

Facility Name & ID Number WEALSHIRE THE

0040956 Report Period Beginning: 01/01/07 Ending: 12/31/07

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 08/15/07

	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	110	Skilled (SNF)	120	41,540	1
2		Skilled Pediatric (SNF/PED)			2
3	22	Intermediate (ICF)	22	8,030	3
4		Intermediate/DD			4
5	12	Sheltered Care (SC)	2	2,990	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	3 Patient Days by Level of Care and Primary Source of Payment				5
		4				
		2 Medicaid Recipient	Private Pay	Other	Total	
8	SNF		5,892	15,137	21,029	8
9	SNF/PED					9
10	ICF	2,924	15,997		18,921	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	2,924	21,889	15,137	39,950	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.01%

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 15,137

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: 12/31/07 Fiscal Year: 12/31/07

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

STATE OF ILLINOIS

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Facility Name & ID Number WEALSHIRE THE # 0040956 Report Period Beginning: 01/01/07 Ending: 12/31/07

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

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	230,622	47,444		278,066		278,066		278,066		1
2	Food Purchase		222,573		222,573		222,573	(421)	222,152		2
3	Housekeeping	365,252	18,550		383,802		383,802		383,802		3
4	Laundry	49,057	32,833		81,890		81,890		81,890		4
5	Heat and Other Utilities			259,856	259,856		259,856		259,856		5
6	Maintenance	70,283	15,328	207,302	292,913		292,913	1,860	294,773		6
7	Other (specify):*										7
8	TOTAL General Services	715,214	336,728	467,158	1,519,100		1,519,100	1,439	1,520,539		8
	B. Health Care and Programs										
9	Medical Director			53,375	53,375		53,375		53,375		9
10	Nursing and Medical Records	3,491,141	246,324	47,492	3,784,957	969	3,785,926		3,785,926		10
10a	Therapy	82,440	5,158	1,351,258	1,438,856	(37,302)	1,401,554		1,401,554		10a
11	Activities	193,360	19,371	10,493	223,224		223,224		223,224		11
12	Social Services	38,740			38,740		38,740		38,740		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,805,681	270,853	1,462,618	5,539,152	(36,333)	5,502,819		5,502,819		16
	C. General Administration										
17	Administrative	92,378		437,636	530,014		530,014		530,014		17
18	Directors Fees										18
19	Professional Services			68,684	68,684	(969)	67,715	(14,368)	53,347		19
20	Dues, Fees, Subscriptions & Promotions			116,224	116,224	(1,125)	115,099	(101,241)	13,858		20
21	Clerical & General Office Expenses	399,913	22,556	205,625	628,094		628,094	(198,586)	429,508		21
22	Employee Benefits & Payroll Taxes			867,067	867,067		867,067		867,067		22
23	Inservice Training & Education			5,477	5,477	37,302	42,779		42,779		23
24	Travel and Seminar			1,037	1,037	1,125	2,162		2,162		24
25	Other Admin. Staff Transportation			19,093	19,093		19,093		19,093		25
26	Insurance-Prop.Liab.Malpractice			83,494	83,494		83,494	57,530	141,024		26
27	Other (specify):*										27
28	TOTAL General Administration	492,291	22,556	1,804,337	2,319,184	36,333	2,355,517	(256,665)	2,098,852		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,013,186	630,137	3,734,113	9,377,436		9,377,436	(255,226)	9,122,210		29

*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 & ID Number

WEALSHIRE THE

#0040956

Report Period Beginning:

01/01/07

Ending:

12/31/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			34,946	34,946		34,946	818,871	853,817			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							883,524	883,524			32
33	Real Estate Taxes							131,388	131,388			33
34	Rent-Facility & Grounds			1,130,412	1,130,412		1,130,412	(1,130,412)	0			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			1,165,358	1,165,358		1,165,358	703,371	1,868,729			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			14,686	14,686		14,686		14,686			38
39	Ancillary Service Centers		608,672	30,957	639,629		639,629		639,629			39
40	Barber and Beauty Shops			34,688	34,688		34,688		34,688			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			74,355	74,355		74,355		74,355			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		608,672	154,686	763,358		763,358		763,358			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,013,186	1,238,809	5,054,157	11,306,152		11,306,152	448,145	11,754,297			45

