		FOR BHF USE					

LL1

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

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0029975

Facility Name: Wilson Care

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

County: Cook

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

HFS ID Number:

Date of Initial License for Current Owners: 09/01/1985

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/10 to 12/31/10 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) Cary Drazner, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	64,896	1,417		66,313	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	64,896	1,417		66,313	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.76%

D. How many bed-hold days during this year were paid by the Department?
2,512 (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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 09/01/88

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 08/31/85 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/10 Fiscal Year: 12/31/10

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/10 Ending: 12/31/10

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							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	215,520	28,075	30,387	273,982		273,982	(14,058)	259,924			1
2	Food Purchase		268,113		268,113	(20,367)	247,746	(57)	247,689			2
3	Housekeeping	186,281	41,569		227,850		227,850	(2,541)	225,309			3
4	Laundry		15,020	20,218	35,238		35,238	(330)	34,908			4
5	Heat and Other Utilities			126,584	126,584		126,584	2,465	129,049			5
6	Maintenance	47,783	47,197	145,339	240,319		240,319	26,468	266,787			6
7	Other (specify):*							7,418	7,418			7
8	**TOTAL General Services**	449,584	399,974	322,528	1,172,086	(20,367)	1,151,719	19,365	1,171,084			8
	B. Health Care and Programs											
9	Medical Director			10,400	10,400		10,400		10,400			9
10	Nursing and Medical Records	1,182,197	34,357	66,499	1,283,053		1,283,053	(21,551)	1,261,502			10
10a	Therapy			21,384	21,384		21,384	(14,494)	6,890			10a
11	Activities	127,875	8,868	2,652	139,395		139,395		139,395			11
12	Social Services	332,007	13,750		345,757		345,757		345,757			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							4,664	4,664			15
16	**TOTAL Health Care and Programs**	1,642,079	56,975	100,935	1,799,989		1,799,989	(31,381)	1,768,608			16
	C. General Administration											
17	Administrative	143,400		313,416	456,816		456,816	(111,084)	345,732			17
18	Directors Fees											18
19	Professional Services			222,516	222,516	(43,145)	179,371	(124,623)	54,748			19
20	Dues, Fees, Subscriptions & Promotions			87,274	87,274		87,274	(56,072)	31,202			20
21	Clerical & General Office Expenses	219,048	28,910	153,659	401,617		401,617	25,091	426,708			21
22	Employee Benefits & Payroll Taxes			454,865	454,865	20,367	475,232		475,232			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,124	3,124		3,124	774	3,898			24
25	Other Admin. Staff Transportation			2,052	2,052		2,052	8,079	10,131			25
26	Insurance-Prop.Liab.Malpractice			156,179	156,179		156,179	12,365	168,544			26
27	Other (specify):*							41,669	41,669			27
28	**TOTAL General Administration**	362,448	28,910	1,393,085	1,784,443	(22,778)	1,761,665	(203,801)	1,557,864			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,454,111	485,859	1,816,548	4,756,518	(43,145)	4,713,373	(215,817)	4,497,556			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Wilson Care #0029975 Report Period Beginning: 01/01/10 Ending: 12/31/10

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			65,969	65,969		65,969	181,691	247,660			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,947	2,947		2,947	922,922	925,869			32
33	Real Estate Taxes			60,000	60,000	43,145	103,145	203,413	306,558			33
34	Rent-Facility & Grounds			1,526,000	1,526,000		1,526,000	(1,526,000)				34
35	Rent-Equipment & Vehicles			5,930	5,930		5,930	9,308	15,238			35
36	Other (specify):*							202,215	202,215			36
37	**TOTAL Ownership**			1,660,846	1,660,846	43,145	1,703,991	(6,451)	1,697,540			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			108,405	108,405		108,405		108,405			42
43	Other (specify):*			333	333		333	(333)				43
44	**TOTAL Special Cost Centers**			108,738	108,738		108,738	(333)	108,405			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,454,111	485,859	3,586,132	6,526,102		6,526,102	(222,601)	6,303,501			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/10 Ending: 12/31/10

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 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	(3,289)	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	109,664	30		9
10	Interest and Other Investment Income	(2)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(57)	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	(32,206)	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	(61,727)	21		24
25	Fund Raising, Advertising and Promotional	(7,680)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(16,255)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(30,740)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (42,292)		$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 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)	(180,309)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (180,309)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (222,601)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Wilson Care

ID# 0029975

Report Period Beginning: 01/01/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous Income	$ (34)	21	1
2	Office Expense- Bank Fees	(5,795)	21	2
3	Theft and Damage	(340)	21	3
4	COPE Dues	(6,368)	20	4
5	Alliance for Living-PAC Dues	(9,801)	20	5
6	2010 Seminars	660	24	6
7	Capitalized R&M	(3,060)	06	7
8	Annual Report	(250)	20	8
9	Non-allowable Legal	(1,393)	19	9
10	Filing Fees- Building Company	(350)	20	10
11	Replacement Tax- Building Company	(3,676)	21	11
12	Non-allowable Expense	(333)	43	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(30,740)		49

