



Facility Name & ID Number Wilson Care

# 0029975 Report Period Beginning: 01/01/09 Ending: 12/31/09

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	<u>198</u>	Intermediate (ICF)	<u>198</u>	<u>72,270</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>198</u>	TOTALS	<u>198</u>	<u>72,270</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	<u>65,752</u>	<u>916</u>		<u>66,668</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>65,752</u>	<u>916</u>		<u>66,668</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.25%

D. How many bed-hold days during this year were paid by the Department? 2,405 (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 \_\_\_\_\_

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

Is your fiscal year identical to your tax year? YES  NO

Tax Year: 12/31/09 Fiscal Year: 12/31/09

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

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/09 Ending: 12/31/09

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary	199,292	23,747	30,372	253,411		253,411	(14,982)	238,429		1
2	Food Purchase		263,994		263,994	(19,874)	244,120	(36)	244,084		2
3	Housekeeping	181,371	39,325		220,696		220,696	(2,770)	217,926		3
4	Laundry		22,954	19,473	42,427		42,427	(389)	42,038		4
5	Heat and Other Utilities			132,694	132,694		132,694	2,306	135,000		5
6	Maintenance	34,993	32,269	118,496	185,758		185,758	(27,456)	158,302		6
7	Other (specify):*							2,007	2,007		7
8	<b>TOTAL General Services</b>	<b>415,656</b>	<b>382,289</b>	<b>301,035</b>	<b>1,098,980</b>	<b>(19,874)</b>	<b>1,079,106</b>	<b>(41,320)</b>	<b>1,037,786</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			13,200	13,200		13,200		13,200		9
10	Nursing and Medical Records	1,087,422	34,139	91,596	1,213,157		1,213,157	(23,182)	1,189,975		10
10a	Therapy			21,384	21,384		21,384	(15,963)	5,421		10a
11	Activities	118,417	6,314	2,700	127,431		127,431		127,431		11
12	Social Services	314,544	14,662		329,206		329,206		329,206		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							4,198	4,198		15
16	<b>TOTAL Health Care and Programs</b>	<b>1,520,383</b>	<b>55,115</b>	<b>128,880</b>	<b>1,704,378</b>		<b>1,704,378</b>	<b>(34,947)</b>	<b>1,669,431</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	144,607		313,416	458,023		458,023	(96,482)	361,541		17
18	Directors Fees										18
19	Professional Services			165,024	165,024	(2,500)	162,524	(124,804)	37,720		19
20	Dues, Fees, Subscriptions & Promotions			60,406	60,406		60,406	(34,096)	26,310		20
21	Clerical & General Office Expenses	202,738	26,796	126,180	355,714		355,714	41,130	396,844		21
22	Employee Benefits & Payroll Taxes			388,670	388,670	19,874	408,544		408,544		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,468	3,468		3,468	(271)	3,197		24
25	Other Admin. Staff Transportation			4,083	4,083		4,083	9,338	13,421		25
26	Insurance-Prop.Liab.Malpractice			148,279	148,279		148,279	1,242	149,521		26
27	Other (specify):*							41,237	41,237		27
28	<b>TOTAL General Administration</b>	<b>347,345</b>	<b>26,796</b>	<b>1,209,526</b>	<b>1,583,667</b>	<b>17,374</b>	<b>1,601,041</b>	<b>(162,706)</b>	<b>1,438,336</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,283,384</b>	<b>464,200</b>	<b>1,639,441</b>	<b>4,387,025</b>	<b>(2,500)</b>	<b>4,384,525</b>	<b>(238,973)</b>	<b>4,145,552</b>		<b>29</b>

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Wilson Care

#0029975

Report Period Beginning:

01/01/09

Ending:

12/31/09

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			74,262	74,262		74,262	132,207	206,469			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			23,213	23,213		23,213	783,824	807,037			32
33	Real Estate Taxes					2,500	2,500	183,917	186,417			33
34	Rent-Facility & Grounds			1,419,000	1,419,000		1,419,000	(1,419,000)				34
35	Rent-Equipment & Vehicles			6,590	6,590		6,590	9,231	15,821			35
36	Other (specify):*							73,532	73,532			36
37	<b>TOTAL Ownership</b>			1,523,065	1,523,065	2,500	1,525,565	(236,289)	1,289,276			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			108,405	108,405		108,405		108,405			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			108,405	108,405		108,405		108,405			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,283,384	464,200	3,270,911	6,018,495		6,018,495	(475,262)	5,543,233			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

**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	(3,218)	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	86,663	30		9
10	Interest and Other Investment Income	(59,852)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(36)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(4,858)	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	(22,530)	21		24
25	Fund Raising, Advertising and Promotional	(11,963)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(24,400)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(59,545)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (99,738)		\$	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)	(375,523)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (375,523)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (475,262)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Wilson Care

