



Facility Name & ID Number THE WEALSHIRE

# 0040956 Report Period Beginning: 01/01/06 Ending: 12/31/06

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	132	Skilled (SNF)	132	48,180	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	12	Sheltered Care (SC)	12	4,380	5
6		ICF/DD 16 or Less			6
7	144	TOTALS	144	52,560	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 Patient Days by Level of Care and Primary Source of Payment			5		
		Medicaid Recipient	Private Pay	Other			Total
		8	SNF	585			6,614
9	SNF/PED					9	
10	ICF	2,845	14,988		17,833	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	3,430	21,602	7,561	32,593	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.01%

D. How many bed-hold days during this year were paid by the Department? 0 (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)

DAYCARE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO

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

I. On what date did you start providing long term care at this location?  
Date started 08/14/95

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 08/14/95 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 60 and days of care provided 7,561

Medicare Intermediary NATIONAL GOVERNMENT SERV (ADMINISTAR FEDERAL)

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/06 Fiscal Year: 12/31/06

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

STATE OF ILLINOIS

Facility Name & ID Number THE WEALSHIRE # 0040956 Report Period Beginning: 01/01/06 Ending: 12/31/06

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

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
<b>A. General Services</b>											
1	Dietary	198,592	24,129		222,721		222,721		222,721		1
2	Food Purchase		193,162		193,162	(10,820)	182,342	(663)	181,679		2
3	Housekeeping	248,173	31,597		279,770		279,770		279,770		3
4	Laundry	50,023	20,882		70,905		70,905		70,905		4
5	Heat and Other Utilities			206,903	206,903		206,903		206,903		5
6	Maintenance	66,778	1,603	201,600	269,981		269,981	1,000	270,981		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>563,566</b>	<b>271,373</b>	<b>408,503</b>	<b>1,243,442</b>	<b>(10,820)</b>	<b>1,232,622</b>	<b>337</b>	<b>1,232,959</b>		<b>8</b>
<b>B. Health Care and Programs</b>											
9	Medical Director			46,360	46,360		46,360		46,360		9
10	Nursing and Medical Records	2,502,604	105,792	32,222	2,640,618	20,302	2,660,920		2,660,920		10
10a	Therapy	116,393	2,576	703,255	822,224	(20,964)	801,260		801,260		10a
11	Activities	229,609	14,053	6,396	250,058		250,058		250,058		11
12	Social Services	29,563			29,563		29,563		29,563		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>2,878,169</b>	<b>122,421</b>	<b>788,233</b>	<b>3,788,823</b>	<b>(662)</b>	<b>3,788,161</b>		<b>3,788,161</b>		<b>16</b>
<b>C. General Administration</b>											
17	Administrative	83,507		203,575	287,082		287,082		287,082		17
18	Directors Fees										18
19	Professional Services			24,458	24,458	662	25,120	2,660	27,780		19
20	Dues, Fees, Subscriptions & Promotions			118,027	118,027		118,027	(108,483)	9,544		20
21	Clerical & General Office Expenses	370,737	22,748	178,932	572,417		572,417	(204,920)	367,497		21
22	Employee Benefits & Payroll Taxes			741,446	741,446	10,820	752,266		752,266		22
23	Inservice Training & Education			1,979	1,979		1,979		1,979		23
24	Travel and Seminar			4,442	4,442		4,442	(2,502)	1,940		24
25	Other Admin. Staff Transportation			17,418	17,418		17,418		17,418		25
26	Insurance-Prop.Liab.Malpractice			71,281	71,281		71,281	67,372	138,653		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>454,244</b>	<b>22,748</b>	<b>1,361,558</b>	<b>1,838,550</b>	<b>11,482</b>	<b>1,850,032</b>	<b>(245,873)</b>	<b>1,604,159</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>3,895,979</b>	<b>416,542</b>	<b>2,558,294</b>	<b>6,870,815</b>		<b>6,870,815</b>	<b>(245,536)</b>	<b>6,625,279</b>		<b>29</b>

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

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

Facility Name &amp; ID Number

THE WEALSHIRE

#0040956

Report Period Beginning:

01/01/06

Ending:

12/31/06

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation							763,308	763,308			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			11,799	11,799		11,799	1,172,581	1,184,380			32
33	Real Estate Taxes							114,439	114,439			33
34	Rent-Facility & Grounds			602,242	602,242		602,242	(602,242)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* AMORT LOAN FEES							109,843	109,843			36
37	<b>TOTAL Ownership</b>			614,041	614,041		614,041	1,557,929	2,171,970			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation			3,598	3,598		3,598		3,598			38
39	Ancillary Service Centers		338,070	8,663	346,733		346,733		346,733			39
40	Barber and Beauty Shops		14	25,204	25,218		25,218		25,218			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			72,270	72,270		72,270		72,270			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		338,084	109,735	447,819		447,819		447,819			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,895,979	754,626	3,282,070	7,932,675		7,932,675	1,312,393	9,245,068			45

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

**VI. ADJUSTMENT DETAIL** A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(663)	2		4
5	Telephone, TV & Radio in Resident Rooms	(898)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	402,480	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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	(101,057)	21		18
19	Entertainment	(2,502)	24		19
20	Contributions	(700)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(32,207)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(171,103)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ 93,350		\$	30

BHF USE ONLY						
48		49		50		51
						52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	1,219,043		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 1,219,043		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 1,312,393		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

**THE WEALSHIRE**

ID# 0040956

Report Period Beginning: 01/01/06

Ending: 12/31/06

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	MARKETING SUPPLIES & INCENTIVES	\$ (76,082)	20	1
2	MARKETING SALARIES	(54,115)	21	2
3	PROMOTIONS AND EVENTS	(26,708)	20	3
4				4
5	MEDICAL ADVISORY COMMITTEE	(1,815)	20	5
6				6
7	WEB SITE MAINTENANCE	(8,505)	21	7
8				8
9				9
10	CREDIT CARD FEES	(3,878)	20	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(171,103)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number THE WEALSHIRE

# 0040956

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(663)	0	0	0	0	0	0	0	0	0	0	(663)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	1,000	0	0	0	0	0	0	0	0	0	1,000	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(663)</b>	<b>1,000</b>	<b>0</b>	<b>337</b>	<b>8</b>								
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	2,660	0	0	0	0	0	0	0	0	0	2,660	19
20	Fees, Subscriptions & Promotions	(108,483)	0	0	0	0	0	0	0	0	0	0	(108,483)	20
21	Clerical & General Office Expenses	(197,482)	(7,438)	0	0	0	0	0	0	0	0	0	(204,920)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(2,502)	0	0	0	0	0	0	0	0	0	0	(2,502)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	67,372	0	0	0	0	0	0	0	0	0	67,372	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(308,467)</b>	<b>62,594</b>	<b>0</b>	<b>(245,873)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(309,130)</b>	<b>63,594</b>	<b>0</b>	<b>(245,536)</b>	<b>29</b>								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number THE WEALSHIRE

# 0040956

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	402,480	360,828	0	0	0	0	0	0	0	0	0	763,308	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	1,172,581	0	0	0	0	0	0	0	0	0	1,172,581	32
33	Real Estate Taxes	0	114,439	0	0	0	0	0	0	0	0	0	114,439	33
34	Rent-Facility & Grounds	0	(602,242)	0	0	0	0	0	0	0	0	0	(602,242)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):* AMORT LOAN F	0	109,843	0	0	0	0	0	0	0	0	0	109,843	36
37	<b>TOTAL Ownership</b>	<b>402,480</b>	<b>1,155,449</b>	<b>0</b>	<b>1,557,929</b>	<b>37</b>								
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	93,350	1,219,043	0	0	0	0	0	0	0	0	0	1,312,393	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ARNOLD GOLDBERG	99.0	THE PONDS OF WEALSHIRE	LINCOLNSHIRE	LINCOLNSHIRE PRO	LINCOLNSHIRE	BLDG PRTRNSH
THE WEALSHIRE, INC.	01.0			ALEXANDER BLAK	SKOKIE	MGMT CO