Wilson Care

ID# 0029975

Report Period Beginning: 01/01/10

Ending: 12/31/10

	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:** 01/01/10 **Ending:** 12/31/10

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary				(14,058)								(14,058)	1
2	Food Purchase	(57)											(57)	2
3	Housekeeping					(2,541)							(2,541)	3
4	Laundry					(330)							(330)	4
5	Heat and Other Utilities				2,465								2,465	5
6	Maintenance	(6,349)	45,653	(8,262)	(4,574)								26,468	6
7	Other (specify):*			979	6,439								7,418	7
8	**TOTAL General Services**	(6,406)	45,653	(7,283)	(9,728)	(2,871)							19,365	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			(27,503)	7,567	(1,615)							(21,551)	10
10a	Therapy				(14,494)								(14,494)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			2,385	2,279								4,664	15
16	**TOTAL Health Care and Programs**			(25,118)	(4,648)	(1,615)							(31,381)	16
	C. General Administration													
17	Administrative			(179,572)	68,488								(111,084)	17
18	Directors Fees													18
19	Professional Services	(1,393)		(138,482)	15,252								(124,623)	19
20	Fees, Subscriptions & Promotions	(56,655)	350	233									(56,072)	20
21	Clerical & General Office Expenses	(87,827)	3,676	109,170	72								25,091	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	660		114									774	24
25	Other Admin. Staff Transportation			8,079									8,079	25
26	Insurance-Prop.Liab.Malpractice		10,899	1,343	123								12,365	26
27	Other (specify):*			27,301	14,368								41,669	27
28	**TOTAL General Administration**	(145,215)	14,925	(171,814)	98,303								(203,801)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(151,621)	60,578	(204,215)	83,927	(4,486)							(215,817)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Wilson Care # 0029975 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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

	Capital Expense D. Ownership	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)	
30	Depreciation	109,664	63,184		8,843								181,691	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(2)	950,179	(34,622)	7,367								922,922	32
33	Real Estate Taxes		199,501		3,912								203,413	33
34	Rent-Facility & Grounds		(1,526,000)										(1,526,000)	34
35	Rent-Equipment & Vehicles			9,308									9,308	35
36	Other (specify):*		202,215										202,215	36
37	**TOTAL Ownership**	109,662	(110,921)	(25,314)	20,122								(6,451)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(333)											(333)	43
44	**TOTAL Special Cost Centers**	(333)											(333)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(42,292)	(50,343)	(229,529)	104,049	(4,486)							(222,601)	45

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/10 Ending: 12/31/10

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 1,526,000	Wilson Care, LLC	100.00%	$	$ (1,526,000)	1
2	V	36	Amortization		Wilson Care, LLC	100.00%	6,057	6,057	2
3	V	06	Buildings Repair & Maint		Wilson Care, LLC	100.00%	45,653	45,653	3
4	V	30	Depreciation		Wilson Care, LLC	100.00%	63,184	63,184	4
5	V	20	Filing Fees		Wilson Care, LLC	100.00%	350	350	5
6	V	32	Interest	1,433	Wilson Care, LLC	100.00%	951,612	950,179	6
7	V	36	Mortgage Insurace		Wilson Care, LLC	100.00%	196,158	196,158	7
8	V	26	Property Insurance		Wilson Care, LLC	100.00%	10,899	10,899	8
9	V	33	Real Estate Taxes	25,499	Wilson Care, LLC	100.00%	225,000	199,501	9
10	V	21	Replacement Tax		Wilson Care, LLC	100.00%	3,676	3,676	10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,552,932			$ 1,502,589	$ * (50,343)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/10 Ending: 12/31/10