ID# 0029975  
 Report Period Beginning: 01/01/09  
 Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Miscellaneous Income	\$ (34)	21	1
2	Office Expense- Bank Fees	(5,967)	21	2
3	COPE Dues	(5,682)	20	3
4	Capitalized R&M	(17,305)	06	4
5	Annual Report	(250)	20	5
6	Collections	(396)	21	6
7	Alliance for Living PAC Dues	(11,631)	20	7
8	2010 Seminars	(660)	24	8
9	Filing & Other Fees- Building Co.	(4,811)	20	9
10	Office Expense- Building Co.	(1,409)	21	10
11	Professional Fees- Building Co.	(7,350)	19	11
12	Replacement Tax- Building Co.	(4,050)	21	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	<b>Total</b>	(59,545)		49

Wilson Care

ID# 0029975

Report Period Beginning: 01/01/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line 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:

01/01/09

Ending:

12/31/09

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary				(14,982)								(14,982)	1
2	Food Purchase	(36)											(36)	2
3	Housekeeping					(2,770)							(2,770)	3
4	Laundry					(389)							(389)	4
5	Heat and Other Utilities				2,306								2,306	5
6	Maintenance	(20,523)	2,689	(10,001)	403	(24)							(27,456)	6
7	Other (specify):*			914	1,093								2,007	7
8	<b>TOTAL General Services</b>	<b>(20,559)</b>	<b>2,689</b>	<b>(9,087)</b>	<b>(11,180)</b>	<b>(3,183)</b>							<b>(41,320)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records			(27,961)	7,334	(2,555)							(23,182)	10
10a	Therapy				(15,963)								(15,963)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			2,233	1,965								4,198	15
16	<b>TOTAL Health Care and Programs</b>			<b>(25,728)</b>	<b>(6,664)</b>	<b>(2,555)</b>							<b>(34,947)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			(181,306)	84,824								(96,482)	17
18	Directors Fees													18
19	Professional Services	(7,350)	7,350	(139,649)	14,845								(124,804)	19
20	Fees, Subscriptions & Promotions	(39,195)	4,811	288									(34,096)	20
21	Clerical & General Office Expenses	(58,786)	5,459	94,390	67								41,130	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(660)		389									(271)	24
25	Other Admin. Staff Transportation			9,338									9,338	25
26	Insurance-Prop.Liab.Malpractice			1,105	137								1,242	26
27	Other (specify):*			24,138	17,099								41,237	27
28	<b>TOTAL General Administration</b>	<b>(105,991)</b>	<b>17,620</b>	<b>(191,307)</b>	<b>116,972</b>								<b>(162,706)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(126,550)</b>	<b>20,309</b>	<b>(226,122)</b>	<b>99,128</b>	<b>(5,738)</b>							<b>(238,973)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Wilson Care# 0029975

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	86,663	34,497		11,047								132,207	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(59,852)	861,073	(24,621)	7,224								783,824	32
33	Real Estate Taxes		177,005		6,912								183,917	33
34	Rent-Facility & Grounds		(1,419,000)										(1,419,000)	34
35	Rent-Equipment & Vehicles			9,231									9,231	35
36	Other (specify):*		73,532										73,532	36
37	<b>TOTAL Ownership</b>	<b>26,811</b>	<b>(272,893)</b>	<b>(15,390)</b>	<b>25,183</b>								<b>(236,289)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	<b>TOTAL Special Cost Centers</b>													<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(99,738)	(252,584)	(241,512)	124,311	(5,738)							(475,262)	45

Facility Name & ID Number

Wilson Care

# 0029975

Report Period Beginning:

01/01/09

Ending:

12/31/09

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent- Base	\$ 1,419,000	Wilson Care, LLC.	100.00%	\$	\$ (1,419,000)	1
2	V	36 Amort. HUD Fees		Wilson Care, LLC.	100.00%	1,009	1,009	2
3	V	36 Amort. Loan Fees		Wilson Care, LLC.	100.00%	39,279	39,279	3
4	V	06 Building Repairs & Maint.		Wilson Care, LLC.	100.00%	2,689	2,689	4
5	V	30 Deprecation		Wilson Care, LLC.	100.00%	34,497	34,497	5
6	V	20 Filing & Other Fees		Wilson Care, LLC.	100.00%	4,811	4,811	6
7	V	32 Interest	170,938	Wilson Care, LLC.	100.00%	1,032,011	861,073	7
8	V	36 Mortgage Insurance		Wilson Care, LLC.	100.00%	33,244	33,244	8
9	V	21 Office Expense		Wilson Care, LLC.	100.00%	1,409	1,409	9
10	V	19 Professional Fees		Wilson Care, LLC.	100%	7,350	7,350	10
11	V	33 Real Estate Taxes		Wilson Care, LLC.	100%	177,005	177,005	11
12	V	21 Replacement Tax		Wilson Care, LLC.	100%	4,050	4,050	12
13	V							13
14	Total		\$ 1,589,938			\$ 1,337,354	\$ * (252,584)	14