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

Facility Name & ID Number WEALSHIRE THE

0040956

Report Period Beginning: 01/01/07

Ending: 12/31/07

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(421)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	308,888	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	(48,068)	21		18
19	Entertainment				19
20	Contributions	(2,004)	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	(87,906)	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	(185,233)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (14,744)		\$	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)	462,889		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 462,889		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 448,145		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.		X	\$ 14,686	38	38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops		X	34,688	40	41
42	Laboratory and Radiology		X	30,957	39	42
43	Prescription Drugs		X	594,003	39	43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 674,334		47

WEALSHIRE THE

ID# 0040956

Report Period Beginning: 01/01/07

Ending: 12/31/07

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	MARKETING SUPPLIES & INCENTIVES	\$ (53,667)	20	1
2	MARKETING SALARIES	(58,548)	21	2
3	PROMOTIONS AND EVENTS	(14,472)	20	3
4	ADVERTISING & BROCHURES	(16,494)	20	4
5				5
6				6
7	CABLE TV/INTERNET ACCESS/WEB SITE MTCE	(8,330)	21	7
8				8
9				9
10	CREDIT CARD FEES	(16,006)	20	10
11				11
12	MARKETING CONSULTANT	(4,355)	19	12
13				13
14	CHAMBER OF COMMERCE DUES	(602)	20	14
15				15
16	LEGAL SEGAL & SEGAL COLLECTIONS COSTS	(12,759)	19	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	(185,233)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WEALSHIRE THE

0040956

Report Period Beginning:

01/01/07

Ending:

12/31/07

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(421)	0	0	0	0	0	0	0	0	0	0	(421)	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	1,860	0	0	0	0	0	0	0	0	0	1,860	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(421)	1,860	0	1,439	8								
	B. Health Care and Programs													
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	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
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	(17,114)	2,746	0	0	0	0	0	0	0	0	0	(14,368)	19
20	Fees, Subscriptions & Promotions	(101,241)	0	0	0	0	0	0	0	0	0	0	(101,241)	20
21	Clerical & General Office Expenses	(204,856)	6,270	0	0	0	0	0	0	0	0	0	(198,586)	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	0	0	0	0	0	0	0	0	0	0	0	0	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	57,530	0	0	0	0	0	0	0	0	0	57,530	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(323,211)	66,546	0	(256,665)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(323,632)	68,406	0	(255,226)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number **WEALSHIRE THE**

0040956

Report Period Beginning:

01/01/07

Ending:

12/31/07

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

	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)	
	D. Ownership													
30	Depreciation	308,888	509,983	0	0	0	0	0	0	0	0	0	818,871	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	883,524	0	0	0	0	0	0	0	0	0	883,524	32
33	Real Estate Taxes	0	131,388	0	0	0	0	0	0	0	0	0	131,388	33
34	Rent-Facility & Grounds	0	(1,130,412)	0	0	0	0	0	0	0	0	0	(1,130,412)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	308,888	394,483	0	703,371	37								
	Ancillary Expense													
	E. Special Cost Centers													
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	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(14,744)	462,889	0	0	0	0	0	0	0	0	0	448,145	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	NORTHBROOK	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	\$ 1,130,412	LINCOLNSHIRE PROPERTIES, LP		\$	\$ (1,130,412) 1
2	V	26 INSURANCE		LINCOLNSHIRE PROPERTIES, LP		57,530	57,530 2
3	V	21 OFFICE EXPENSES		LINCOLNSHIRE PROPERTIES, LP		6,270	6,270 3
4	V	6 MAINTENANCE		LINCOLNSHIRE PROPERTIES, LP		1,860	1,860 4
5	V	33 REAL ESTATE TAXES		LINCOLNSHIRE PROPERTIES, LP		131,388	131,388 5
6	V	30 BOOK DEPRECIATION		LINCOLNSHIRE PROPERTIES, LP		347,222	347,222 6
7	V	30 AMORTIZATION		LINCOLNSHIRE PROPERTIES, LP		162,761	162,761 7
8	V	19 ACCOUNTING FEES		LINCOLNSHIRE PROPERTIES, LP		2,746	2,746 8
9	V	32 INTEREST EXPENSE		LINCOLNSHIRE PROPERTIES, LP		884,753	884,753 9
10	V	32 INTEREST INCOME		LINCOLNSHIRE PROPERTIES, LP		(1,229)	(1,229) 10
11	V						
12	V						
13	V						
14	Total		\$ 1,130,412			\$ 1,593,301	\$ * 462,889 14

