



Facility Name & ID Number THE WEALSHIRE

# 0040956 Report Period Beginning: 01/1/2008 Ending: 12/31/2008

**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	120	Skilled (SNF)	120	43,920	1
2		Skilled Pediatric (SNF/PED)			2
3	22	Intermediate (ICF)	22	8,052	3
4		Intermediate/DD			4
5	2	Sheltered Care (SC)	2	732	5
6		ICF/DD 16 or Less			6
7	144	TOTALS	144	52,704	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
		2 Medicaid Recipient		4 Other	Total	
		Private Pay				
8	SNF	366	11,013	16,581	27,960	8
9	SNF/PED					9
10	ICF	4,221	10,956		15,177	10
11	ICF/DD					11
12	SC		732		732	12
13	DD 16 OR LESS					13
14	TOTALS	4,587	22,701	16,581	43,869	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.24%

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)  
\_\_\_\_\_

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 74 and days of care provided \_\_\_\_\_

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

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

Facility Name &amp; ID Number THE WEALSHIRE # 0040956 Report Period Beginning: 01/1/2008 Ending: 12/31/2008

## 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
	<b>A. General Services</b>										
1	Dietary	280,568	36,934	9,773	327,275		327,275		327,275		1
2	Food Purchase		340,879		340,879		340,879	(149)	340,730		2
3	Housekeeping	499,135	50,358		549,493		549,493		549,493		3
4	Laundry	58,041	43,668		101,709		101,709		101,709		4
5	Heat and Other Utilities			225,192	225,192		225,192		225,192		5
6	Maintenance	99,466	13,423	187,840	300,729		300,729	12,533	313,262		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	937,210	485,262	422,805	1,845,277		1,845,277	12,384	1,857,661		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			67,400	67,400		67,400		67,400		9
10	Nursing and Medical Records	4,375,128	425,405	1,093	4,801,626		4,801,626		4,801,626		10
10a	Therapy	28,383		1,436,388	1,464,771	(58,212)	1,406,559		1,406,559		10a
11	Activities	191,983	38,781		230,764		230,764		230,764		11
12	Social Services	40,173			40,173		40,173		40,173		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	4,635,667	464,186	1,504,881	6,604,734	(58,212)	6,546,522		6,546,522		16
	<b>C. General Administration</b>										
17	Administrative			708,079	708,079		708,079		708,079		17
18	Directors Fees										18
19	Professional Services			84,234	84,234		84,234	(7,375)	76,859		19
20	Dues, Fees, Subscriptions & Promotions			101,241	101,241		101,241	(86,939)	14,302		20
21	Clerical & General Office Expenses	474,485	43,185	289,704	807,374		807,374	(185,651)	621,723		21
22	Employee Benefits & Payroll Taxes			1,086,339	1,086,339		1,086,339		1,086,339		22
23	Inservice Training & Education			2,303	2,303	58,212	60,515		60,515		23
24	Travel and Seminar			1,384	1,384		1,384		1,384		24
25	Other Admin. Staff Transportation			24,322	24,322		24,322		24,322		25
26	Insurance-Prop.Liab.Malpractice			64,577	64,577		64,577	131,889	196,466		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	474,485	43,185	2,362,183	2,879,853	58,212	2,938,065	(148,076)	2,789,989		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	6,047,362	992,633	4,289,869	11,329,864		11,329,864	(135,692)	11,194,172		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 **THE WEALSHIRE**

#0040956

Report Period Beginning: 01/1/2008 Ending: 12/31/2008

12/31/2008

## 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	
	<b>D. Ownership</b>											
30	Depreciation			2,793	2,793		2,793	473,086	475,879			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							664,533	664,533			32
33	Real Estate Taxes							132,465	132,465			33
34	Rent-Facility & Grounds			1,034,343	1,034,343		1,034,343	(1,034,343)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			1,037,136	1,037,136		1,037,136	235,741	1,272,877			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation			42,364	42,364		42,364		42,364			38
39	Ancillary Service Centers		696,614	101,131	797,745		797,745		797,745			39
40	Barber and Beauty Shops		198	29,539	29,737		29,737		29,737			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			77,997	77,997		77,997		77,997			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		696,812	251,031	947,843		947,843		947,843			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	6,047,362	1,689,445	5,578,036	13,314,843		13,314,843	100,049	13,414,892			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 THE WEALSHIRE