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	34 RENT	\$	LINCOLNSHIRE PROPERTIES, LP		\$	\$(602,242) 1
2	V	19 PROFESSIONAL FEES		LINCOLNSHIRE PROPERTIES, LP		2,660	2,660 2
3	V	26 INSURANCE		LINCOLNSHIRE PROPERTIES, LP		67,372	67,372 3
4	V	32 MORTGAGE INTEREST		LINCOLNSHIRE PROPERTIES, LP		1,172,581	1,172,581 4
5	V	21 OFFICE EXPENSES		LINCOLNSHIRE PROPERTIES, LP		(7,438)	(7,438) 5
6	V	6 MAINTENANCE		LINCOLNSHIRE PROPERTIES, LP		1,000	1,000 6
7	V	33 REAL ESTATE TAXES		LINCOLNSHIRE PROPERTIES, LP		114,439	114,439 7
8	V	30 BOOK DEPRECIATION		LINCOLNSHIRE PROPERTIES, LP		360,828	360,828 8
9	V	36 AMORTIZATION		LINCOLNSHIRE PROPERTIES, LP		109,843	109,843 9
10	V						10
11	V						11
12	V						12
13	V						13
14	Total		\$			\$ 1,821,285	\$ * 1,219,043 14

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

Facility Name & ID Number      THE WEALSHIRE      #      0040956      Report Period Beginning:      01/01/06      Ending:      12/31/06

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ARNOLD GOLDBERG	OWNER	ADMINISTRATIV	99.00	NONE	35	70.00	ALLOC MGM	\$ 203,575	17-3	1
2	(Alexander Blake )										2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 203,575		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 THE WEALSHIRE # 0040956 Report Period Beginning: 01/01/06 Ending: 12/31/06

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

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

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

Facility Name & ID Number THE WEALSHIRE# 0040956

Report Period Beginning:

01/01/06

Ending:

12/31/06

## 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	
						Original	Balance					
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO									
	<b>A. Directly Facility Related</b>											
	<b>Long-Term</b>											
1	RELATED PARTY LINCOLNSHIRE PROP			MORTGAGE LOAN	\$129,285.00	10/31/97	\$ 16,000,000	\$			\$ 951,409	1
2	DIAWA FINANCE CORP		X	MORTGAGE LOAN		10/31/97	593,987				108,895	2
3	FIRST EQUITY		X	MORTGAGE LOAN			4,579,834	4,579,834	09/2007	9.2500	107,422	3
4	6TH MILLENIUM OPPORTUNITY I		X	MORTGAGE LOAN	INT ONLY	09/14/06	3,000,000	3,000,000	09/2007	15.0000	113,750	4
5	6TH MILLENIUM OPPORTUNITY I		X	MORTGAGE LOAN FEES		09/14/06	170,641	169,693	09/2007		948	5
	<b>Working Capital</b>											
6	I GOLDBERG LINCOLNSHIR	X		WORKING CAPITAL				1,252,121		6.0000		6
7	H GOLDBERG LINCOLNSHI	X		WORKING CAPITAL				325,000		6.0000		7
8	PREMIER BANK OF WILLMETTE		X	WORKING CAPITAL	INTEREST ON	01/06	250,000				11,799	8
9	TOTAL Facility Related				\$129,285.00		\$ 24,594,462	\$ 9,326,648			\$ 1,294,223	9
	<b>B. Non-Facility Related*</b>											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 24,594,462	\$ 9,326,648			\$ 1,294,223	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line # \_\_\_\_\_

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)



**IMPORTANT NOTICE**

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

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

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

**2005 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME THE WEALSHIRE COUNTY LAKE

FACILITY IDPH LICENSE NUMBER 0040956

CONTACT PERSON REGARDING THIS REPORT SUSAN CORONADO

TELEPHONE ( 847) 883-9000 FAX #: ( 847) 478-9287

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

Enter the tax index number and real estate tax assessed for 2005 on the lines provided below. Enter only the portion of total cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>15-15-200-062</u>	<u>NURSING HOME</u>	\$ <u>116,187.95</u>	\$ <u>116,187.95</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>116,187.95</u>	\$ <u>116,187.95</u>

**B. Real Estate Tax Cost Allocation:**

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   X   NO

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

**C. Tax Bills**

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006

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

Facility Name &amp; ID Number THE WEALSHIRE

# 0040956 Report Period Beginning:

01/01/06 Ending:

12/31/06

## X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 62,477 B. General Construction Type: Exterior BRICK Frame \_\_\_\_\_ Number of Stories 1C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground (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)

The Ponds of Wealshire LLC; Assisted Living Sheltered Care, 141 Licensed BedsF. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
If so, please complete the following:

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

3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs: \_\_\_\_\_

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

## XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>FACILITY</u>	<u>273,375</u>	<u>1994</u>	<u>\$ 970,925</u>	<u>1</u>
2					<u>2</u>
3	<u>TOTALS</u>	<u>273,375</u>		<u>\$ 970,925</u>	<u>3</u>