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

Facility Name & ID Number WEALSHIRE THE # 0040956 Report Period Beginning: 01/01/07 Ending: 12/31/07

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ARNOLD GOLDBERG	OWNER	ADMINISTRATIVE	99.00	NONE	35	70.00		\$ 300,314	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	\$ 300,314		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 WEALSHIRE THE # 0040956 Report Period Beginning: 01/01/07 Ending: 12/31/07

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number **WEALSHIRE THE**# **0040956**

Report Period Beginning:

01/01/07

Ending:

12/31/07**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					Purpose of Loan						Monthly Payment Required
		Related**						Original	Balance				
		YES	NO										
	A. Directly Facility Related												
	Long-Term												
1	FIRST EQUITY			MORTGAGE LOAN LINCOLNSHIRE PROPERTIES				\$ 4,579,834	\$	09/07	9.2500	\$ 422,088	1
2	6TH MILLENIUM OPPORTUNITY FUND						09/14/06	3,000,000		09/07	15.0000	380,812	2
3	6TH MILLENIUM OPPORTUNITY FUND			MORTGAGE LOAN FEES LI	AMORTIZE		09/14/06	170,641		09/07		159,265	3
4	HUD CAMBRIDGE CAPITAL			MORTGAGE LOAN LINCOL		\$62,944.00	10/18/07	10,746,400	10,739,248	09/18/42	6.2300	81,852	4
5	HUD CAMBRIDGE CAPITAL			MORTGAGE LOAN FEES LI	AMORTIZE		10/18/07	489,466	485,970			3,496	5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related					\$62,944.00		\$ 18,986,341	\$ 11,225,218			\$ 1,047,513	9
	B. Non-Facility Related*												
10													10
11	GMAC LOAN			Truck		\$497.00	10/09/07	29,820	29,820	09/09/12			11
12													12
13													13
14	TOTAL Non-Facility Related					\$497.00		\$ 29,820	\$ 29,820			\$	14
15	TOTALS (line 9+line14)							\$ 19,016,161	\$ 11,255,038			\$ 1,047,513	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 22,388 Line # 26* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

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

B. Real Estate Taxes

		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 2006 report.		\$	120,000	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.)		\$	125,379	2
3.	Under or (over) accrual (line 2 minus line 1).		\$	5,379	3
4.	Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	126,000	4
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	9	6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	131,388	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2002	117,858	8	
		2003	121,564	9	
		2004	128,852	10	
		2005	116,188	11	
		2006	125,379	12	
FOR BHF USE ONLY					
		13	FROM R. E. TAX STATEMENT FOR 2006	\$	13
		14	PLUS APPEAL COST FROM LINE 5	\$	14
		15	LESS REFUND FROM LINE 6	\$	15
		16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2006 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2007 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WEALSHIRE THE COUNTY LAKE

FACILITY IDPH LICENSE NUMBER 0040956

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE 847-883-9000 FAX #: 847-883-9049

A. Summary of Real Estate Tax Cos

Enter the tax index number and real estate tax assessed for 2006 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2006

(A)	(B)	(C)	(D)
<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>SKILLED NURSING FACILITY</u>	<u>\$ 125,379.25</u>	<u>\$ 125,379.25</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		<u>\$ 125,379.25</u>	<u>\$ 125,379.25</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007

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

Facility Name & ID Number WEALSHIRE THE

0040956 Report Period Beginning:

01/01/07 Ending:

12/31/07

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's 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	TOTALS	<u>273,375</u>		<u>\$ 970,925</u>	<u>3</u>

Facility Name & ID Number WEALSHIRE THE

0040956

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR 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	\$ 231,508	20	\$ 576,052	\$ 344,544	\$ 7,128,643	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	4,737	10
11	SIDEWALK		1999	4,660	275	20	233	(42)	1,539	11
12	PATIO		2001	5,200	307	20	260	(47)	999	12
13	SIDEWALK		2001	2,325	137	20	116	(21)	2,182	13
14	CARPETING		2002	12,473	1,194	20	624	(570)	2,367	14
15	SPRINKLER SYSTEM		2002	6,805	429	20	340	(89)	3,047	15
16	REMODELING		2003	20,650	2,028	20	1,033	(996)	3,208	16
17	SIGNAGE		2004	6,000	749	7	857	108	2,969	17
18	REMODELING - WINDOWS PB		2004	9,411	725	15	627	(98)	8,731	18
19	REMODELING KITCHEN - CC		2004	34,889	4,358	7	4,984	626	17,444	19
20	TELEPHONE EQUIPMENT		2006	9,460	1,352	7	1,351	(1)	2,703	20
21	LIGHTING		2006	24,655	3,522	7	3,522	0	7,044	21
22	CARPETS		2006	23,788	3,398	5	4,758	1,360	9,515	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 & ID Number WEALSHIRE THE