\* 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	6 REPAIRS AND MAINT.	\$ 21,384	S.I.R. MANAGEMENT, INC.	100.00%	\$ 11,383	\$ (10,001)
16	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	914	914
17	V	10 NURSING	42,768	S.I.R. MANAGEMENT, INC.	100.00%	14,807	(27,961)
18	V	15 EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	2,233	2,233
19	V	19 PROFESSIONAL FEES	142,944	S.I.R. MANAGEMENT, INC.	100.00%	2,478	(140,466)
20	V	20 FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	288	288
21	V	21 CLERICAL & GENERAL	42,768	S.I.R. MANAGEMENT, INC.	100.00%	33,924	(8,844)
22	V	24 EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	389	389
23	V	25 OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	9,338	9,338
24	V	26 INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	1,105	1,105
25	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	4,343	4,343
26	V	32 INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(24,621)	(24,621)
27	V	35 EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	9,231	9,231
28	V						
29	V	17 ADMINISTRATIVE	206,724	S.I.R. MANAGEMENT, INC.	100.00%	25,418	(181,306)
30	V	19 PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	817	817
31	V	21 CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	103,234	103,234
32	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	19,795	19,795
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 456,588			\$ 215,076	\$ * (241,512)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1	DIETARY SALARIES	\$ 21,384	S.I.R. MANAGEMENT, INC.	100.00%	\$ 6,402	\$ (14,982)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	989	989	16
17	V	10	NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	7,334	7,334	17
18	V	15	EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	1,115	1,115	18
19	V	17	ADMIN./LEGAL SALARIES	10,692	S.I.R. MANAGEMENT, INC.	100.00%	95,516	84,824	19
20	V	19	FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	14,789	14,789	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	17,099	17,099	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	21,384	S.I.R. MANAGEMENT, INC.	100.00%	5,421	(15,963)	24
25	V	15	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	850	850	25
26	V								26
27	V	6	MAINTENANCE SALARIES	828	S.I.R. MANAGEMENT, INC.	100.00%	571	(257)	27
28	V	7	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	104	104	28
29	V								29
30	V	5	UTILITIES		S.I.R. MANAGEMENT, INC.	100.00%	2,306	2,306	30
31	V	6	REPAIRS AND MAINT.		S.I.R. MANAGEMENT, INC.	100.00%	660	660	31
32	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	56	56	32
33	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	67	67	33
34	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	137	137	34
35	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	11,047	11,047	35
36	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	7,224	7,224	36
37	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	6,912	6,912	37
38	V								38
39	Total		\$ 54,288				\$ 178,599	\$ * 124,311	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary	\$	Xcel Supply, LLC	100.00%	\$		15
16	V	3 Housekeeping	30,166	Xcel Supply, LLC	100.00%	27,395	(2,770)	16
17	V	4 Laundry	4,238	Xcel Supply, LLC	100.00%	3,849	(389)	17
18	V	6 Repairs & Maintenance	257	Xcel Supply, LLC	100.00%	234	(24)	18
19	V	10 Nursing	27,824	Xcel Supply, LLC	100.00%	25,268	(2,555)	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		\$ 62,484			\$ 56,746	\$ * (5,738)	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%	\$ 100,371	\$ 100,371	15
16	V							16
17	V							17
18	V							18
19	V	22 Employee Health Insurance	100,371	CCS Employee Benefits Group	100.00%		(100,371)	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		\$ 100,371			\$ 100,371	\$ *	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		\$			\$	\$	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	<b>Total</b>		\$			\$	\$ *	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		\$			\$	\$	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.

**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	<b>Total</b>		\$			\$	\$ *	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		\$			\$	\$	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	<b>Total</b>		\$			\$	\$ *	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		\$			\$	\$	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	<b>Total</b>		\$			\$	\$ *	39

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

Facility Name &amp; ID Number

Wilson Care

# 0029975

Report Period Beginning:

01/01/09

Ending:

12/31/09

## 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	2.48	6.20%	Alloc. Salary	\$ 16,126	17-7	1
2	Eric Rothner	Owner	Administrative	20.00%	See Attached	0.58	1.25%	Alloc. Salary	8,270	17-7	2
3	Nenita Guzman	Relative	Dietary	0.00%	See Attached	4.13	8.26%	Alloc. Salary	6,402	1-7	3
4	Noah Wolff	Owner	Administrative	5.56%	See Attached	3.00	13.64%	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	Kirsten Barish	Owner	Clerical	0.28%	See Attached	1.41	8.29%	Alloc. Salary	1,118	21-7	6
7	Sarah Barrish	Owner	Administrative	0.56%	See Attached	3.31	8.28%	Alloc. Salary	8,432	17-7	7
8	Adam Vales	Relative	Clerical	0.00%	See Attached	0.58	1.45%	Alloc. Salary	1,053	22-7	8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 137,401		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:

01/01/09

Ending: 12/31/09

**VIII. ALLOCATION OF INDIRECT COSTS**

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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.