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	REPAIRS AND MAINT.	$ 21,384	S.I.R. MANAGEMENT, INC.	100.00%	$ 13,122	$ (8,262)	15
16	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	979	979	16
17	V	10	NURSING	42,768	S.I.R. MANAGEMENT, INC.	100.00%	15,265	(27,503)	17
18	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	2,385	2,385	18
19	V	19	PROFESSIONAL FEES	140,544	S.I.R. MANAGEMENT, INC.	100.00%	2,062	(138,482)	19
20	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	233	233	20
21	V	21	CLERICAL & GENERAL	42,768	S.I.R. MANAGEMENT, INC.	100.00%	58,005	15,237	21
22	V	24	EDUCATION & SEMINAR	873	S.I.R. MANAGEMENT, INC.	100.00%	987	114	22
23	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	8,079	8,079	23
24	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	1,343	1,343	24
25	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	8,130	8,130	25
26	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(34,622)	(34,622)	26
27	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	9,308	9,308	27
28	V								28
29	V	17	ADMINISTRATIVE	206,724	S.I.R. MANAGEMENT, INC.	100.00%	27,152	(179,572)	29
30	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	1,028		30
31	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	93,933	93,933	31
32	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	19,171	19,171	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 455,061			$ 226,560	$ * (229,529)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SALARIES	$ 21,384	S.I.R. MANAGEMENT, INC.	100.00%	$ 7,326	$ (14,058)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	1,157	1,157	16
17	V	10	NURSING SALARIES		S.I.R. MANAGEMENT, INC.	100.00%	7,567	7,567	17
18	V	15	EMP. BEN.-NURSING		S.I.R. MANAGEMENT, INC.	100.00%	1,190	1,190	18
19	V	17	ADMIN./LEGAL SALARIES	10,692	S.I.R. MANAGEMENT, INC.	100.00%	79,180	68,488	19
20	V	19	FIN. CONSULT./REGL. DIR.		S.I.R. MANAGEMENT, INC.	100.00%	15,194	15,194	20
21	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	14,368	14,368	21
22	V								22
23	V								23
24	V	10A	DIRECTOR OF SPECIAL REHAB	21,384	S.I.R. MANAGEMENT, INC.	100.00%	6,890	(14,494)	24
25	V	15	EMPLOYEE BENFITS		S.I.R. MANAGEMENT, INC.	100.00%	1,089	1,089	25
26	V								26
27	V	6	MAINTENANCE SALARIES	33,304	S.I.R. MANAGEMENT, INC.	100.00%	27,924	(5,380)	27
28	V	7	EMPLOYEE BENEFITS		S.I.R. MANAGEMENT, INC.	100.00%	5,282	5,282	28
29	V								29
30	V	5	UTILITIES		S.I.R. MANAGEMENT, INC.	100.00%	2,465	2,465	30
31	V	6	REPAIRS AND MAINT.		S.I.R. MANAGEMENT, INC.	100.00%	806	806	31
32	V	19	PROFESSIONAL FEES		S.I.R. MANAGEMENT, INC.	100.00%	58	58	32
33	V	21	CLERICAL & GENERAL		S.I.R. MANAGEMENT, INC.	100.00%	72	72	33
34	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	123	123	34
35	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	8,843	8,843	35
36	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	7,367	7,367	36
37	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	3,912	3,912	37
38	V								38
39	Total			$ 86,764			$ 190,813	$ * 104,049	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/10 Ending: 12/31/10

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Xcel Supply, LLC	100.00%	$	$	15
16	V	3	Housekeeping	38,139	Xcel Supply, LLC	100.00%	35,598	(2,541)	16
17	V	4	Laundry	4,958	Xcel Supply, LLC	100.00%	4,628	(330)	17
18	V	6	Repairs & Maintenance		Xcel Supply, LLC	100.00%			18
19	V	10	Nursing	24,229	Xcel Supply, LLC	100.00%	22,614	(1,615)	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			$ 67,326			$ 62,840	$ * (4,486)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/10 Ending: 12/31/10

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Health Insurance	$	CCS Employee Benefits Group	100.00%	$ 134,083	$ 134,083	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	134,083	CCS Employee Benefits Group	100.00%		(134,083)	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			$ 134,083			$ 134,083	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Bryan Barrish	Owner	Administrative	11.11	See Attached	3.30	7.33%	Alloc. Salary	$ 16,484	17-7	1
2	Eric Rothner	Owner	Administrative	20.00	See Attached	0.49	1.05%	Alloc. Salary	8,242	17-7	2
3	Nenita Guzman	Relative	Dietary	N/A	See Attached	4.12	8.24%	Alloc. Salary	7,326	1-7	3
4	Noah Wolff	Owner	Administrative	5.56	See Attached	3.00	15.00%	Consult. Fee	48,000	17-3	4
5	Kristen Barrish	Owner	Clerical	0.28	See Attached	1.40	8.24%	Alloc. Salary	3,064	21-7	5
6	Sarah Barrish	Owner	Administrative	0.56	See Attached	4.12	8.24%	Alloc. Salary	8,784	17-7	6
7	Adam Vales	Relative	Clerical	N/A	See Attached	0.70	1.75%	Alloc. Salary	1,231	22-7	7
8	Howard Geller	Owner	Administrative	4.44	None	8.00	16.00%	Consult. Fee	48,000	17-3	8
9	G. Matt Silvers	Relative	Administrative	N/A	See Attached	3.65	16.36%	Alloc. Salary	12,424	17-7	9
10											10
11											11
12	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only amounts anticipated to be considered allowable by the Il. Dept of HFS.										12
13								TOTAL	$ 153,555		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

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [X]