0040956

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	LEASEHOLD IMPROVEMENTS	1995	\$ 34,126	\$ 875	20	\$ 1,706	\$ 831	\$ 19,925	37
38	LEASEHOLD IMPROVEMENTS	1996	4,059	104	20	203	99	2,224	38
39	LEASEHOLD IMPROVEMENTS	1998	3,993		20	399	399	3,724	39
40	ALARM SYSTEM	1999	9,183	235	20	459	224	3,564	40
41	SECURITY SYSTEM	1999	4,427	114	20	221	107	1,697	41
42	CABLING/WINDOWS/CABINETS/LUMBER/FIRE SAFETY/ETC	2000	23,775	610	20	1,189	579	8,407	42
43	SIGN	2000	1,611	41	20	81	40	560	43
44	BOILER WORK	2000	871		20	44	44	308	44
45	BEARING & ASSEMBLING	2001	1,136		20	57	57	380	45
46	PUMP W/MOTOR	2001	704		20	35	35	219	46
47	COMPRESSOR	2001	1,797		20	90	90	593	47
48	BOILER WORK	2001	1,722		20	86	86	595	48
49	BOILER WORK	2001	1,008		20	50	50	346	49
50	ROOF REPAIR	2001	500	13	20	25	12	147	50
51	PHONE SYSTEM	2001	1,713	44	20	86	42	551	51
52	BLACKTOP & PATCH	2001	4,799		20	240	240	1,680	52
53	CARPETING	2002	1,158	165	20	58	(107)	180	53
54	EXTERIOR DOORS	2002	9,700	485	20	485		1,991	54
55	BOILER REPAIRS	2002	8,124		20	406	406	2,436	55
56	SPRINKLER SYSTEM	2002	950		20	48	48	288	56
57	BLACKTOP REPAIR	2002	2,799		20	140	140	840	57
58	BOILER REPAIRS	2002	1,077		20	54	54	324	58
59	PUMP & BOILER REPAIRS	2002	3,376		20	169	169	1,014	59
60	FIRE SAFETY UPGRADES	2003	9,901		20	495	495	2,228	60
61	SEWAGE EJECTORS/DISPOSER/PUMP	2003	12,848	329	20	642	313	2,560	61
62	BORIS BARBARIC-PAINTING	2003	5,950	672	5	1,190	518	4,683	62
63	TELEPHONE LINES	2003	4,229		20	211	211	950	63
64	IRRIGATION SYSTEM BOOSTER PUMP/HEADS	2004	2,109	54	39	54		113	64
65	UPGRADE BOILER CONTROLS	2004	5,530	142	39	142		308	65
66	SIGNAGE	2005	2,788	488	20	139	(349)	(117)	66
67	HANDICAP RAMP	2005	1,700	326	20	85	(241)	(124)	67
68	LANDSCAPE LIGHTING	2005	7,022	1,348	20	351	(997)	(587)	68
69	CHILLER REPLACEMENT EXCESS	2005	5,000	874	15	333	(541)	(83)	69
70	TOTAL (lines 4 thru 69)		\$ 11,894,035	\$ 257,747		\$ 606,381	\$ 348,634	\$ 7,257,053	70