Facility Name & ID Number THE WEALSHIRE

# 0040956

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	LINCOLNSHIRE PROPERTIES:		1995	\$ 11,521,031	\$ 225,889	20	\$ 576,052	\$ 350,163	\$ 6,552,591	4
5	144									5
6										6
7										7
8										8
Improvement Type**										
9	LINCOLNSHIRE PROPERTIES:									9
10	MUSIC SYSTEM		1999	33,003	846	20	1,650	804	3,087	10
11	SIDEWALK		1999	4,660	275	20	233	(42)	1,306	11
12	PATIO		2001	5,200	337	20	260	(77)	739	12
13	SIDEWALK		2001	2,325	151	20	116	(35)	2,066	13
14	CARPETING		2002	12,473	1,365	20	624	(741)	1,743	14
15	SPRINKLER SYSTEM		2002	6,805	478	20	340	(138)	2,707	15
16	REMODELING		2003	20,650	2,205	20	1,033	(1,173)	2,176	16
17	SIGNAGE		2004	6,000	1,049	7	857	(192)	2,112	17
18	REMODELING - WINDOWS PB		2004	9,411	805	15	627	(178)	8,104	18
19	REMODELING KITCHEN - CC		2004	34,889	6,102	7	4,984	(1,118)	12,460	19
20	TELEPHONE EQUIPMENT		2006	9,460	1,352	7	1,351	(1)	1,351	20
21	LIGHTING		2006	24,655	3,525	7	3,522	(3)	3,522	21
22	CARPETS		2006	23,788	4,758	5	4,758	(0)	4,758	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

\*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 &amp; ID Number THE WEALSHIRE

# 0040956

Report Period Beginning:

01/01/06

Ending:

12/31/06

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	LEASEHOLD IMPROVEMENTS	1995	\$ 34,126	\$	20	\$ 1,706	\$ 1,706	\$ 19,094	37
38	LEASEHOLD IMPROVEMENTS	1996	4,059		20	203	203	2,125	38
39	LEASEHOLD IMPROVEMENTS	1998	3,993		20	399	399	3,325	39
40	ALARM SYSTEM	1999	9,183		20	459	459	3,340	40
41	SECURITY SYSTEM	1999	4,427		20	221	221	1,590	41
42	CABLING/WINDOWS/CABINETS/LUMBER/FIRE SAFETY/ETC	2000	23,775		20	1,189	1,189	7,828	42
43	SIGN	2000	1,611		20	81	81	520	43
44	BOILER WORK	2000	871		20	44	44	264	44
45	BEARING & ASSEMBLING	2001	1,136		20	57	57	323	45
46	PUMP W/MOTOR	2001	704		20	35	35	184	46
47	COMPRESSOR	2001	1,797		20	90	90	503	47
48	BOILER WORK	2001	1,722		20	86	86	509	48
49	BOILER WORK	2001	1,008		20	50	50	296	49
50	ROOF REPAIR	2001	500		20	25	25	135	50
51	PHONE SYSTEM	2001	1,713		20	86	86	509	51
52	BLACKTOP & PATCH	2001	4,799		20	240	240	1,440	52
53	CARPETING	2002	1,158		20	58	58	287	53
54	EXTERIOR DOORS	2002	9,700		20	485	485	1,991	54
55	BOILER REPAIRS	2002	8,124		20	406	406	2,030	55
56	SPRINKLER SYSTEM	2002	950		20	48	48	240	56
57	BLACKTOP REPAIR	2002	2,799		20	140	140	700	57
58	BOILER REPAIRS	2002	1,077		20	54	54	270	58
59	PUMP & BOILER REPAIRS	2002	3,376		20	169	169	845	59
60	FIRE SAFETY UPGRADES	2003	9,901		20	495	495	1,733	60
61	SEWAGE EJECTORS/DISPOSER/PUMP	2003	12,848		20	642	642	2,247	61
62	BORIS BARBARIC-PAINTING	2003	5,950		5	1,190	1,190	4,165	62
63	TELEPHONE LINES	2003	4,229		20	211	211	739	63
64	IRRIGATION SYSTEM BOOSTER PUMP/HEADS	2004	2,109		39	54	54	113	64
65	UPGRADE BOILER CONTROLS	2004	5,530		39	142	142	308	65
66	SIGNAGE	2005	2,788		20	139	139	232	66
67	HANDICAP RAMP	2005	1,700		20	85	85	117	67
68	LANDSCAPE LIGHTING	2005	7,022		20	351	351	410	68
69	CHILLER REPLACEMENT EXCESS	2005	5,000		15	333	333	458	69
70	TOTAL (lines 4 thru 69)		\$ 11,894,035	\$ 249,137		\$ 606,381	\$ 357,244	\$ 6,657,591	70