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	REPAIRS AND MAINT.	PATIENT DAYS	804,585	12	$ 159,205	$ 76,299	66,313	$ 13,122	1
2	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	804,585	12	11,878		66,313	979	2
3	10	NURSING	PATIENT DAYS	804,585	12	185,214	185,214	66,313	15,265	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	804,585	12	28,944		66,313	2,385	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	804,585	12	25,021	21,345	66,313	2,062	5
6	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	804,585	12	2,832		66,313	233	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	804,585	12	703,778	634,731	66,313	58,005	7
8	24	EDUCATION & SEMINAR	PATIENT DAYS	804,585	12	11,977		66,313	987	8
9	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	804,585	12	98,022		66,313	8,079	9
10	26	INSURANCE	PATIENT DAYS	804,585	12	16,300		66,313	1,343	10
11	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	804,585	12	98,638		66,313	8,130	11
12	32	INTEREST	PATIENT DAYS	804,585	12	(420,069)		66,313	(34,622)	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	804,585	12	112,938		66,313	9,308	13
14										14
15	17	ADMINISTRATIVE	PATIENT DAYS	804,585	12	329,434	329,434	66,313	27,152	15
16	19	PROFESSIONAL FEES	PATIENT DAYS	804,585	12	12,469		66,313	1,028	16
17	21	CLERICAL & GENERAL	PATIENT DAYS	804,585	12	1,139,702	1,053,550	66,313	93,933	17
18	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	804,585	12	232,600		66,313	19,171	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,748,883	$ 2,300,573		$ 226,560	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	PATIENT DAYS	804,585	12	$ 88,890	$ 88,890	66,313	$ 7,326	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	804,585	12	14,038		66,313	1,157	2
3	10	NURSING SALARIES	PATIENT DAYS	804,585	12	91,810	91,810	66,313	7,567	3
4	15	EMP. BEN.-NURSING	PATIENT DAYS	804,585	12	14,444		66,313	1,190	4
5	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	804,585	12	960,703	960,703	66,313	79,180	5
6	19	FIN. CONSULT./REGL. DIR.	PATIENT DAYS	804,585	12	184,350		66,313	15,194	6
7	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	804,585	12	174,335		66,313	14,368	7
8										8
9										9
10	10A	DIRECTOR OF SPECIAL REHA	SPECIAL REHAB INC.	273,888	12	88,247	88,247	21,384	6,890	10
11	15	EMPLOYEE BENFITS	SPECIAL REHAB INC.	273,888	12	13,949		21,384	1,089	11
12										12
13	6	MAINTENANCE SALARIES	MAINTENANCE INC.	322,046	11	270,018	270,018	33,304	27,924	13
14	7	EMPLOYEE BENEFITS	MAINTENANCE INC.	322,046	11	51,079		33,304	5,282	14
15										15
16	5	UTILITIES	ALLOCATED SQ FT	12,879	12	29,926		1,061	2,465	16
17	6	REPAIRS AND MAINT.	ALLOCATED SQ FT	12,879	12	9,787		1,061	806	17
18	19	PROFESSIONAL FEES	ALLOCATED SQ FT	12,879	12	705		1,061	58	18
19	21	CLERICAL & GENERAL	ALLOCATED SQ FT	12,879	12	872		1,061	72	19
20	26	INSURANCE	ALLOCATED SQ FT	12,879	12	1,497		1,061	123	20
21	30	DEPRECIATION	ALLOCATED SQ FT	12,879	12	107,338		1,061	8,843	21
22	32	INTEREST	ALLOCATED SQ FT	12,879	12	89,427		1,061	7,367	22
23	33	REAL ESTATE TAXES	ALLOCATED SQ FT	12,879	12	47,487		1,061	3,912	23
24										24
25	TOTALS					$ 2,238,902	$ 1,499,668		$ 190,813	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Direct Allocation			$	$		$	1
2	3	Housekeeping	Direct Allocation						35,598	2
3	4	Laundry	Direct Allocation						4,628	3
4	6	Repairs & Maintenance	Direct Allocation							4
5	10	Nursing	Direct Allocation						22,614	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					$	$		$ 62,840	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [X] NO [ ]

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

Name of Related Organization: CCS Employee Benefits Group, Inc.
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847)905-4000
Fax Number: (847)905-4040

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Employee Health Insurance	Direct Allocation			$	$		$ 134,083	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					$	$		$ 134,083	25

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/10 Ending: 12/31/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Private Bank		X	Mortgage Payable			$	$ 19,721,172			$ 951,612	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Lake Forest Bank & Trust		X	Line of Credit				200,000			2,947	6
7	Alloc. - SIR Management										(27,255)	7
8	See Supplemental Schedule											8
9	TOTAL Facility Related						$	$ 19,921,172			$ 927,304	9
	B. Non-Facility Related*											
10	Interest Income- Bldg Co.		X								(1,433)	10
11	Interest Income		X								(2)	11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (1,435)	14
15	TOTALS (line 9+line14)						$	$ 19,921,172			$ 925,869	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: 01/01/10 Ending: 12/31/10