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

Facility Name & ID Number WEALSHIRE THE

0040956

Report Period Beginning:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12A, Carried Forward	\$ 11,894,035	\$ 257,747		\$ 606,381	\$ 348,634	\$ 7,257,053		1
2	NEW HVAC COIL	2006 7,128		10	713	713	1,069		2
3	NEW HVAC COIL	2006 6,414		10	641	641	855		3
4	SIGNAGE	2006 2,274		10	227	227	171		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)	\$ 11,909,851	\$ 257,747		\$ 607,962	\$ 350,215	\$ 7,259,148		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	\$ 1,641,915	\$ 20,879	\$ 28,822	\$ 7,943	3-20 yr	\$ 1,721,685	71
72	Current Year Purchases	8,396	8,396	644	(7,752)	5,7 yr	644	72
73	Fully Depreciated Assets	303,261					303,261	73
74	LINCOLNSHIRE PROPERTIES	405,818	31,573	54,376	22,803	3-20 yr		74
75	TOTALS	\$ 2,359,390	\$ 60,848	\$ 83,842	\$ 22,994		\$ 2,025,590	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78		96 DODGE RAM		14,500					14,500	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)	\$ 15,254,666	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 318,595	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 691,804	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 373,209	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 9,299,238	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	17,209	87
88	LANDSCAPING	43,000	2,537	31,687	88
89	BUILDING 1997 SECT 754	4,185,474	55,734	1,000,680	89
90	Auto 2005	28,983	5,059	16,181	90
91	TOTALS	\$ 4,315,618	\$ 64,821	\$ 1,065,757	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? YES NO
If NO, see instructions.

		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	<u>1996/1997</u>	<u>144</u>	<u>1997</u>	<u>1,130,412</u>			4
5								5
6								6
7	TOTAL		144		\$ 1,130,412			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>/2008</u>	\$ _____
13.	<u>/2009</u>	\$ _____
14.	<u>/2010</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: NOT SPECIFIED
(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.

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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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	TOTALS	\$	\$	\$	\$
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)	
TOTAL TRAINED	

- (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	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8			
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)				
			Units of Service			Units	Cost							
1	Licensed Occupational Therapist	10-3	hrs	\$		29,336	\$	448,996	\$	29,336	\$	448,996	1	
2	Licensed Speech and Language Development Therapist	10-1	240 hrs		20,873					240		20,873	2	
3	Licensed Recreational Therapist		hrs										3	
4	Licensed Physical Therapist	10-3	hrs			60,524		889,158		60,524		889,158	4	
5	Physician Care		visits										5	
6	Dental Care		visits										6	
7	Work Related Program		hrs										7	
8	Habilitation		hrs										8	
9	Pharmacy	39-3	# of prescripts						594,003			594,003	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs										10	
11	Academic Education		hrs										11	
12	Exceptional Care Program												12	
13	Other (specify): Swallow Evals							13,104	5,158			18,262	13	
14	TOTAL			\$	20,873	89,860	\$	1,351,258	\$	599,161	90,100	\$	1,971,292	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

Page 17

Facility Name & ID Number WEALSHIRE THE

0040956

Report Period Beginning: 01/01/07

Ending:

12/31/07

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/07

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 289,945	\$ 294,382	1
2	Cash-Patient Deposits	720	720	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,367,821	1,367,821	3
4	Supply Inventory (priced at cost)	38,905	38,905	4
5	Short-Term Investments			5
6	Prepaid Insurance	28,045	113,121	6
7	Other Prepaid Expenses	1,002	1,002	7
8	Accounts Receivable (owners or related parties)	2,989,218	2,668,066	8
9	Other(specify): <u>IRS pend/Escrows</u>	114,000	190,521	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,829,656	\$ 4,674,538	10
	B. Long-Term Assets			
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	575,328	1,100,652	16
17	Accumulated Depreciation (book methods)	(553,690)	(8,900,663)	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 (spec <u>Equip/Repair Reserves</u>)		1,355,682	22
23	Other(specify): <u>Unamort Loan Fees</u>		488,970	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 145,356	\$ 14,543,186	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,975,012	\$ 19,217,724	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,199,935	\$ 1,199,935	26
27	Officer's Accounts Payable	498,350	498,350	27
28	Accounts Payable-Patient Deposits	720	720	28
29	Short-Term Notes Payable		87,600	29
30	Accrued Salaries Payable	211,578	211,578	30
31	Accrued Taxes Payable (excluding real estate taxes)	246,128	246,128	31
32	Accrued Real Estate Taxes(Sch.IX-B)		126,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Management Fees</u>	539,005	539,005	36
37	<u>Due to Affiliates</u>	1,395,430	284,702	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,091,146	\$ 3,194,018	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		29,820	39
40	Mortgage Payable		10,651,648	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Trade Patable</u>	307,353	307,353	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 307,353	\$ 10,988,821	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,398,499	\$ 14,182,839	46
47	TOTAL EQUITY(page 18, line 24)	\$ 576,514	\$ 5,034,885	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,975,013	\$ 19,217,724	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (271,748)	1
2	Restatements (describe):		2
3	Prior year Revenue and Depreciation adjustmetns	(72,599)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (344,347)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	920,861	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)	\$ 920,861	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)	\$ 576,514	24 *

* This must agree with page 17, line 47.