# 0040956

Report Period Beginning: 01/1/2008

Ending: 12/31/2008

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	(149)	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				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	(37,107)	21		18
19	Entertainment				19
20	Contributions	(4,009)	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	(89,774)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal				26
27	Property Replacement Tax				27
28	CNA Training for Non-Employees				28
29	Yellow Page Advertising				29
29	Other-Attach Schedule	(152,583)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (283,622)		\$	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)	383,671		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 383,671		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 100,049		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	\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

**THE WEALSHIRE**

ID# 0040956

Report Period Beginning: 01/1/2008

Ending: 12/31/2008

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	MARKETING SUPPLIES & INCENTIVES	\$ (27,382)	20	1
2	MARKETING SALARIES	(43,772)	21	2
3	PROMOTIONS AND EVENTS	(18,867)	20	3
4	ADVERTISING AND BROCHURES	(7,852)	20	4
5	CABLE TV/INTERNET ACCESS/WEB SITE	(14,497)	21	5
6	CREDIT CARD FEES	(32,310)	20	6
7	CHAMBER OF COMMERCE DUES	(528)	20	7
8	LEGAL SEGAL & SEGAL COLLECTIONS COSTS	(7,375)	19	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				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>	(152,583)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number THE WEALSHIRE

# 0040956

Report Period Beginning:

01/1/2008

Ending:

12/31/2008

## 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	(149)	0	0	0	0	0	0	0	0	0	0	(149)	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	12,533	0	0	0	0	0	0	0	0	0	12,533	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(149)</b>	<b>12,533</b>	<b>0</b>	<b>12,384</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	(7,375)	0	0	0	0	0	0	0	0	0	0	(7,375)	19
20	Fees, Subscriptions & Promotions	(86,939)	0	0	0	0	0	0	0	0	0	0	(86,939)	20
21	Clerical & General Office Expenses	(189,159)	3,508	0	0	0	0	0	0	0	0	0	(185,651)	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	131,889	0	0	0	0	0	0	0	0	0	131,889	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(283,473)</b>	<b>135,397</b>	<b>0</b>	<b>(148,076)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(283,622)</b>	<b>147,930</b>	<b>0</b>	<b>(135,692)</b>	<b>29</b>								



Facility Name & ID Number THE WEALSHIRE

# 0040956

Report Period Beginning: 01/1/2008

Ending: 12/31/2008

**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	\$ 1,034,343	LINCOLNSHIRE PROPERTIES, LP		\$	\$(1,034,343) 1
2	V	26 INSURANCE		LINCOLNSHIRE PROPERTIES, LP		131,889	131,889 2
3	V	21 OFFICE EXPENSES		LINCOLNSHIRE PROPERTIES, LP		3,508	3,508 3
4	V	6 MAINTENANCE		LINCOLNSHIRE PROPERTIES, LP		12,533	12,533 4
5	V	33 REAL ESTATE TAXES		LINCOLNSHIRE PROPERTIES, LP		132,465	132,465 5
6	V	30 BOOK DEPRECIATION		LINCOLNSHIRE PROPERTIES, LP		459,101	459,101 6
7	V	30 AMORTIZATION		LINCOLNSHIRE PROPERTIES, LP		13,985	13,985 7
8	V	32 INTEREST EXPENSE		LINCOLNSHIRE PROPERTIES, LP		666,549	666,549 8
9	V	32 INTEREST INCOME		LINCOLNSHIRE PROPERTIES, LP		(2,016)	(2,016) 9
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 1,034,343			\$ 1,418,014	\$ * 383,671 14

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

Facility Name & ID Number      THE WEALSHIRE      #      0040956      Report Period Beginning:      01/1/2008      Ending:      12/31/2008

## 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	79.20		\$ 405,056	17-3	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 405,056		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: 01/1/2008 Ending: 2/31/2008