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

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

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

Facility Name & ID Number Wilson Care # 0029975 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2009 report.	$	179,800	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.)	$	218,213	2
3. Under or (over) accrual (line 2 minus line 1).	$	38,413	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)	$	225,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.	$	43,145	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND** $ 103,249 **For** 06,07 **Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	306,558	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	71,860	8
	2006	169,658	9
	2007	169,130	10
	2008	171,205	11
	2009	214,301	12

Accrual= 214,301 x 1.05= $225,000

Alloc.- SIR Management= $3,912

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Wilson Care COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0029975

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-17-220-009-0000	Long Term Care Property	$ 214,301.35	$ 214,301.35
2.	See Attached	See Attached	$ 80,891.59	$ 5,218.97
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 295,192.94	$ 219,520.32

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

IMPORTANT NOTICE

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

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

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

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

2008 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Wilson Care COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0029975

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2009.

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 [X] (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? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (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 [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1985	$ 25,200	1
2					2
3	TOTALS			$ 25,200	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1985	65,366		20			65,340	9
10	Various			1986	161,365		20			161,346	10
11	Various			1987	49,380		20			49,349	11
12	Various			1989	49,210		20			49,196	12
13	Various			1990	105,470		20	4,621	4,621	105,271	13
14	Various			1991	29,903		20	1,495	1,495	29,243	14
15	Various			1992	69,669		20	3,483	3,483	64,644	15
16	Various			1993	61,688		20	3,084	3,084	53,954	16
17	Various			1994	55,691		20	2,653	2,653	46,192	17
18	Various			1995	87,144		20	4,357	4,357	67,554	18
19	Various			1996	303,393		20	15,170	15,170	219,022	19
20	Various			1997	145,411		20	7,347	7,347	93,835	20
21	Various			1998	34,959		20	1,748	1,748	21,934	21
22	Various			1999	53,478		20	2,674	2,674	30,949	22
23	Various			2000	342,218		20	17,111	17,111	176,264	23
24	Various			2001	102,633		20	5,132	5,132	49,592	24
25	Various			2002	67,986		20	4,957	4,957	60,030	25
26	Various			2003	97,187		20	6,025	6,025	44,558	26
27	Various			2004	62,333		20	4,333	4,333	28,194	27
28	Various			2005	214,966		20	13,469	13,469	74,683	28
29	Various			2006	56,219		20	2,958	2,958	13,025	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

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	
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
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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)		2,457,175	63,184		90,678	27,494	1,780,438	67
68	Related Party Allocations (Pages 12H & 12I)		134,412	4,058		5,443	1,385	59,907	68
69	Financial Statement Depreciation			65,969			(65,969)		69
70	TOTAL (lines 4 thru 69)		$ 4,807,256	$ 133,211		$ 196,740	$ 63,529	$ 3,344,519	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,807,256	$ 133,211		$ 196,740	$ 63,529	$ 3,344,519	1
2	Reception Station	2007	12,557		20	1,256	1,256	4,814	2
3	Security System Work	2007	2,525		20	253	253	968	3
4	Bathroom Remodeling	2007	11,700		20	585	585	2,194	4
5	Bathroom Remodeling	2007	12,085		20	604	604	2,266	5
6	Bathroom Remodeling	2007	11,700		20	585	585	2,145	6
7	Bathroom Remodeling	2007	10,980		20	549	549	1,967	7
8	Cameras	2007	2,970		20	297	297	1,089	8
9	Bathroom Remodeling	2007	11,700		20	585	585	2,096	9
10	Bathroom Remodeling	2007	12,085		20	604	604	2,165	10
11	Tile Flooring	2007	39,410		20	1,971	1,971	7,061	11
12	Bathroom Remodeling	2007	12,085		20	604	604	2,165	12
13	Bathroom Remodeling	2007	11,700		20	585	585	2,048	13
14	Hot Water Heater	2007	6,211		20	311	311	1,190	14
15	Bathroom Remodeling	2007	11,700		20	585	585	1,999	15
16	Bathroom Remodeling	2007	12,160		20	608	608	2,077	16
17	Fire Doors	2007	6,850		20	343	343	1,142	17
18	Security System	2007	4,110		20	411	411	1,336	18
19	Security System	2007	8,310		20	831	831	2,701	19
20	Tile Flooring	2007	29,171		20	1,459	1,459	4,740	20
21	Bathroom Work	2007	2,080		20	104	104	338	21
22	Boiler Work	2007	5,323		20	266	266	865	22
23	Bathroom Remodeling	2007	11,700		20	585	585	1,901	23
24	Bathroom Remodeling	2007	11,700		20	585	585	1,901	24
25	Tile Flooring	2007	50,378		20	2,519	2,519	7,977	25
26	Fire Doors	2007	7,975		20	399	399	1,263	26
27	Handrails	2007	10,930		20	547	547	1,685	27
28	Bathroom Work	2007	11,700		20	585	585	1,950	28
29	Bathroom Work	2007	11,700		20	585	585	1,853	29
30	Ceiling Panels	2007	2,550		20	128	128	425	30
31	Boiler Work	2007	2,660		20	133	133	432	31
32	Roof Work	2007	3,565		20	178	178	654	32
33	Boiler Work	2007	3,100		20	155	155	530	33
34	TOTAL (lines 1 thru 33)		$ 5,172,626	$ 133,211		$ 216,532	$ 83,321	$ 3,412,454	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: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 5,172,626	$ 133,211		$ 216,532	$ 83,321	$ 3,412,454	1
2	Landscaping - Trees. Bush	2008	5,185		20	259	259	605	2
3	Elevator Cables	2008	3,925		20	196	196	523	3
4	Return Steam Trap & Valves	2008	10,440		20	522	522	1,523	4
5	Heat Repair	2008	3,069		20	153	153	448	5
6	Chiller Repair	2008	3,196		20	160	160	426	6
7	Electrical Work	2008	3,013		20	151	151	377	7
8	Mixing Valves	2008	3,050		20	153	153	318	8
9	Heating System	2008	8,136		20	407	407	1,187	9
10	Boiler Work	2009	4,297		20	215	215	376	10
11	Water Pump	2009	2,717		20	136	136	260	11
12	Plumbing Work	2009	2,840		20	142	142	284	12
13	Plumbing Work	2009	2,580		20	129	129	226	13
14	Fire Pump Check Valve	2009	2,860		20	143	143	286	14
15	Smoke Detector	2009	2,620		20	131	131	186	15
16	Exhaust Fan	2010	4,997		20	500	500	500	16
17	Boiler Dampers	2010	3,912		20	391	391	391	17
18	Water Pump	2010	4,650		20	465	465	465	18
19	Boiler Repair	2010	3,060		20	153	153	153	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)		$ 5,247,173	$ 133,211		$ 220,937	$ 87,726	$ 3,420,986	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: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 5,247,173	$ 133,211		$ 220,937	$ 87,726	$ 3,420,986	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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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)		$ 5,247,173	$ 133,211		$ 220,937	$ 87,726	$ 3,420,986	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: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 5,247,173	$ 133,211		$ 220,937	$ 87,726	$ 3,420,986	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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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)		$ 5,247,173	$ 133,211		$ 220,937	$ 87,726	$ 3,420,986	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: 01/01/10 Ending: 12/31/10

