354	29
30	V	33 REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	5,831	5,831	30
31	V	35 EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	6,816	6,816	31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 454,188			\$ 203,557	\$ * (250,631)	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: 01/01/08Ending: 12/31/08

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	\$ 21,384	S.I.R. MANAGEMENT, INC.	100.00%	\$ 6,092	\$ (15,292)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	996	996	16
17	V	10	NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	7,262	7,262	17
18	V	15	EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	1,152	1,152	18
19	V	17	ADMIN./LEGAL SALARIES	10,692	S.I.R. MANAGEMENT, INC.	100.00%	109,277	98,585	19
20	V	21	CLERICAL & OFFICE SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	4,677	4,677	20
21	V	19	FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	13,907	13,907	21
22	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	21,196	21,196	22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	21,384	S.I.R. MANAGEMENT, INC.	100.00%	3,157	(18,227)	24
25	V	15	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	600	600	25
26	V								26
27	V	6	MAINTENANCE SALARIES	5,904	S.I.R. MANAGEMENT, INC.	100.00%	4,591	(1,313)	27
28	V	7	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	958	958	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		\$ 59,364				\$ 173,865	\$ * 114,501	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	1 Dietary	\$	Xcel Supply, LLC	100.00%	\$		15
16	V	3 Housekeeping	23,910	Xcel Supply, LLC	100.00%	21,792	(2,118)	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	21,159	Xcel Supply, LLC	100.00%	19,285	(1,874)	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		\$ 45,069			\$ 41,077	\$ * (3,992)	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	22	Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 100,149	\$ 100,149	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	100,149	CCS Employee Benefits Group	100.00%		(100,149)	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			\$ 100,149			\$ 100,149	\$ *	39

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

Facility Name & ID Number Wilson Care

0029975

Report Period Beginning: 01/01/08

Ending: 12/31/08

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: 01/01/08

Ending: 12/31/08

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: 01/01/08

Ending: 12/31/08

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: 01/01/08

Ending: 12/31/08

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: 01/01/08

Ending: 12/31/08

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: 01/01/08 Ending: 12/31/08

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	11.11%	See Attached	2.45	6.13%	Alloc. Salary	\$ 15,943	17-7	1
2	Eric Rothner	Owner	Administrative	20.00%	See Attached	0.57	1.24%	Alloc. Salary	8,991	17-7	2
3	Nenita Guzman	Relative	Dietary	0.00%	See Attached	4.09	8.18%	Alloc. Salary	6,092	1-7	3
4	Noah Wolf	Owner	Administrative	5.56%	See Attached	3.00	10.71%	Mgmt. Fee	48,000	17-3	4
5	Howard Geller	Owner	Administrative	4.44%	See Attached	8.00	16.00%	Mgmt. Fee	48,000	17-3	5
6	Kim Rudolph	Relative	Clerical	0.00%	See Attached	0.32	1.92%	Alloc. Salary	280	22-7	6
7	Adam Vales	Relative	Clerical	0.00%	See Attached	0.77	1.93%	Alloc. Salary	1,379	22-7	7
8	Sarah Barrish	Relative	Administrative	0.00%	See Attached	0.45	8.14%	Alloc. Salary	1,176	17-7	8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 129,861		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: 01/01/08 Ending: 12/31/08

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:

01/01/08

Ending: 12/31/08

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	809,665	13	\$ 28,924	\$ 66,196	\$ 2,365	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	809,665	13	142,892	66,196	11,682	2
3	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	809,665	13	10,063	66,196	823	3
4	10	NURSING	PATIENT DAYS	809,665	13	122,335	66,196	10,002	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	809,665	13	20,583	66,196	1,683	5
6	17	ADMINISTRATIVE	PATIENT DAYS	809,665	13		66,196		6
7	19	PROFESSIONAL FEES	PATIENT DAYS	809,665	13	228,501	66,196	18,682	7
8	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	809,665	13	20,828	66,196	1,703	8
9	21	CLERICAL & GENERAL	PATIENT DAYS	809,665	13	1,226,029	66,196	100,237	9
10	24	EDUCATION & SEMINAR	PATIENT DAYS	809,665	13	6,483	66,196	530	10
11	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	809,665	13	103,811	66,196	8,487	11
12	26	INSURANCE	PATIENT DAYS	809,665	13	11,341	66,196	927	12
13	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	809,665	13	202,715	66,196	16,573	13
14	30	DEPRECIATION	PATIENT DAYS	809,665	13	145,092	66,196	11,862	14
15	32	INTEREST	PATIENT DAYS	809,665	13	65,487	66,196	5,354	15
16	33	REAL ESTATE TAXES	PATIENT DAYS	809,665	13	71,319	66,196	5,831	16
17	35	EQUIPMENT RENTAL	PATIENT DAYS	809,665	13	83,368	66,196	6,816	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,489,771	\$ 1,402,210	\$ 203,557	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care

0029975

Report Period Beginning:

01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	PATIENT DAYS	809,665	13	\$ 74,508	\$ 66,196	\$ 6,092	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	809,665	13	12,182	66,196	996	2
3	10	NURSING SALARIES	PATIENT DAYS	809,665	13	88,823	66,196	7,262	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	809,665	13	14,090	66,196	1,152	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	809,665	13	1,336,598	66,196	109,277	5
6	21	CLERICAL & OFFICE SALARIES	PATIENT DAYS	809,665	13	57,211	66,196	4,677	6
7	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	809,665	13	170,103	66,196	13,907	7
8	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	809,665	13	259,260	66,196	21,196	8
9									9
10	10A	DIRECTOR OF SPECIAL REHAB	SPECIAL REHAB INC.	268,263	13	39,604	21,384	3,157	10
11	15	EMPLOYEE BENEFITS	SPECIAL REHAB INC.	268,263	13	7,528	21,384	600	11
12									12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	153,288	9	119,187	5,904	4,591	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	153,288	9	24,879	5,904	958	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,203,973	\$ 1,715,931	\$ 173,865	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care

0029975

Report Period Beginning: 01/01/08

Ending: 12/31/08

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					21,792	2
3	4	Laundry	Direct Allocation						3
4	6	Repairs & Maintenance	Direct Allocation						4
5	10	Nursing	Direct Allocation					19,285	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				\$	\$		\$	41,077

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care

0029975

Report Period Beginning: 01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization CCS Employee Benefits Group, Inc.
 Street Address 2201 Main Street
 City / State / Zip Code Evanston, Illinois 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		\$	\$		\$ 100,149	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				\$	\$		\$ 100,149	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care

0029975 Report Period Beginning: 01/01/08 Ending: 12/31/08

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: 01/01/08 Ending: 12/31/08

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: 01/01/08 Ending: 12/31/08

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: 01/01/08 Ending: 12/31/08

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: 01/01/08 Ending: 12/31/08

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:

01/01/08

Ending:

12/31/08

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 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Private Bank		X	Mortgage Payable			\$ 17,103,500	\$ 17,103,500			\$ 989,038	1
2	Notes Payable		X					538,909				2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Lake Forest Bank & Trust		X	Line of Credit				1,643,833		3.5000	84,627	6
7	Alloc- S.I.R Management										5,354	7
8	See Supplemental Schedule											8
9	TOTAL Facility Related						\$ 17,103,500	\$ 19,286,242			\$ 1,079,019	9
	B. Non-Facility Related*											
10	Interest Income		X								(45,673)	10
11	Interest Income- Bldg. Co.		X								(210,480)	11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						\$	\$			(256,153)	14
15	TOTALS (line 9+line14)						\$ 17,103,500	\$ 19,286,242			\$ 822,866	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:

01/01/08

Ending:

12/31/08

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

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

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

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

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

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2007 report.		\$ 175,200	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.)		\$ 174,961	2
3. Under or (over) accrual (line 2 minus line 1).		\$ (239)	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 174,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 173,761	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2003	67,251	8
	2004	68,745	9
	2005	71,860	10
	2006	169,658	11
	2007	169,130	12
Accrual for 2006 = \$169,130 x 1.03 = \$174,000			
Alloc. - S.I.R. Management = \$5,831			
FOR BHF USE ONLY			
	13	FROM R. E. TAX STATEMENT FOR 2007 \$	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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 2007 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 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>14-17-220-009-0000</u>	<u>Long Term Care Property</u>	\$ <u>169,130.34</u>	\$ <u>169,130.34</u>
2. <u>See Attached</u>	<u>See Attached</u>	\$ <u>101,615.67</u>	\$ <u>5,975.81</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>270,746.01</u>	\$ <u>175,106.15</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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:** 2007 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 2007 real estate tax costs, as well as copies of your real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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.		\$	\$
TOTALS		\$	\$

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

Facility Name & ID Number Wilson Care

0029975 Report Period Beginning:

01/01/08 Ending:

12/31/08

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

None

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

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

Nature of Costs: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1985</u>	\$ <u>13,300</u>	1
2					2
3	TOTALS			\$ 13,300	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
		Improvement Type**									
9	Various		1985		65,366		20			65,340	9
10	Various		1986		161,365		20			161,346	10
11	Various		1987		49,380		20			49,348	11
12	Various		1989		49,210		20	2,461	2,461	48,130	12
13	Various		1990		105,470		20	5,274	5,274	95,376	13
14	Various		1991		29,903		20	1,494	1,494	26,252	14
15	Various		1992		69,669		20	3,484	3,484	57,678	15
16	Various		1993		61,688		20	3,087	3,087	47,785	16
17	Various		1994		55,691		20	2,654	2,654	40,886	17
18	Various		1995		87,144		20	4,360	4,360	58,842	18
19	Various		1996		303,393		20	15,172	15,172	188,683	19
20	Various		1997		145,411		20	7,348	7,348	79,141	20
21	Various		1998		34,959		20	1,748	1,748	18,437	21
22	Various		1999		53,478		20	2,675	2,675	25,602	22
23	Various		2000		342,218		20	17,110	17,110	142,041	23
24	Various		2001		102,633		20	5,132	5,132	39,328	24
25	Various		2002		67,986		20	4,958	4,958	50,114	25
26	Various		2003		97,187		20	6,028	6,028	32,509	26
27	Various		2004		62,333		20	4,336	4,336	19,527	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