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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care

# 0029975

Report Period Beginning:

01/01/09

Ending: 12/31/09

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	6	REPAIRS AND MAINT.	PATIENT DAYS	806,183	12	\$ 137,654	\$ 73,265	66,668	\$ 11,383	1
2	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	806,183	12	11,057		66,668	914	2
3	10	NURSING	PATIENT DAYS	806,183	12	179,054	179,054	66,668	14,807	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	806,183	12	27,001		66,668	2,233	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	806,183	12	29,965	15,891	66,668	2,478	5
6	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	806,183	12	3,480		66,668	288	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	806,183	12	410,223	335,902	66,668	33,924	7
8	24	EDUCATION & SEMINAR	PATIENT DAYS	806,183	12	4,701		66,668	389	8
9	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	806,183	12	112,924		66,668	9,338	9
10	26	INSURANCE	PATIENT DAYS	806,183	12	13,360		66,668	1,105	10
11	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	806,183	12	52,522		66,668	4,343	11
12	32	INTEREST	PATIENT DAYS	806,183	12	(297,734)		66,668	(24,621)	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	806,183	12	111,631		66,668	9,231	13
14										14
15	17	ADMINISTRATIVE	PATIENT DAYS	841,652	13	320,892	320,892	66,668	25,418	15
16	19	PROFESSIONAL FEES	PATIENT DAYS	841,652	13	10,309		66,668	817	16
17	21	CLERICAL & GENERAL	PATIENT DAYS	841,652	13	1,303,285	68,837	66,668	103,234	17
18	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	841,652	13	249,900		66,668	19,795	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,680,224	\$ 993,841		\$ 215,076	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care

# 0029975

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	DIETARY SALARIES	PATIENT DAYS	806,183	12	\$ 77,418	\$ 77,418	66,668	\$ 6,402	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	806,183	12	11,962		66,668	989	2
3	10	NURSING SALARIES	PATIENT DAYS	806,183	12	88,682	88,682	66,668	7,334	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	806,183	12	13,479		66,668	1,115	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	806,183	12	1,155,033	1,155,033	66,668	95,516	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	806,183	12	178,836		66,668	14,789	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	806,183	12	206,767		66,668	17,099	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	273,348	13	69,299	69,299	21,384	5,421	10
11	15	EMPLOYEE BENEFITS	SPECIAL REHAB INC.	273,348	13	10,868		21,384	850	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	257,623	9	177,531	177,531	828	571	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	257,623	9	32,348		828	104	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,879	13	28,260		1,051	2,306	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,879	13	8,091		1,051	660	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,879	13	689		1,051	56	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,879	13	822		1,051	67	19
20	26	INSURANCE	ALLOCATED SQ FT	12,879	13	1,678		1,051	137	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,879	13	135,367		1,051	11,047	21
22	32	INTEREST	ALLOCATED SQ FT	12,879	13	88,526		1,051	7,224	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,879	13	84,702		1,051	6,912	23
24										24
25	TOTALS					\$ 2,370,358	\$ 1,567,963		\$ 178,599	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care

# 0029975

Report Period Beginning:

01/01/09

Ending: 12/31/09

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					27,395	2
3	4	Laundry	Direct Allocation					3,849	3
4	6	Repairs & Maintenance	Direct Allocation					234	4
5	10	Nursing	Direct Allocation					25,268	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				\$	\$		\$	56,746

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care

# 0029975

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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		\$	\$		\$ 100,371	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				\$	\$		\$ 100,371	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care

# 0029975

Report Period Beginning:

01/01/09

Ending: 12/31/09

**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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care

# 0029975

Report Period Beginning:

01/01/09

Ending: 12/31/09

**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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care

# 0029975

Report Period Beginning:

01/01/09

Ending: 12/31/09

**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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care

# 0029975 Report Period Beginning: 01/01/09 Ending: 12/31/09

**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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care

# 0029975

Report Period Beginning:

01/01/09

Ending: 12/31/09

**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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Wilson Care

# 0029975

Report Period Beginning:

01/01/09

Ending:

12/31/09

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1	Private Bank		X	Mortgage Payable			\$	\$ 19,946,300		\$ 1,007,841	1								
2	Notes Payable		X					72,889			2								
3											3								
4											4								
5	See Supplemental Schedule										5								
<b>Working Capital</b>																			
6	Lake Forest Bank & Trust		X							23,213	6								
7	Interest- Related Parties		X							24,170	7								
8	See Supplemental Schedule									(17,397)	8								
9	<b>TOTAL Facility Related</b>						\$	\$ 20,019,189		\$ 1,037,827	9								
<b>B. Non-Facility Related*</b>																			
10	Interest Income		X							(59,852)	10								
11	Interest Income- Bldg. Co.		X							(170,938)	11								
12											12								
13	See Supplemental Schedule										13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$		\$ (230,790)	14								
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 20,019,189		\$ 807,037	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:

01/01/09

Ending:

12/31/09

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		8	9	10									
					Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
						YES							NO	Original				Balance
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1						\$	\$			\$	1							
2											2							
3											3							
4											4							
5											5							
6											6							
7	<b>TOTAL Long-Term</b>										7							
<b>Working Capital</b>																		
8	Alloc. S.I.R. Management					\$	\$			\$ (17,397)	8							
9											9							
10											10							
11											11							
12											12							
13											13							
14	<b>TOTAL Working Capital</b>										14							
<b>B. Non-Facility Related*</b>																		
15						\$	\$			\$	15							
16											16							
17											17							
18											18							
19											19							
20	<b>TOTAL Non-Facility Related</b>										20							

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

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

**B. Real Estate Taxes**

		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and																							
1. Real Estate Tax accrual used on 2008 report.		\$	<b>174,000</b>	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.)		\$	<b>178,117</b>	2																					
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>4,117</b>	3																					
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>179,800</b>	4																					
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	<b>2,500</b>	5																					
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6																					
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>186,417</b>	7																					
Real Estate Tax History:																									
Real Estate Tax Bill for Calendar Year:	2004	<b>68,745</b>	8	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="4" style="text-align: center;"><b>FOR BHF USE ONLY</b></td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2008</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td style="text-align: right;">\$</td> <td style="text-align: center;">16</td> </tr> </table>		<b>FOR BHF USE ONLY</b>				13	FROM R. E. TAX STATEMENT FOR 2008	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
<b>FOR BHF USE ONLY</b>																									
13	FROM R. E. TAX STATEMENT FOR 2008	\$	13																						
14	PLUS APPEAL COST FROM LINE 5	\$	14																						
15	LESS REFUND FROM LINE 6	\$	15																						
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																						
	2005	<b>71,860</b>	9																						
	2006	<b>169,658</b>	10																						
	2007	<b>169,130</b>	11																						
	2008	<b>171,205</b>	12																						
<b>Accrual= 171205 x 1.05= 179,800</b>																									
<b>Alloc. - S.I.R. Management= \$6,912</b>																									

**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





Facility Name & ID Number Wilson Care

# 0029975 Report Period Beginning:

01/01/09 Ending:

12/31/09

**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:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1985</u>	<u>\$ 25,200</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>			<b>\$ 25,200</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care

# 0029975

Report Period Beginning:

01/01/09

Ending:

12/31/09

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9	Various		1985	65,366		20			65,340	9
10	Various		1986	161,365		20			161,346	10
11	Various		1987	49,380		20			49,348	11
12	Various		1989	49,210		20	1,068	1,068	49,197	12
13	Various		1990	105,470		20	5,274	5,274	100,650	13
14	Various		1991	29,903		20	1,494	1,494	27,749	14
15	Various		1992	69,669		20	3,484	3,484	61,160	15
16	Various		1993	61,688		20	3,087	3,087	50,869	16
17	Various		1994	55,691		20	2,654	2,654	43,539	17
18	Various		1995	87,144		20	4,360	4,360	63,197	18
19	Various		1996	303,393		20	15,172	15,172	203,853	19
20	Various		1997	145,411		20	7,348	7,348	86,487	20
21	Various		1998	34,959		20	1,748	1,748	20,186	21
22	Various		1999	53,478		20	2,675	2,675	28,276	22
23	Various		2000	342,218		20	17,110	17,110	159,155	23
24	Various		2001	102,633		20	5,132	5,132	44,459	24
25	Various		2002	67,986		20	4,958	4,958	55,073	25
26	Various		2003	97,187		20	6,028	6,028	38,532	26
27	Various		2004	62,333		20	4,336	4,336	23,862	27
28	Various		2005	214,966		20	13,471	13,471	61,215	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	Related Building Company (Pages 12F & 12G)	2,074,638	29,977		46,645	16,668	1,689,871	67
68	Related Party Allocations (Pages 12H & 12I)	131,021	5,370		4,223	(1,147)	54,053	68
69	Financial Statement Depreciation		74,262			(74,262)		69
70	TOTAL (lines 4 thru 69)	\$ 4,365,109	\$ 109,609		\$ 150,267	\$ 40,658	\$ 3,137,417	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Wilson Care

# 0029975

Report Period Beginning:

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## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 4,365,109	\$ 109,609		\$ 150,267	\$ 40,658	\$ 3,137,417	1
2	Stairs And Flooring	2006	10,338		20	517	517	1,594	2
3	Locks	2006	2,950		20	295	295	1,082	3
4	Rewiring Fire Pump	2006	4,640		20	232	232	831	4
5	Sheet Flooring	2006	11,662		20	583	583	2,089	5
6	Fire Doors	2006	7,475		20	374	374	1,370	6
7	Fire Doors	2006	2,800		20	140	140	478	7
8	Bathroom Remodel	2006	5,850		20	293	293	926	8
9	Electrical Work	2006	7,848		20	392	392	1,275	9
10	Electrical Work	2006	2,656		20	133	133	421	10
11	Reception Station	2007	12,557		20	1,256	1,256	3,558	11
12	Security System Work	2007	2,525		20	253	253	715	12
13	Bathroom Remodeling	2007	11,700		20	585	585	1,609	13
14	Bathroom Remodeling	2007	12,085		20	604	604	1,662	14
15	Bathroom Remodeling	2007	11,700		20	585	585	1,560	15
16	Bathroom Remodeling	2007	10,980		20	549	549	1,418	16
17	Cameras	2007	2,970		20	297	297	792	17
18	Bathroom Remodeling	2007	11,700		20	585	585	1,511	18
19	Bathroom Remodeling	2007	12,085		20	604	604	1,561	19
20	Tile Flooring	2007	39,410		20	1,971	1,971	5,090	20
21	Bathroom Remodeling	2007	12,085		20	604	604	1,561	21
22	Bathroom Remodeling	2007	11,700		20	585	585	1,463	22
23	Hot Water Heater	2007	6,211		20	311	311	880	23
24	Bathroom Remodeling	2007	11,700		20	585	585	1,414	24
25	Bathroom Remodeling	2007	12,160		20	608	608	1,469	25
26	Fire Doors	2007	6,850		20	343	343	799	26
27	Security System	2007	4,110		20	411	411	925	27
28	Security System	2007	8,310		20	831	831	1,870	28
29	Tile Flooring	2007	29,171		20	1,459	1,459	3,282	29
30	Bathroom Work	2007	2,080		20	104	104	234	30
31	Boiler Work	2007	5,323		20	266	266	599	31
32	Bathroom Remodeling	2007	11,700		20	585	585	1,316	32
33	Bathroom Remodeling	2007	11,700		20	585	585	1,316	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,682,140	\$ 109,609		\$ 167,792	\$ 58,183	\$ 3,184,087	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Wilson Care

# 0029975

Report Period Beginning:

01/01/09

Ending:

12/31/09

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 4,682,140	\$ 109,609		\$ 167,792	\$ 58,183	\$ 3,184,087	1
2	Tile Flooring	2007	50,378		20	2,519	2,519	5,458	2
3	Fire Doors	2007	7,975		20	399	399	864	3
4	Handrails	2007	10,930		20	547	547	1,139	4
5	Bathroom Work	2007	11,700		20	585	585	1,365	5
6	Bathroom Work	2007	11,700		20	585	585	1,268	6
7	Ceiling Panels	2007	2,550		20	128	128	298	7
8	Boiler Work	2007	2,660		20	133	133	299	8
9	Roof Work	2007	3,565		20	178	178	475	9
10	Boiler Work	2007	3,100		20	155	155	375	10
11	Landscaping- Trees, Bush	2008	5,185		20	259	259	346	11
12	Elevator Cables & Phone	2008	3,925		20	196	196	327	12
13	Return Steam Trap & Valves	2008	10,440		20	522	522	1,001	13
14	Heat Repair	2008	3,069		20	153	153	294	14
15	Chiller Repair	2008	3,196		20	160	160	266	15
16	Electrical Work	2008	3,013		20	151	151	226	16
17	Mixing Valves	2008	3,050		20	153	153	165	17
18	Heating System	2008	8,136		20	407	407	780	18
19	Boiler Work	2009	4,297		20	161	161	161	19
20	Water Pump	2009	2,717		20	136	136	136	20
21	Plumbing Work	2009	2,840		20	142	142	142	21
22	Plumbing Work	2009	2,580		20	129	129	129	22
23	Fire Pump Check Valve	2009	2,860		20	143	143	143	23
24	Smoke Detector	2009	2,620		20	131	131	131	24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 4,844,626	\$ 109,609		\$ 175,864	\$ 66,255	\$ 3,199,874	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	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		\$ 4,844,626	\$ 109,609		\$ 175,864	\$ 66,255	\$ 3,199,874	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 4,844,626	\$ 109,609		\$ 175,864	\$ 66,255	\$ 3,199,874	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	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		\$ 4,844,626	\$ 109,609		\$ 175,864	\$ 66,255	\$ 3,199,874	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 4,844,626	\$ 109,609		\$ 175,864	\$ 66,255	\$ 3,199,874	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Building Company Information</b>								1
2	<b>Buildings:</b>								2
3		1967	1,539,800	29,977		19,088	(10,889)	1,635,240	3
4									4
5									5
6									6
7									7
8	<b>Leasehold Improvements:</b>								8
9	Bathroom-Rebuild Wall, Tiles, New Fixtures, Painting	2007	35,100		20	1,755	1,755	5,265	9
10	Flooring (4th)	2008	29,171		20	1,459	1,459	2,918	10
11	Flooring (5th)	2008	29,171		20	1,459	1,459	2,918	11
12	Bathroom-Rebuild Wall, Tiles, New Fixtures, Painting	2008	135,720		20	6,786	6,786	13,572	12
13	Bathroom-Rebuild Wall, Tiles, New Fixtures, Painting	2008	23,400		20	1,170	1,170	2,340	13
14	Painting	2008	146,700		20	7,335	7,335	14,670	14
15	Bathtub Liner	2008	16,250		20	813	813	1,625	15
16	Elevator Controller	2008	35,150		20	1,758	1,758	3,515	16
17	Handrails	2008	9,794		20	490	490	979	17
18	Phone System	2008	11,656		20	583	583	1,166	18
19	Hot Water Boilers	2008	29,247		20	1,462	1,462	2,925	19
20	Gas Line Piping	2008	4,979		20	249	249	498	20
21	Bathtub Liners	2009	12,200		20	610	610	610	21
22	Painting	2009	16,300		10	1,630	1,630	1,630	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