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	Building Company Information								1
2	Buildings:								2
3		1967	1,539,800	63,184	35	43,994	(19,190)	1,679,234	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Bathroom Remodel	2007	35,100		20	1,755	1,755	7,020	9
10	Flooring (4th)	2008	29,171		20	1,459	1,459	4,377	10
11	Flooring (5th)	2008	29,171		20	1,459	1,459	4,377	11
12	Bathroom Remodel	2008	135,720		20	6,786	6,786	20,358	12
13	Bathroom Remodel	2008	23,400		20	1,170	1,170	3,510	13
14	Painting	2008	146,700		20	7,335	7,335	22,005	14
15	Bathtub Liner	2008	16,250		20	813	813	2,438	15
16	Elevator Controller	2008	35,150		20	1,758	1,758	5,273	16
17	Handrails	2008	9,794		20	490	490	1,469	17
18	Phone System	2008	11,656		20	583	583	1,749	18
19	Hot Water Boilers	2008	29,247		20	1,462	1,462	4,387	19
20	Gas Line Piping	2008	4,979		20	249	249	747	20
21	Bathtub Liners	2009	12,200		20	610	610	1,220	21
22	Painting	2009	16,300		10	1,630	1,630	3,260	22
23	Terra Cotta Work	2010	154,950		20	7,748	7,748	7,748	23
24	HVAC Unit	2010	15,992		20	800	800	800	24
25	Dining Room Flooring	2010	47,092		20	2,355	2,355	2,355	25
26	Laundry Vent- Drain	2010	6,100		20	305	305	305	26
27	HVAC Electrical	2010	8,997		20	450	450	450	27
28	Flooring	2010	4,034		20	202	202	202	28
29	Concrete and Beams	2010	70,300		20	3,515	3,515	3,515	29
30	Oxygen Room Work- Installation of Exhaust Fan	2010	8,000		20	400	400	400	30
31	Fire Doors	2010	8,500		20	425	425	425	31
32	Nurse Station- Built in Custom Cabinets	2010	7,000		20	350	350	350	32
33	Fire Doors	2010	2,700		20	135	135	20	33
34									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: 01/01/10 Ending: 12/31/10

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	Building Company Information Continued		$	$		$	$	$	1
2	Fire Doors	2010	27,610		20	1,381	1,381	1,381	2
3	Satellite- Cableing and Installation	2010	17,612		20	881	881	881	3
4	Fire Doors	2010	3,650		20	183	183	183	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
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19									19
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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)		$ 2,457,175	$ 63,184		$ 90,678	$ 27,494	$ 1,780,438	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: 01/01/10 Ending: 12/31/10