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		2,046,138	21,175		44,405	23,230	1,637,327	67
68		95,835	3,124		3,543	419	48,218	68
69			87,751			(87,751)		69
70		\$ 4,086,457	\$ 112,050		\$ 135,269	\$ 23,219	\$ 2,931,910	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:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 4,086,457	\$ 112,050		\$ 135,269	\$ 23,219	\$ 2,931,910	1
2	Elevator Work	2005	5,670		20	567	567	2,174	2
3	Plumbing Work	2005	12,800		20	640	640	2,347	3
4	Walk - In Freezer	2005	42,000		20	2,100	2,100	7,525	4
5	Roof Work	2005	6,500		20	325	325	1,165	5
6	Roof Work	2005	48,750		20	4,875	4,875	17,469	6
7	Roof Work	2005	5,200		20	260	260	932	7
8	Wall Repair	2005	2,800		20	140	140	478	8
9	Plumbing Work	2005	6,350		20	318	318	1,085	9
10	Cubicle Tracks	2005	4,615		20	231	231	788	10
11	Hvac Work	2005	2,269		20	113	113	388	11
12	Flooring - Tile	2005	10,317		20	516	516	1,591	12
13	Sprinkler System	2005	4,785		20	239	239	778	13
14	Boiler Work	2005	4,699		20	235	235	764	14
15	Alarm System	2005	3,031		20	152	152	480	15
16	Masonry	2005	32,650		20	1,633	1,633	5,850	16
17	Masonry	2005	9,870		20	494	494	1,768	17
18	Radiator Repiping	2005	1,444		20	72	72	223	18
19	Radiator Repiping	2005	1,455		20	73	73	224	19
20	Radiator Repiping	2005	908		20	45	45	140	20
21	Carpeting	2005	1,787		20	89	89	320	21
22	Blinds	2005	3,233		20	162	162	579	22
23	Wall Panels	2005	2,053		20	103	103	368	23
24	Railing	2005	1,780		20	89	89	312	24
25	Stairs And Flooring	2006	10,338		20	517	517	1,077	25
26	Locks	2006	2,950		20	295	295	787	26
27	Rewiring Fire Pump	2006	4,640		20	232	232	599	27
28	Sheet Flooring	2006	11,662		20	583	583	1,506	28
29	Fire Doors	2006	7,475		20	374	374	997	29
30	Fire Doors	2006	2,800		20	140	140	338	30
31	Bathroom Remodel	2006	5,850		20	293	293	634	31
32	Electrical Work	2006	7,848		20	392	392	883	32
33	Electrical Work	2006	2,656		20	133	133	288	33
34	TOTAL (lines 1 thru 33)		\$ 4,357,642	\$ 112,050		\$ 151,699	\$ 39,649	\$ 2,986,767	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:

01/01/08

Ending:

12/31/08

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 4,357,642	\$ 112,050		\$ 151,699	\$ 39,649	\$ 2,986,767	1
2	Reception Station	2007	12,557		20	1,256	1,256	2,302	2
3	Security System Work	2007	2,525		20	253	253	463	3
4	Bathroom Remodeling	2007	11,700		20	585	585	1,024	4
5	Bathroom Remodeling	2007	12,085		20	604	604	1,057	5
6	Bathroom Remodeling	2007	11,700		20	585	585	975	6
7	Bathroom Remodeling	2007	10,980		20	549	549	869	7
8	Cameras	2007	2,970		20	297	297	495	8
9	Bathroom Remodeling	2007	11,700		20	585	585	926	9
10	Bathroom Remodeling	2007	12,085		20	604	604	957	10
11	Tile Flooring	2007	39,410		20	1,971	1,971	3,120	11
12	Bathroom Remodeling	2007	12,085		20	604	604	957	12
13	Bathroom Remodeling	2007	11,700		20	585	585	878	13
14	Hot Water Heater	2007	6,211		20	311	311	569	14
15	Bathroom Remodeling	2007	11,700		20	585	585	829	15
16	Bathroom Remodeling	2007	12,160		20	608	608	861	16
17	Fire Doors	2007	6,850		20	343	343	457	17
18	Security System	2007	4,110		20	411	411	514	18
19	Security System	2007	8,310		20	831	831	1,039	19
20	Tile Flooring	2007	29,171		20	1,459	1,459	1,823	20
21	Bathroom Work	2007	2,080		20	104	104	130	21
22	Boiler Work	2007	5,323		20	266	266	333	22
23	Bathroom Remodeling	2007	11,700		20	585	585	731	23
24	Bathroom Remodeling	2007	11,700		20	585	585	731	24
25	Tile Flooring	2007	50,378		20	2,519	2,519	2,939	25
26	Fire Doors	2007	7,975		20	399	399	465	26
27	Handrails	2007	10,930		20	547	547	592	27
28	Bathroom Work	2007	11,700		20	585	585	780	28
29	Bathroom Work	2007	11,700		20	585	585	683	29
30	Ceiling Panels	2007	2,550		20	128	128	170	30
31	Boiler Work	2007	2,660		20	133	133	166	31
32	Roof Work	2007	3,565		20	178	178	297	32
33	Boiler Work	2007	3,100		20	155	155	155	33
34	TOTAL (lines 1 thru 33)		\$ 4,723,012	\$ 112,050		\$ 171,494	\$ 59,444	\$ 3,015,054	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:

01/01/08

Ending:

12/31/08

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 12C, Carried Forward		\$ 4,723,012	\$ 112,050		\$ 171,494	\$ 59,444	\$ 3,015,054	1
2	Landscaping- Trees, Bush	2008	5,185		20	259	259	259	2
3	Elevator Cables & Phone	2008	3,925		20	196	196	196	3
4	Return Steam Trap & Valves	2008	10,440		20	522	522	522	4
5	Heat Repair	2008	3,069		20	153	153	153	5
6	Chiller Repair	2008	3,196		20	160	160	160	6
7	Electrical Work	2008	3,013		20	151	151	151	7
8	Mixing Valves	2008	3,050		20	153	153	153	8
9	Heating System	2008	8,136		20	407	407	407	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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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)		\$ 4,763,026	\$ 112,050		\$ 173,495	\$ 61,445	\$ 3,017,055	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:

01/01/08

Ending:

12/31/08

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		\$ 4,763,026	\$ 112,050		\$ 173,495	\$ 61,445	\$ 3,017,055	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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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,763,026	\$ 112,050		\$ 173,495	\$ 61,445	\$ 3,017,055	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:

01/01/08

Ending:

12/31/08

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		\$ 4,763,026	\$ 112,050		\$ 173,495	\$ 61,445	\$ 3,017,055	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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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,763,026	\$ 112,050		\$ 173,495	\$ 61,445	\$ 3,017,055	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:

01/01/08

Ending:

12/31/08

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		\$ 4,763,026	\$ 112,050		\$ 173,495	\$ 61,445	\$ 3,017,055	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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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,763,026	\$ 112,050		\$ 173,495	\$ 61,445	\$ 3,017,055	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:

01/01/08

Ending:

12/31/08

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		\$ 4,763,026	\$ 112,050		\$ 173,495	\$ 61,445	\$ 3,017,055	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,763,026	\$ 112,050		\$ 173,495	\$ 61,445	\$ 3,017,055	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:

01/01/08

Ending:

12/31/08

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		\$ 4,763,026	\$ 112,050		\$ 173,495	\$ 61,445	\$ 3,017,055	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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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,763,026	\$ 112,050		\$ 173,495	\$ 61,445	\$ 3,017,055	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:

01/01/08

Ending:

12/31/08

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		\$ 4,763,026	\$ 112,050		\$ 173,495	\$ 61,445	\$ 3,017,055	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,763,026	\$ 112,050		\$ 173,495	\$ 61,445	\$ 3,017,055	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:

01/01/08

Ending:

12/31/08

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		\$ 4,763,026	\$ 112,050		\$ 173,495	\$ 61,445	\$ 3,017,055	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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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,763,026	\$ 112,050		\$ 173,495	\$ 61,445	\$ 3,017,055	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:

01/01/08

Ending:

12/31/08

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		\$ 4,763,026	\$ 112,050		\$ 173,495	\$ 61,445	\$ 3,017,055	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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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,763,026	\$ 112,050		\$ 173,495	\$ 61,445	\$ 3,017,055	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:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12L, Carried Forward		\$ 4,763,026	\$ 112,050		\$ 173,495	\$ 61,445	\$ 3,017,055	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,763,026	\$ 112,050		\$ 173,495	\$ 61,445	\$ 3,017,055	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:

01/01/08

Ending:

12/31/08

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		\$ 4,763,026	\$ 112,050		\$ 173,495	\$ 61,445	\$ 3,017,055	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,763,026	\$ 112,050		\$ 173,495	\$ 61,445	\$ 3,017,055	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:

01/01/08

Ending:

12/31/08

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		\$ 4,763,026	\$ 112,050		\$ 173,495	\$ 61,445	\$ 3,017,055	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,763,026	\$ 112,050		\$ 173,495	\$ 61,445	\$ 3,017,055	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:

01/01/08

Ending:

12/31/08

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		\$ 4,763,026	\$ 112,050		\$ 173,495	\$ 61,445	\$ 3,017,055	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,763,026	\$ 112,050		\$ 173,495	\$ 61,445	\$ 3,017,055	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:

01/01/08

Ending:

12/31/08

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		\$ 4,763,026	\$ 112,050		\$ 173,495	\$ 61,445	\$ 3,017,055	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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27									27
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,763,026	\$ 112,050		\$ 173,495	\$ 61,445	\$ 3,017,055	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:

01/01/08

Ending:

12/31/08

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	
	Bed* FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	198	1985	1967	\$ 1,539,800	\$		\$ 19,088	\$ 19,088	\$ 1,616,152	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Bathroom Remodel		2007	35,100	1,174	20	1,755	581	1,174	9
10	Flooring (4th)		2008	29,171	1,945	20	1,459	(486)	1,945	10
11	Flooring (5th)		2008	29,171	810	20	1,459	649	810	11
12	Bathroom Remodel		2008	135,720	4,539	20	6,786	2,247	4,539	12
13	Bathroom Remodel		2008	23,400	910	20	1,170	260	910	13
14	Painting		2008	146,700	3,668	20	7,335	3,667	3,668	14
15	Bathtub Liner		2008	16,250	181	20	813	632	181	15
16	Elevator Controller		2008	35,150	1,465	20	1,758	293	1,465	16
17	Handrails		2008	9,794	571	20	490	(81)	571	17
18	Phone System		2008	11,656	777	20	583	(194)	777	18
19	Hot Water Boilers		2008	29,247	156	20	1,462	1,306	156	19
20	Gas Line Piping		2008	4,979	4,979	20	249	(4,730)	4,979	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:

01/01/08

Ending:

12/31/08

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)	\$ 2,046,138	\$ 21,175		\$ 44,405	\$ 23,230	\$ 1,637,327	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:

01/01/08

Ending:

12/31/08

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	
	Bed* 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	\$ 33,991	\$ 1,079	35	\$ 971	\$ (108)	\$ 15,053	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	S.I.R. Properties - S.I.R. Management - Allocation		2007	595	116	20	30	(86)	60	9
10	S.I.R. Properties - S.I.R. Management - Allocation		2002	135	-	20	7	7	44	10
11	S.I.R. Properties - S.I.R. Management - Allocation		1999	4,307	431	20	215	(216)	2,046	11
12	S.I.R. Properties - S.I.R. Management - Allocation		1998	2,058	-	20	103	103	1,081	12
13	S.I.R. Properties - S.I.R. Management - Allocation		1997	128	-	20	6	6	80	13
14	S.I.R. Properties - S.I.R. Management - Allocation		1994	324	8	20	16	8	235	14
15	S.I.R. Properties - S.I.R. Management - Allocation		1993	551	3	20	28	25	427	15
16										16
17	S.I.R. Management - Allocation		1993	9,383	261	20	465	204	7,443	17
18	S.I.R. Management - Allocation		1994	29	-	20	-		29	18
19	S.I.R. Management - Allocation		1995	214	-	20	11	11	144	19
20	S.I.R. Management - Allocation		1997	14,417	322	20	721	399	8,513	20
21	S.I.R. Management - Allocation		1999	12,213	-	20	57	57	11,603	21
22	S.I.R. Management - Allocation		2000	1,338	-	20	67	67	572	22
23	S.I.R. Management - Allocation		2007	4,300	-	20	215	215	257	23
24	S.I.R. Management - Allocation		2008	11,852	904	20	631	(273)	631	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:

01/01/08

Ending:

12/31/08

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)	\$	\$ 95,835		\$ 3,124	\$ 3,543	\$ 419	\$ 48,218	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: 01/01/08 Ending: 12/31/08