**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: 01/1/2008 Ending: 12/31/2008

**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	HUD CAMBRIDGE CAPITAL			MORTGAGE LOAN LINCOLN	\$62,944.00	10/18/07	\$ 10,746,400	\$ 10,650,473	09/18/42	6.2300	\$ 666,549
2	HUD CAMBRIDGE CAPITAL			MORTGAGE LOAN FEES LI	AMORTIZE	10/18/07	489,466	471,985			3,496
3											
4											
5											
<b>Working Capital</b>											
6											
7											
8											
9	<b>TOTAL Facility Related</b>				\$62,944.00		\$ 11,235,866	\$ 11,122,458			\$ 670,045
<b>B. Non-Facility Related*</b>											
10											
11											
12											
13											
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$
15	<b>TOTALS (line 9+line14)</b>						\$ 11,235,866	\$ 11,122,458			\$ 670,045

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 29,913 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**

		<b>Important</b> , 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 2007 report.		\$ 126,000		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.)		\$ 132,465		2
3.	Under or (over) accrual (line 2 minus line 1).		\$ 6,465		3
4.	Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 130,000		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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		5
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 136,465		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2003	121,564	8	
		2004	128,852	9	
		2005	116,188	10	
		2006	125,379	11	
		2007	132,465	12	
<b>FOR BHF USE ONLY</b>					
		13	FROM R. E. TAX STATEMENT FOR 2007 \$		13
		14	PLUS APPEAL COST FROM LINE 5 \$		14
		15	LESS REFUND FROM LINE 6 \$		15
		16	AMOUNT TO USE FOR RATE CALCULATION \$		16

**NOTES:**

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

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2008 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions,

**2007 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME THE WEALSHIRE COUNTY LAKE

FACILITY IDPH LICENSE NUMBER 0040956

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

TELEPHONE (224) 543 7100 FAX #: (847) 883-9028

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

Enter the tax index number and real estate tax assessed for 2007 on the lines provided below. Enter only the portion of t cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>15-15-200-062</u>	<u>SKILLED NURSING FACILITY</u>	<u>\$ 132,465.00</u>	<u>\$ 132,465.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		<b>\$ <u>132,465.00</u></b>	<b>\$ <u>132,465.00</u></b>

**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 direct 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 hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

**C. Tax Bills**

Attach a copy of the original 2007 tax bills which were listed in Section A to this statement. Be sure to use the 20C tax bill which is normally paid during 2008

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

Facility Name &amp; ID Number THE WEALSHIRE

# 0040956 Report Period Beginning:

01/1/2008 Ending: 12/31/2008

**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)

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

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

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

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

Facility Name & ID Number THE WEALSHIRE

# 0040956

Report Period Beginning:

01/1/2008

Ending:

12/31/2008

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Bed*	FOR 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	\$ 198,915	20	\$ 576,052	\$ 377,137	\$ 7,704,695
5	144								
6									
7									
8									
Improvement Type**									
9	LINCOLNSHIRE PROPERTIES:								
10	MUSIC SYSTEM		1999	33,003	846	20	1,650	804	6,387
11	SIDEWALK		1999	4,660	275	20	233	(42)	1,772
12	PATIO		2001	5,200	307	20	260	(47)	1,259
13	SIDEWALK		2001	2,325	137	20	116	(21)	2,298
14	CARPETING		2002	12,473	1,194	20	624	(570)	2,990
15	SPRINKLER SYSTEM		2002	6,805	429	20	340	(89)	3,387
16	REMODELING		2003	20,650	2,028	20	1,033	(996)	4,241
17	SIGNAGE		2004	6,000	749	7	857	108	3,826
18	REMODELING-WINDOWS PB		2004	9,411	725	15	627	(98)	9,358
19	REMODELING KITCHEN - CC		2004	34,889	4,358	7	4,984	626	22,428
20	TELEPHONE EQUIPMENT		2006	9,460	1,352	7	1,351	(1)	4,054
21	LIGHTING		2006	24,655	3,522	7	3,522	0	10,566
22	CARPETS		2006	23,788	3,398	5	4,758	1,360	14,273
23	ROOF REPAIRS		2008	21,880	1094	15	1,459	365	1,459
24	BOILER		2008	122,706	1302	27.5	4,462	3,160	4,462
25	PAVING		2008	43,663	2183	15	2,911	728	2,911
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
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:

01/1/2008

Ending:

12/31/2008

## 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	\$ 21,631	37
38	LEASEHOLD IMPROVEMENTS	1996	4,059	104	20	203	99	2,427	38
39	LEASEHOLD IMPROVEMENTS	1998	3,993		20	200	200	4,123	39
40	ALARM SYSTEM	1999	9,183	235	20	459	224	4,023	40
41	SECURITY SYSTEM	1999	4,427	114	20	221	107	1,918	41
42	CABLING/WINDOWS/CABINETS/LUMBER/FIRE SAFETY/ETC	2000	23,775	610	20	1,189	579	9,596	42
43	SIGN	2000	1,611	41	20	81	40	641	43
44	BOILER WORK	2000	871		20	44	44	352	44
45	BEARING & ASSEMBLING	2001	1,136		20	57	57	437	45
46	PUMP W/ MOTOR	2001	704		20	35	35	254	46
47	COMPRESSOR	2001	1,797		20	90	90	683	47
48	BOILER WORK	2001	1,722		20	86	86	681	48
49	BOILER WORK	2001	1,008		20	50	50	396	49
50	ROOF REPAIR	2001	500	13	20	25	12	172	50
51	PHONE SYSTEM	2001	1,713	44	20	86	42	637	51
52	BLACKTOP & PATCH	2001	4,799		20	240	240	1,920	52
53	CARPETING	2002	1,158	165	20	58	(107)	238	53
54	EXTERIOR DOORS	2002	9,700	485	20	485		2,476	54
55	BOILER REPAIRS	2002	8,124		20	406	406	2,842	55
56	SPRINKLER SYSTEM	2002	950		20	48	48	336	56
57	BALCKTOP REPAIR	2002	2,799		20	140	140	980	57
58	BOILER REPAIRS	2002	1,077		20	54	54	378	58
59	PUMP & BOILER REPAIRS	2002	3,376		20	169	169	1,183	59
60	FIRE SAFETY UPGRADES	2003	9,901		20	495	495	2,723	60
61	SEWAGE EJECTORS/DISPOSER/PUMP	2003	12,848	329	20	642	313	3,202	61
62	BORIS BARBARIC-PAINTING	2003	5,950	420	5	1,190	770	5,873	62
63	TELEPHONE LINES	2003	4,229	276	20	211	(65)	1,161	63
64	IRRIGATION SYSTEM BOOSTER PUMP/HEADS	2004	2,109	54	39	54	0	167	64
65	UPGRADE BOILER CONTROLS	2004	5,530	142	39	142	(0)	450	65
66	SIGNAGE	2005	2,788	348	20	139	(209)	22	66
67	HANDICAP RAMP	2005	1,700	196	20	85	(111)	(39)	67
68	LANDSCAPE LIGHTING	2005	7,022	809	20	351	(458)	(236)	68
69	CHILLER REPLACEMENT EXCESS	2005	5,000	624	15	333	(291)	250	69
70	TOTAL (lines 4 thru 69)		\$ 12,082,284	\$ 228,698		\$ 615,013	\$ 386,315	\$ 7,872,265	70

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

Facility Name & ID Number THE WEALSHIRE

# 0040956

Report Period Beginning:

01/1/2008 Ending: 12/31/2008

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	Totals from Page 12A, Carried Forward	\$ 12,082,284	\$ 228,698		\$ 615,013	\$ 386,315	\$ 7,872,265		37
38	NEW HVAC COIL	2006 7,128		10	713	713	1,782		38
39	NEW HVAC COIL	2006 6,414		10	641	641	1,497		39
40	SIGNAGE	2006 2,274		10	227	227	398		40
41									41
42	CAPITALIZED TELEPHONE SYSTEM	2008 173,195	173195	20	227	(172,968)	227		42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
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60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)	\$ 12,271,295	\$ 401,893		\$ 616,822	\$ 214,929	\$ 7,876,169		70

\*\*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	\$ 1,650,311	\$ 20,879	\$ 28,822	\$ 7,943	3-20 yr	\$ 1,750,507	71
72	Current Year Purchases	31,260	31,260	6,252	(25,008)	5	6,896	72
73	Fully Depreciated Assets	303,261					303,261	73
74	LINCOLNSHIRE PROPERTIES	1,028,263	167,604	91,430	(76,174)	3-20 yr		74
75	TOTALS	\$ 3,013,095	\$ 219,743	\$ 126,504	\$ (93,239)		\$ 2,060,664	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		2007 CHEVY	2007	29,820	9,542	5,964	(3,578)	5	14,500	78
79										79
80	TOTALS			\$ 29,820	\$ 9,542	\$ 5,964	\$ (3,578)		\$ 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)	\$ 16,096,124	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 457,983	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 747,481	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 289,498	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 9,947,429	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	18,700	87
88	LANDSCAPING	68,503	3,390	35,077	88
89	BUILDING 1997 SECT 754	4,185,474	55,734	1,056,414	89
90					90
91	TOTALS	\$ 4,312,138	\$ 60,615	\$ 1,110,191	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: \_\_\_\_\_