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	Related Party Information		$	$		$	$	$	1
2	Buildings:								2
3	SIR	1993	37,291	1,184	35	1,065	(119)	18,645	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	S.I.R. Properties- S.I.R. Management- Allocation	2010	2,250		20	38	38	38	9
10	S.I.R. Properties- S.I.R. Management- Allocation	2009	2,239	274	20	112	(162)	202	10
11	S.I.R. Properties- S.I.R. Management- Allocation	2007	653	71	20	33	(38)	131	11
12	S.I.R. Properties- S.I.R. Management- Allocation	2002	148		20	7	7	63	12
13	S.I.R. Properties- S.I.R. Management- Allocation	1999	4,725		20	236	236	2,717	13
14	S.I.R. Properties- S.I.R. Management- Allocation	1998	2,258		20	113	113	1,411	14
15	S.I.R. Properties- S.I.R. Management- Allocation	1997	140		20	7	7	102	15
16	S.I.R. Properties- S.I.R. Management- Allocation	1994	355	9	20	18	9	293	16
17	S.I.R. Properties- S.I.R. Management- Allocation	1993	605	3	20	30	27	530	17
18									18
19	S.I.R. Management- Allocation	1993	9,455	263	20	469	206	8,437	19
20	S.I.R. Management- Allocation	1994	29		20			29	20
21	S.I.R. Management- Allocation	1995	216		20	11	11	166	21
22	S.I.R. Management- Allocation	1997	14,528	325	20	726	401	10,031	22
23	S.I.R. Management- Allocation	1999	1,142		20	57	57	642	23
24	S.I.R. Management- Allocation	1999	11,079		20			11,079	24
25	S.I.R. Management- Allocation	2000	1,349		20	67	67	711	25
26	S.I.R. Management- Allocation	2007	4,333	464	20	217	(247)	692	26
27	S.I.R. Management- Allocation	2008	11,942	1,194	20	753	(441)	2,141	27
28	S.I.R. Management- Allocation	2009	29,675	271	20	1,484	1,213	1,847	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.

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	Related Party Information Continued								1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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18									18
19									19
20									20
21									21
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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)		$ 134,412	$ 4,058		$ 5,443	$ 1,385	$ 59,907	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: 01/01/10 Ending: 12/31/10

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	$ 421,173	$ 4,486	$ 26,441	$ 21,955	10	$ 319,460	71
72	Current Year Purchases	370,099	134	117	(17)	10	21,226	72
73	Fully Depreciated Assets	573,043				10	573,043	73
74								74
75	TOTALS	$ 1,364,315	$ 4,620	$ 26,558	$ 21,938		$ 913,729	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		Alloc- SIR Management	2010	$ 2,183	$ 164	$ 164	$	5	$ 164	76
77										77
78										78
79										79
80	TOTALS			$ 2,183	$ 164	$ 164	$		$ 164	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)	$ 6,638,871	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 137,995	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 247,659	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 109,664	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,334,879	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.

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/10 Ending: 12/31/10

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: ____ *

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.	/2011	$
13.	/2012	$
14.	/2013	$

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: $ 15,238 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/10 Ending: 12/31/10

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care

STATE OF ILLINOIS
0029975 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

	1	2	3	4	5	6	7	8	
	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 prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental									13
14	TOTAL			$		$	$		$	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/10 Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/10 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 52,609	$ 119,975	1
2	Cash-Patient Deposits	32,499	32,499	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,067,859	1,067,859	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	21,224	22,215	6
7	Other Prepaid Expenses	4,050	4,050	7
8	Accounts Receivable (owners or related parties)	52,742	28,615	8
9	Other(specify): See Attached Schedule	125,221	1,477,993	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,356,204	$ 2,753,206	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		25,200	13
14	Buildings, at Historical Cost		1,539,800	14
15	Leasehold Improvements, at Historical Cost	1,706,218	2,509,715	15
16	Equipment, at Historical Cost	1,406,487	1,876,924	16
17	Accumulated Depreciation (book methods)	(2,039,169)	(3,778,167)	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): See Attached Schedule		343,972	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,073,536	$ 2,517,444	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,429,740	$ 5,270,650	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 115,095	$ 115,096	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	32,013	32,013	28
29	Short-Term Notes Payable	200,000	200,000	29
30	Accrued Salaries Payable	186,197	186,197	30
31	Accrued Taxes Payable (excluding real estate taxes)	15,932	15,932	31
32	Accrued Real Estate Taxes(Sch.IX-B)		225,000	32
33	Accrued Interest Payable		78,885	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	11,000	157,444	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 560,237	$ 1,010,567	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		19,721,172	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule		64,612	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 19,785,784	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 560,237	$ 20,796,351	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,869,503	$ (15,525,701)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,429,740	$ 5,270,650	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/10 Ending: 12/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,188,387	1	
2	Restatements (describe):		2	
3	Rounding	2	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,188,389	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,085,114	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	(1,404,000)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (318,886)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,869,503	24	*