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	\$ 372,292	\$ 7,526	\$ 22,807	\$ 15,281	10	\$ 287,571	71
72	Current Year Purchases	71,866	1,212	3,698	2,486	10	3,698	72
73	Fully Depreciated Assets	565,045				10	565,045	73
74								74
75	TOTALS	\$ 1,009,203	\$ 8,738	\$ 26,505	\$ 17,767		\$ 856,314	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)	\$ 5,785,529	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 120,788	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 200,000	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 79,212	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,873,369	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	Tile Flooring	\$ 18,203	92
93			93
94			94
95		\$ 18,203	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: 01/01/08

Ending: 12/31/08

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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: \$ 8,802 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. - SIR Management</u>		\$	\$ <u>5,401</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$ <u>5,401</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	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8		
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			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	Other (specify):																12
13	Other (specify): See Supplemental																13
14	TOTAL			\$				\$		\$							14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/08 Ending: 12/31/08

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/08 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 15,348	\$ 172,374	1
2	Cash-Patient Deposits	34,316	34,316	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	2,552,000	2,552,000	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments		198,618	5
6	Prepaid Insurance	25,991	25,991	6
7	Other Prepaid Expenses	3,351	3,351	7
8	Accounts Receivable (owners or related parties)	538,909	538,909	8
9	Other(specify): <u>See Attached Schedule</u>			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,169,915	\$ 3,525,559	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments		6,668,864	12
13	Land		25,200	13
14	Buildings, at Historical Cost		1,986,803	14
15	Leasehold Improvements, at Historical Cost	1,688,300	1,688,300	15
16	Equipment, at Historical Cost	1,353,683	1,507,080	16
17	Accumulated Depreciation (book methods)	(1,898,938)	(3,268,580)	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>		39,279	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,143,045	\$ 8,646,946	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,312,960	\$ 12,172,505	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 217,216	\$ 722,865	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	37,185	37,185	28
29	Short-Term Notes Payable	1,643,833	1,643,833	29
30	Accrued Salaries Payable	168,732	168,732	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,631	10,631	31
32	Accrued Real Estate Taxes(Sch.IX-B)	101,500	174,000	32
33	Accrued Interest Payable		51,600	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	5,200	5,200	35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	2,426	2,426	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,186,723	\$ 2,816,472	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable		538,909	39
40	Mortgage Payable		17,103,500	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 17,642,409	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,186,723	\$ 20,458,881	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,126,237	\$ (8,286,376)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,312,960	\$ 12,172,505	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,705,756	1
2	Restatements (describe):		2
3	<u>Rounding</u>	5	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,705,761	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,284,476	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(864,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 420,476	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,126,237	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care

0029975

Report Period Beginning: 01/01/08

Ending: 12/31/08

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,201,733	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,201,733	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	45,673	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 45,673	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	1,241	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,241	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,248,647	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,135,297	31
32	Health Care	1,659,673	32
33	General Administration	1,592,924	33
B. Capital Expense			
34	Ownership	1,467,575	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	108,702	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,964,171	40
41	Income before Income Taxes (line 30 minus line 40)**	1,284,476	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,284,476	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete 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: 01/01/08

Ending:

12/31/08

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	2,041	2,091	\$ 70,468	\$ 33.70	1
2	Assistant Director of Nursing	1,146	1,183	34,499	29.16	2
3	Registered Nurses	1,741	2,028	52,887	26.08	3
4	Licensed Practical Nurses	10,979	12,213	269,611	22.08	4
5	CNAs & Orderlies	55,494	59,112	567,215	9.60	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,324	1,520	22,759	14.97	9
10	Activity Assistants	8,005	8,517	78,417	9.21	10
11	Social Service Workers	15,631	16,865	270,515	16.04	11
12	Dietician					12
13	Food Service Supervisor	2,041	2,091	27,415	13.11	13
14	Head Cook	6,217	6,393	55,687	8.71	14
15	Cook Helpers/Assistants	11,419	12,205	112,066	9.18	15
16	Dishwashers					16
17	Maintenance Workers	2,774	2,857	24,440	8.55	17
18	Housekeepers	17,501	18,691	179,285	9.59	18
19	Laundry					19
20	Administrator	1,880	2,080	97,339	46.80	20
21	Assistant Administrator	1,816	2,123	39,362	18.54	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,941	14,073	168,019	11.94	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	3,379	3,613	69,086	19.12	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	2,213	2,213	8,420	3.80	33
34	TOTAL (lines 1 - 33)	158,542	169,868	\$ 2,147,490 *	\$ 12.64	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	\$ 30,372	01-03	35
36	Medical Director	Monthly	6,400	09-03	36
37	Medical Records Consultant	Monthly	4,320	10-03	37
38	Nurse Consultant	1,177	42,768	10-03	38
39	Pharmacist Consultant	Monthly	3,277	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	2,513	11-03	44
45	Social Service Consultant	6	616	12-03	45
46	Other(specify)				46
47	<u>Specialized Rehab Consultant</u>	Monthly	21,384	10a-03	47
48	<u>Psychiatric Director</u>	Monthly	8,100	10-03	48
49	TOTAL (lines 35 - 48)	1,183	\$ 119,750		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses			50	
51	Licensed Practical Nurses	3,671	81,857	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	3,671	\$ 81,857		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care

0029975

Report Period Beginning: 01/01/08

Ending: 12/31/08

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Augusto Beley	Administrator	0%	\$ 97,339	Workers' Compensation Insurance	\$ 42,983	IDPH License Fee	\$ 994		
Patrick Ballke	Asst. Admin	0%	39,362	Unemployment Compensation Insurance	25,364	Advertising: Employee Recruitment	911		
				FICA Taxes	161,601	Health Care Worker Background Check (Indicate # of checks performed <u>246</u>)	2,469		
				Employee Health Insurance	150,684	Patient Background Checks			
				Employee Meals	20,752	Licenses & Permits	2,966		
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	16,409		
				City Head Tax	4,486	Advertising & Promotion	11,358		
				401K Contribution	3,365	Alloc. - S.I.R Management	1,703		
				Employee Benefits- Other	8,411				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 136,701	TOTAL (agree to Schedule V, line 22, col.8)		\$ 417,646	TOTAL (agree to Sch. V, line 20, col. 8)		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
Management Fees- SIR Management			\$ 120,000				Out-of-State Travel	\$	
SIR Management- Director of Admin. Services			42,768						
SIR Management- Admin Charges			43,956				In-State Travel		
See Supplemental Schedule			106,692						
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 313,416				Seminar Expense	4,563	
C. Professional Services							Alloc. - S.I.R Management	530	
Vendor/Payee	Type		Amount						
S.I.R. Management	Dir. Of Regulatory Svcs		\$ 21,384				Entertainment Expense	()	
Frost, Ruttenberg & Rothblatt	Accounting		17,615				TOTAL (agree to Sch. V, line 24, col. 8)		
S.I.R. Management	Accounting		36,000				\$ 5,093		
S.I.R. Management	Bookkeeping Services		83,160						
Arnstein & Lehr	Legal		7,237						
Personnel Planners	Unemployment Tax Cnsltg		1,636						
LTC Solutions	Data Processing		1,500						
Pinnacle Consulting	Customer Satisfaction Prg		1,687						
Adj on Page 5A	Legal		3,882						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 174,101	TOTAL		\$			

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Facility Name & ID Number Wilson Care

Report Period Beginning: 01/01/08 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 FY2005	6 FY2006	7 FY2007	8 FY2008	9 FY2009	10 FY2010	11 FY2011	12 FY2012	13 FY2013
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
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13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