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 10,458,704	1
2	Discounts and Allowances for all Levels	(1,154,304)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,304,400	3
B. Ancillary Revenue			
4	Day Care	80	4
5	Other Care for Outpatients		5
6	Therapy	2,875,271	6
7	Oxygen	3,863	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,879,214	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	38,537	13
14	Non-Patient Meals	421	14
15	Telephone, Television and Radio	169	15
16	Rental of Facility Space	450	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)	\$ 39,577	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,902	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,902	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28		920	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 920	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,227,013	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,519,100	31
32	Health Care	5,539,152	32
33	General Administration	2,319,184	33
B. Capital Expense			
34	Ownership	1,165,358	34
C. Ancillary Expense			
35	Special Cost Centers	689,003	35
36	Provider Participation Fee	74,355	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,306,152	40
41	Income before Income Taxes (line 30 minus line 40)**	920,861	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 920,861	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. Late Fees only not investment inc

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

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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	1,007	1,142	\$ 53,613	\$ 46.95	1
2	Assistant Director of Nursing					2
3	Registered Nurses	29,321	29,606	863,057	29.15	3
4	Licensed Practical Nurses	25,641	28,795	743,286	25.81	4
5	CNAs & Orderlies	131,649	141,075	1,617,883	11.47	5
6	CNA Trainees					6
7	Licensed Therapist	240	417	20,874	50.06	7
8	Rehab/Therapy Aides	1,304	1,489	24,264	16.30	8
9	Activity Director	1,872	1,964	44,721	22.77	9
10	Activity Assistants	11,638	12,503	148,640	11.89	10
11	Social Service Workers	734	816	15,133	18.55	11
12	Dietician	764	766	17,200	22.45	12
13	Food Service Supervisor	1,434	1,485	42,879	28.87	13
14	Head Cook	4,425	4,854	72,619	14.96	14
15	Cook Helpers/Assistants	11,281	11,987	97,924	8.17	15
16	Dishwashers					16
17	Maintenance Workers	2,694	3,003	70,283	23.40	17
18	Housekeepers	34,877	37,688	365,252	9.69	18
19	Laundry	5,081	5,669	49,057	8.65	19
20	Administrator	644	656	47,277	72.07	20
21	Assistant Administrator	1,442	1,550	45,101	29.10	21
22	Other Administrative	6,981	7,695	193,484	25.14	22
23	Office Manager					23
24	Clerical	10,909	11,368	147,880	13.01	24
25	Vocational Instruction	1,234	1,447	37,302	25.78	25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,299	2,477	78,688	31.77	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,588	2,849	41,890	14.70	31
32	Other Health Care Nrs Supervisor	3,399	3,677	116,331	31.64	32
33	Other(specify) Marketing	1,755	1,873	58,548	31.26	33
34	TOTAL (lines 1 - 33)	295,213	316,851	\$ 5,013,186 *	\$ 15.82	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	\$ 448	19-3	35
36	Medical Director	53,375	9-3	36
37	Medical Records Consultant	2,895	19-3	37
38	Nurse Consultant	1,095	10-3	38
39	Pharmacist Consultant	1,070	10-3	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) Unemployment	1,691	21-3	46
47	Marketing	855	19-3	47
48				48
49	TOTAL (lines 35 - 48)	\$ 61,429		49

C. CONTRACT NURSES

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

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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? 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? _____
- (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? 5 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 50,020 Line 10-2
- (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. _____
- (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. \$ 74,355
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. \$ 12,154 Has any meal income been offset against related costs? YES Indicate the amount. \$ 421
- (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? 0
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? NO
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? YES
Attach invoices and a summary of services for all architect and appraisal fees.

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V- COLUMN 5 RECLASSIFICATIONS		Amount	Sch. V Line Reference
1			
2	PHARMACY CONSULTANT	969	10
3	PHARMACY CONSULTANT	(969)	19
4			
5	INSERVICE TRAINER	(37,302)	10a
6	INSERVICE TRAINER	37,302	23
7			
8	SEMINAR EXPENSE	(1,125)	20
9	SEMINAR EXPENSE	1,125	24
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
21			
22			
23			
24			
25			
26			
27			
28			
29			
30			
31			
32	Total	0	