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	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		\$	\$		\$	\$	\$	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (12F & 12G lines 1 thru 33)	\$ 2,074,638	\$ 29,977		\$ 46,645	\$ 16,668	\$ 1,689,871	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Related Party Information</b>		\$	\$		\$	\$	\$	1
2	<b>Buildings:</b>								2
3	<b>SIR</b>	1993	36,940	1,173	35	1,055	(118)	17,414	3
4									4
5									5
6									6
7									7
8	<b>Leasehold Improvements:</b>								8
9	S.I.R. Properties- S.I.R. Management- Allocation	2009	2,218	1,267	20	89	(1,178)	89	9
10	S.I.R. Properties- S.I.R. Management- Allocation	2007	647	94	20	32	(62)	97	10
11	S.I.R. Properties- S.I.R. Management- Allocation	2002	146		20	7	7	55	11
12	S.I.R. Properties- S.I.R. Management- Allocation	1999	4,681	234	20	234		2,457	12
13	S.I.R. Properties- S.I.R. Management- Allocation	1998	2,237		20	112	112	1,286	13
14	S.I.R. Properties- S.I.R. Management- Allocation	1997	139		20	7	7	94	14
15	S.I.R. Properties- S.I.R. Management- Allocation	1994	352	9	20	18	9	272	15
16	S.I.R. Properties- S.I.R. Management- Allocation	1993	599	3	20	30	27	495	16
17									17
18	S.I.R. Management- Allocation	1993	9,365	261	20	464	203	7,893	18
19	S.I.R. Management- Allocation	1994	29		20			29	19
20	S.I.R. Management- Allocation	1995	214		20	11	11	154	20
21	S.I.R. Management- Allocation	1997	14,391	322	20	720	398	9,217	21
22	S.I.R. Management- Allocation	1999	12,210		20	57	57	11,659	22
23	S.I.R. Management- Allocation	2000	1,336		20	67	67	637	23
24	S.I.R. Management- Allocation	2007	4,292	765	20	215	(550)	471	24
25	S.I.R. Management- Allocation	2008	11,830	1,183	20	746	(437)	1,375	25
26	S.I.R. Management- Allocation	2009	29,395	59	20	359	300	359	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	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								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (12H & 12I lines 1 thru 33)	\$ 131,021	\$ 5,370		\$ 4,223	\$ (1,147)	\$ 54,053	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:

01/01/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 423,357	\$ 10,023	\$ 29,461	\$ 19,438	10	\$ 304,731	71
72	Current Year Purchases	36,157	173	1,049	876	10	1,049	72
73	Fully Depreciated Assets	566,356		94	94	10	566,356	73
74								74
75	TOTALS	\$ 1,025,870	\$ 10,196	\$ 30,605	\$ 20,409		\$ 872,136	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)	\$ 5,895,695	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 119,805	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 206,468	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 86,663	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,072,011	85

\*\*

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

**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

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: \$ 15,821 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

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

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18			_____	_____	18
19			_____	_____	19
20			_____	_____	20
21	TOTAL		\$ _____	\$ _____	21

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 \$ \_\_\_\_\_

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care# 0029975Report Period Beginning: 01/01/09Ending: 12/31/09

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 375,202	\$ 408,290	1
2	Cash-Patient Deposits	39,900	39,900	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	993,501	993,501	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	23,382	189,601	6
7	Other Prepaid Expenses	3,459	3,459	7
8	Accounts Receivable (owners or related parties)	72,889	72,889	8
9	Other(specify): <u>See Attached Schedule</u>	89,224	1,967,571	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,597,557	\$ 3,675,211	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		25,200	13
14	Buildings, at Historical Cost		1,571,291	14
15	Leasehold Improvements, at Historical Cost	1,706,218	2,194,250	15
16	Equipment, at Historical Cost	1,392,928	1,502,305	16
17	Accumulated Depreciation (book methods)	(1,973,200)	(3,882,748)	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>		268,979	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,125,946	\$ 1,679,277	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,723,503	\$ 5,354,488	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 258,325	\$ 258,325	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	40,179	40,179	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	173,854	173,854	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,770	11,770	31
32	Accrued Real Estate Taxes(Sch.IX-B)		179,800	32
33	Accrued Interest Payable		79,785	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	46,500	46,500	35
<b>Other Current Liabilities(specify):</b>				
36	<u>See Attached Schedule</u>	4,488	4,488	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 535,116	\$ 794,701	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable		72,889	39
40	Mortgage Payable		19,946,300	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>See Attached Schedule</u>			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 20,019,189	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 535,116	\$ 20,813,890	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 2,188,387	\$ (15,459,402)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,723,503	\$ 5,354,488	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>2,126,237</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>2,126,237</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>1,466,150</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(1,404,000)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>62,150</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>2,188,387</b>	<b>24</b> *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care# 0029975Report Period Beginning: 01/01/09Ending: 12/31/09**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.****Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 7,423,559	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 7,423,559	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	59,852	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 59,852	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	1,234	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,234	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 7,484,645	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,098,980	31
32	Health Care	1,704,378	32
33	General Administration	1,583,667	33
<b>B. Capital Expense</b>			
34	Ownership	1,523,065	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	108,405	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,018,495	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	1,466,150	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 1,466,150	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:

**01/01/09**

Ending:

**12/31/09**

**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,989	2,086	\$ 74,621	\$ 35.77	1
2	Assistant Director of Nursing	1,967	2,086	62,187	29.81	2
3	Registered Nurses	1,856	1,933	62,525	32.35	3
4	Licensed Practical Nurses	11,226	11,915	273,570	22.96	4
5	CNAs & Orderlies	51,114	54,587	533,798	9.78	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,802	1,886	29,558	15.67	9
10	Activity Assistants	7,872	8,600	79,809	9.28	10
11	Social Service Workers	17,496	19,121	314,544	16.45	11
12	Dietician					12
13	Food Service Supervisor	1,973	2,079	28,129	13.53	13
14	Head Cook	6,966	7,260	65,430	9.01	14
15	Cook Helpers/Assistants	10,338	11,171	105,733	9.46	15
16	Dishwashers					16
17	Maintenance Workers	3,812	3,924	34,993	8.92	17
18	Housekeepers	16,858	18,173	181,371	9.98	18
19	Laundry					19
20	Administrator	2,000	2,160	103,147	47.75	20
21	Assistant Administrator	1,792	2,040	41,460	20.32	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	17,044	18,381	202,738	11.03	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,171	4,461	80,721	18.09	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	2,297	2,297	9,050	3.94	33
34	TOTAL (lines 1 - 33)	162,573	174,160	\$ 2,283,384 *	\$ 13.11	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	13,200	09-03	36
37	Medical Records Consultant	Monthly	4,328	10-03	37
38	Nurse Consultant	Monthly	42,768	10-03	38
39	Pharmacist Consultant	Monthly	3,365	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	2,700	11-03	44
45	Social Service Consultant				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)		\$ 126,217		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	928	33,035	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	928	\$ 33,035		53

SEE ACCOUNTANTS' COMPILATION REPORT

**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%	\$ 103,147	Workers' Compensation Insurance	\$ 30,118	IDPH License Fee	\$ 996	
Patrick Ballke	Asst. Admin	0%	41,460	Unemployment Compensation Insurance	20,743	Advertising: Employee Recruitment	9,303	
				FICA Taxes	170,164	Health Care Worker Background Check		
				Employee Health Insurance	125,928	(Indicate # of checks performed <u>251</u> )	2,510	
				Employee Meals	19,874	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Advertising and Promotion	11,963	
				City Head Tax	4,668	Licenses and Permits	2,174	
				401K Contribution	2,790	Dues and Subscriptions	11,039	
				Employee Benefits- Other	11,065	Alloc. -S.I.R. Management	288	
				Union Pension Expense	23,196			
						Less: Public Relations Expense	( )	
						Non-allowable advertising	(11,963)	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 144,607	TOTAL (agree to Schedule V, line 22, col.8)	\$ 408,545	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 26,310	
(List each licensed administrator separately.)								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fees- SIR Management			\$ 120,000				Out-of-State Travel	\$
SIR- 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)			\$ 313,416				Seminar Expense	2,808
(Attach a copy of any management service agreement)							Alloc.- S.I.R. Management	389
C. Professional Services								
Vendor/Payee	Type		Amount					
S.I.R. Management	Dir. Of Regulatory Srvc		\$ 21,384					
Frost, Ruttenberg, & Rothblatt	Accounting		14,120					
S.I.R. Management	Accounting		38,400					
S.I.R. Management	Bookkeeping Services		83,160					
Personnel Planners	Unemployment Tax Cnsltg		1,646					
LTC Solutions	Data Processing		1,500					
Pinnacle Consulting	Customer Satisfaction Prg		2,314					
Property Valuation Services	Appraisal Services		2,500					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 165,024	TOTAL		\$	Entertainment Expense	( )
(If total legal fees exceed \$5,000, attach copy of invoices.)							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 3,197

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Wilson Care

# 0029975

Report Period Beginning:

01/01/09

Ending:

12/31/09

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. See Attached
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 9,000 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- 
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 108,405  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 19,874 Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? None
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.