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12A, Carried Forward	\$ 11,894,035	\$ 249,137		\$ 606,381	\$ 357,244	\$ 6,657,591		1
2									2
3	NEW HVAC COIL	2006	7,128	10	356	356	356		3
4	NEW HVAC COIL	2006	6,414	10	214	214	214		4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 11,907,577	\$ 249,137		\$ 606,951	\$ 357,814	\$ 6,658,161		34

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

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	\$ 1,747,530	\$	\$ 112,946	\$ 112,946	3-20 YR	\$ 1,692,863	71
72	Current Year Purchases	23,657		1,618	1,618	5,7,15,20YR	1,618	72
73	Fully Depreciated Assets	174,019					174,019	73
74	LINCOLNSHIRE PROPERTIES	396,078	35,222	41,793	6,571	3-20 YR	225,351	74
75	TOTALS	\$ 2,341,284	\$ 35,222	\$ 156,357	\$ 121,135		\$ 2,093,851	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77		96 DODGE RAM	2001	14,500				5	14,500	77
78										78
79										79
80	TOTALS			\$ 14,500	\$	\$	\$		\$ 14,500	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$ 15,234,286	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 284,359	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 763,308	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 478,949	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 8,766,512	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	LINCONSHIRE PROPERTIES	\$	\$	\$	86
87	COMPLETION OF BLDG 1996	58,161	1,491	15,718	87
88	LANDSCAPING	43,000	2,541	29,150	88
89	BUILDING 1997 SECT 754	4,185,474	64,006	944,946	89
90	Auto 2005	28,983	8,431	11,122	90
91	TOTALS	\$ 4,315,618	\$ 76,469	\$ 1,000,936	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.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: Lincolnshire Properties - Consolidationg Related Party  
 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:	<u>1996/1997</u>	<u>144</u>	<u>1997</u>	\$ <u>602,242</u>			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>		<b>144</b>		\$ <b>602,242</b>			7

10. Effective dates of current rental agreement:  
 Beginning \_\_\_\_\_  
 Ending \_\_\_\_\_

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2007</u>	\$ _____
13.	<u>/2008</u>	\$ _____
14.	<u>/2009</u>	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.  
 This amount was calculated by dividing the total amount to be amortized  
 by the length of the lease \_\_\_\_\_

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

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

15. Is Movable equipment rental included in building rental?  YES  NO  
 16. Rental Amount for movable equipment: \$ \_\_\_\_\_ Description: \_\_\_\_\_

(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	<b>TOTAL</b>		\$ _____	\$ _____	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.

**A. TYPE OF TRAINING PROGRAM** (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <b>CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <b>CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

- (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.

**C. CONTRACTUAL INCOME**

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

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

**D. NUMBER OF CNAs TRAINED**

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

- (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.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		494.79 hrs	\$ 13,198	12,600	\$ 196,765		13,095	\$ 209,963	1
2	Licensed Speech and Language Development Therapist		1605.45 hrs	17,579	149	2,247		1,754	19,826	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		1424 hrs	21,175	33,342	492,124	2,576	34,766	515,875	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <b>Swallow Evals</b>					12,119			12,119	13
14	<b>TOTAL</b>			\$ 51,952	46,091	\$ 703,255	\$ 2,576	49,615	\$ 757,783	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.