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/10 Ending: 12/31/10

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,506,708	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,506,708	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	104,506	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 104,506	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,611,216	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,172,086	31
32	Health Care	1,799,989	32
33	General Administration	1,784,443	33
	B. Capital Expense		
34	Ownership	1,660,846	34
	C. Ancillary Expense		
35	Special Cost Centers	333	35
36	Provider Participation Fee	108,405	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,526,102	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,085,114	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,085,114	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: 01/01/10 Ending: 12/31/10

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,997	2,078	$ 83,449	$ 40.16	1
2	Assistant Director of Nursing	1,994	2,093	67,558	32.28	2
3	Registered Nurses	1,730	2,141	68,048	31.78	3
4	Licensed Practical Nurses	12,333	13,171	305,379	23.19	4
5	CNAs & Orderlies	53,588	56,452	573,770	10.16	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,903	2,116	33,738	15.94	9
10	Activity Assistants	8,147	8,868	85,564	9.65	10
11	Social Service Workers	18,085	19,672	332,007	16.88	11
12	Dietician					12
13	Food Service Supervisor	2,013	2,467	36,252	14.69	13
14	Head Cook	7,908	8,319	77,285	9.29	14
15	Cook Helpers/Assistants	10,111	10,766	101,983	9.47	15
16	Dishwashers					16
17	Maintenance Workers	4,295	4,426	47,783	10.80	17
18	Housekeepers	17,726	19,164	186,281	9.72	18
19	Laundry					19
20	Administrator	1,984	2,160	102,802	47.59	20
21	Assistant Administrator	2,056	2,160	40,598	18.80	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	18,227	19,595	219,048	11.18	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	4,190	4,504	83,993	18.65	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	2,110	2,110	8,573	4.06	33
34	TOTAL (lines 1 - 33)	170,397	182,262	$ 2,454,111 *	$ 13.46	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 30,387	01-03	35
36	Medical Director	Monthly	10,400	09-03	36
37	Medical Records Consultant	Monthly	4,416	10-03	37
38	Nurse Consultant	Monthly	42,768	10-03	38
39	Pharmacist Consultant	Monthly	9,754	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	2,652	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Psychiatric Consult.	Monthly	8,100	10-03	47
48	Specialized Rehab Consultant	Monthly	21,384	10a-03	48
49	TOTAL (lines 35 - 48)		$ 129,861		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	38	1,461	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	38	$ 1,461		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/10 Ending: 12/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Augusto Baley	Administrator	0%	$ 102,802
Elizabeth Webster	Asst. Admin	0%	40,598
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 143,400

B. Administrative - Other

Description	Amount
Consulting Fees- SIR Managemant	$ 120,000
SIR-Director of Admin. Services	42,768
SIR Management- Admin Charges	43,956
See Supplemetal Schedule	106,692
TOTAL (agree to Schedule V, line 17, col. 3)	$ 313,416
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
S.I.R. Management	Dir. Of Regulatory Serive	$ 21,384
S.I.R. Management	Accounting	36,000
Frost, Ruttenberg, & Rothblatt	Accounting	18,030
S.I.R. Management	Bookkeeping Services	83,160
Pinnacle Consulting	Customer Satisfaction Prg	2,010
LTC Solutions	Data Processing	1,800
Rieff Schramm & Kanter	Real Estate Appeal	34,634
Rieff Schramm & Kanter	Valuation Services	8,161
Legal Services	See Attahced	15,296
Personnel Planners	Unemployment Tax Cnsltg	2,041
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 222,516

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 40,820
Unemployment Compensation Insurance	23,160
FICA Taxes	183,640
Employee Health Insurance	162,313
Employee Meals	20,367
Illinois Municipal Retirement Fund (IMRF)*	
City Head Tax	4,512
Union Pension Expense	25,966
Employee Benefits- Other	11,814
401K Contributions	2,640
TOTAL (agree to Schedule V, line 22, col.8)	$ 475,232

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,077
Advertising: Employee Recruitment	1,479
Health Care Worker Background Check	
(Indicate # of checks performed 185)	2,350
Patient Background Checks	
Dues and Subscriptions	11,795
Advertising and Promotion	7,680
Licenses and Permits	14,268
Alloc.- SIR Management	233
Less: Public Relations Expense	( )
Non-allowable advertising	(7,680)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 31,202

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,911
Alloc. -SIR Management	987
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,898

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care # 0029975 Report Period Beginning: 01/01/10 Ending: 12/31/10

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								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
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14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wilson Care # 0029975 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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. $ **8,952** 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. $ **20,367** 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?
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? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.