STATE OF ILLINOIS

Facility Name & ID Number THE WEALSHIRE # 0040956 Report Period Beginning: 01/01/06 Ending: 12/31/06  
 XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/06 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 175,475	\$ 217,811	1
2	Cash-Patient Deposits	3,378	3,378	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	800,746	800,746	3
4	Supply Inventory (priced at )	38,621	38,621	4
5	Short-Term Investments			5
6	Prepaid Insurance	246,348	246,348	6
7	Other Prepaid Expenses	1,266	1,266	7
8	Accounts Receivable (owners or related parties)	2,314,265	2,383,558	8
9	Other(specify): EMPLOYEE LOANS/ESCROW	26,009	59,096	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 3,606,108	\$ 3,750,824	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		3,190,356	13
14	Buildings, at Historical Cost		17,001,379	14
15	Leasehold Improvements, at Historical Cost	123,718	306,810	15
16	Equipment, at Historical Cost	567,033	1,050,131	16
17	Accumulated Depreciation (book methods)	(443,570)	(8,468,119)	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) UNAMORTIZED LOAN FEES		169,693	22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 247,181	\$ 13,250,250	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,853,289	\$ 17,001,074	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 1,314,730	\$ 1,314,730	26
27	Officer's Accounts Payable	186,713	186,713	27
28	Accounts Payable-Patient Deposits	3,378	3,378	28
29	Short-Term Notes Payable		9,156,955	29
30	Accrued Salaries Payable	179,382	179,382	30
31	Accrued Taxes Payable (excluding real estate taxes)	502,116	502,116	31
32	Accrued Real Estate Taxes(Sch.IX-B)		125,379	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	ACCRUED MANAGEMENT FEES	539,005	539,005	36
37	DUE TO AFFILIATES	1,399,713	364,853	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 4,125,037	\$ 12,372,511	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 4,125,037	\$ 12,372,511	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (271,748)	\$ 4,628,563	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,853,289	\$ 17,001,074	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,253,501)	1
2	Restatements (describe):		2
3	Prior year revenue adjustment	69,202	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,184,299)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	912,551	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	( )	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)	\$ 912,551	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (271,748)	24 *

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

## STATE OF ILLINOIS

Facility Name &amp; ID Number THE WEALSHIRE

# 0040956

Report Period Beginning: 01/01/06

Ending:

Page 19

12/31/06

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 8,118,632	1
2	Discounts and Allowances for all Levels	(578,548)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 7,540,084	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,209,826	6
7	Oxygen	49,901	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,259,727	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	32,277	13
14	Non-Patient Meals	623	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 32,900	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>	12,515	27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 12,515	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 8,845,226	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,243,442	31
32	Health Care	3,788,823	32
33	General Administration	1,838,550	33
<b>B. Capital Expense</b>			
34	Ownership	614,041	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	375,549	35
36	Provider Participation Fee	72,270	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 7,932,675	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	912,551	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 912,551	43

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

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

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number THE WEALSHIRE

# 0040956

Report Period Beginning: 01/01/06

Ending:

12/31/06

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,370	1,567	\$ 59,982	\$ 38.28	1
2	Assistant Director of Nursing	241	246	8,294	33.72	2
3	Registered Nurses	22,322	24,639	678,476	27.54	3
4	Licensed Practical Nurses	18,213	19,931	513,864	25.78	4
5	CNAs & Orderlies	95,144	101,683	1,159,182	11.40	5
6	CNA Trainees					6
7	Licensed Therapist	1,123	1,280	51,952	40.59	7
8	Rehab/Therapy Aides	1,803	2,070	32,204	15.56	8
9	Activity Director	2,159	2,474	35,609	14.39	9
10	Activity Assistants	15,942	16,972	194,000	11.43	10
11	Social Service Workers	1,702	1,801	29,563	16.41	11
12	Dietician	444	444	8,017	18.06	12
13	Food Service Supervisor	1,325	1,448	40,676	28.09	13
14	Head Cook	3,965	4,465	50,363	11.28	14
15	Cook Helpers/Assistants	9,977	10,568	99,536	9.42	15
16	Dishwashers					16
17	Maintenance Workers	2,552	2,846	66,778	23.46	17
18	Housekeepers	23,474	25,583	248,173	9.70	18
19	Laundry	5,456	5,937	50,022	8.43	19
20	Administrator	972	1,104	54,509	49.37	20
21	Assistant Administrator	1,051	1,148	28,997	25.26	21
22	Other Administrative	8,345	9,139	230,251	25.19	22
23	Office Manager					23
24	Clerical	7,111	7,308	86,371	11.82	24
25	Vocational Instruction	1,195	1,268	32,238	25.42	25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,184	1,245	36,815	29.57	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,604	1,870	21,234	11.36	31
32	Other Health Care Nurse Supervisors	780	872	24,758	28.39	32
33	Other(specify) Marketing	1,420	1,824	54,115	29.67	33
34	TOTAL (lines 1 - 33)	230,874	249,732	\$ 3,895,979 *	\$ 15.60	34

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

\*\* See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$ 3,794	19-3	35
36	Medical Director	46,360	9-3	36
37	Medical Records Consultant			37
38	Nurse Consultant	641	10-3	38
39	Pharmacist Consultant	648	19-3	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 51,443		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	\$ 8	175	10-6	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	40	629	10-6	52
53	TOTAL (lines 50 - 52)	48	\$ 804		53

Facility Name & ID Number THE WEALSHIRE

# 0040956

Report Period Beginning: 01/01/06

Ending: 12/31/06

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Norma Wilson	Administrator		\$ 54,510	Workers' Compensation Insurance	\$ 215,754	IDPH License Fee	\$	
Sharyce Floss	Asst Administrator		28,997	Unemployment Compensation Insurance	109,876	Advertising: Employee Recruitment	5,615	
				FICA Taxes	280,240	Health Care Worker Background Check (Indicate # of checks performed _____)	528	
				Employee Health Insurance	118,775	Patient Background Checks	1,700	
				Employee Meals	10,820	DUES	372	
				Illinois Municipal Retirement Fund (IMRF)*		STATE AND HEALTH DEPT LIC/FEES	1,329	
				Employee Life Insurance	2,933	Credit Card Fees	3,877	
				Employee Relations ( Awards, Holiday and Awards celebrations Holiday gifts)	13,400	Marketing & Public Relations	104,604	
				Misc	468	Less : Credit Card Fees	(3,877)	
						Less: Public Relations Expense	(104,604)	
						Non-allowable advertising (	)	
						Yellow page advertising (	)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 83,507	TOTAL (agree to Schedule V, line 22, col.8)	\$ 752,266	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 9,544	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
MANAGEMENT FEES			\$ 203,575			\$	Out-of-State Travel	\$
							In-State Travel	1,940
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 203,575				Seminar Expense	662
							Entertainment Expense (	)
							(agree to Sch. V, line 24, col. 8)	\$ 2,602
C. Professional Services				TOTAL				
Vendor/Payee	Type		Amount			\$		
LERMAN BOUDART & ASSOC	ACCOUNTING FEES		\$ 4,144	TOTAL		\$		
ELIZABETH WILSON	ACCOUNTING FEES-BILLING		10,050					
RONALD COURMAYA	MEDICARE COST REPORT		3,250					
SANDY TEN PASS	DIETICIAN		3,794					
CLIA	LAB WAIVER		150					
FATIMA GUTIEREZ	AGENCY NURSE		175					
FOLEY, LARDNER	LICENSURE/VIOLATIONS		4,820					
OMNICARE NORTH IL	PHARMACY CONSULT		648					
LEGAL			(2,573)					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 24,458					

\* Attach copy of IMRF notifications

\*\*See instructions.



XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? NO  
If YES, give association name and amount. \_\_\_\_\_
- (3) Did the nursing home make political contributions or payments to a political organization? NO If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 7 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 35,032 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? \_\_\_\_\_ If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 72,270  
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? YES
- (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 benefit: on Schedule V. \$ 10,820 Has any meal income been offset against related costs? YES Indicate the amount. \$ 663
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? \_\_\_\_\_  
d. Have vehicle usage logs been maintained? \_\_\_\_\_  
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? YES  
**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.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? \_\_\_\_\_ Attach invoices and a summary of services for all architect and appraisal fees.

STATE OF ILLINOIS  
THE WEALSHIRE

ID# 0040956  
01/01/06  
12/31/06

Report Period Beginning:  
Ending:

V- COLUMN 5 RECLASSIFICATIONS		Amount	Sch. V Line Reference
1			
2	EMPLOYEE MEALS	(10,820)	2
3	EMPLOYEE MEALS	10,820	22
4			
5	INSERVICE TRAINER	(32,238)	10a
6	INSERVICE TRAINER	32,238	10
7			
8	REHAB AIDE	(21,139)	10a
9	REAHB AIDE	21,139	10
10			
11	NURSING - AGENCY	175	10
12	CONSULTANTS	(175)	19
13			
14	SEMINAR EXPENSE	(662)	23
15	SEMINAR EXPENSE	662	24
16			
17			
18			
19			
20			
21			
22			
23			
24			
25			
26			
27			
28			
29			
30			
31			
32	<b>Total</b>	0	