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

If NO, see instructions.  YES  NO

	1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:			\$			3
4	Additions	<u>1996/1997</u>	<u>144</u>	<u>1997</u>	<u>1,034,343</u>		4
5							5
6							6
7	<b>TOTAL</b>		<b>144</b>		<b>\$ 1,034,343</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>/2009</u>	\$ _____
13.	<u>/2010</u>	\$ _____
14.	<u>/2011</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)

\* 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.

**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

**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	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost						
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist	10-3	hrs	\$	35,547	\$	505,833	\$	35,547	\$	505,833	1		
2	Licensed Speech and Language Development Therapist	10-1, 10-3	631 hrs	28,383	1,362	18,945			1,993		47,328	2		
3	Licensed Recreational Therapist		hrs									3		
4	Licensed Physical Therapist	10-3	hrs		63,121	911,610			63,121		911,610	4		
5	Physician Care		visits									5		
6	Dental Care		visits									6		
7	Work Related Program		hrs									7		
8	Habilitation		hrs									8		
9	Pharmacy		# of prescripts									9		
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10		
11	Academic Education		hrs									11		
12	Other (specify):											12		
13	Other (specify):											13		
14	<b>TOTAL</b>			\$ 28,383	100,030	\$ 1,436,388	\$	100,661	\$	1,464,771	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 &amp; ID Number THE WEALSHIRE

# 0040956

Report Period Beginning: 01/1/2008

Ending:

12/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 45,090	\$ 55,088	1
2	Cash-Patient Deposits	3,617	3,617	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,826,232	1,826,232	3
4	Supply Inventory (priced at )	15,200	15,200	4
5	Short-Term Investments			5
6	Prepaid Insurance	49,077	113,097	6
7	Other Prepaid Expenses	1,032	1,032	7
8	Accounts Receivable (owners or related parties)	2,940,097	4,337,222	8
9	Other(specify):	3,735	79,939	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 4,884,080	\$ 6,431,427	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		3,190,355	13
14	Buildings, at Historical Cost		17,001,379	14
15	Leasehold Improvements, at Historical Cost	296,913	693,757	15
16	Equipment, at Historical Cost	623,345	1,742,127	16
17	Accumulated Depreciation (book methods)	(556,483)	(9,346,107)	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: <u>Repair/Emp. Reserves</u> )		526,253	22
23	Other(specify): <u>Unamort Loan Fees</u>		471,985	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 363,775	\$ 14,279,749	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 5,247,855	\$ 20,711,176	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 1,259,301	\$ 1,259,301	26
27	Officer's Accounts Payable	356,103	356,103	27
28	Accounts Payable-Patient Deposits	5,315	5,315	28
29	Short-Term Notes Payable		94,466	29
30	Accrued Salaries Payable	350,756	350,756	30
31	Accrued Taxes Payable (excluding real estate taxes)	123,409	123,409	31
32	Accrued Real Estate Taxes(Sch.IX-B)		130,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Accrued Management Fees</u>	539,005	539,005	36
37	<u>Due to Affiliates</u>	1,394,126	1,664,633	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 4,028,015	\$ 4,522,988	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		10,556,007	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>Trade Payable</u>	215,147	215,147	43
44	<u>Long Term Cap Lease</u>	134,146	134,146	44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 349,293	\$ 10,905,300	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 4,377,308	\$ 15,428,288	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 870,548	\$ 5,282,888	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 5,247,856	\$ 20,711,176	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ 576,514	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ 576,514	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	294,034	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) <b>Partner's Equity</b>		15
16	Other (describe)		16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ 294,034	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 870,548	24 *

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

## STATE OF ILLINOIS

Facility Name &amp; ID Number THE WEALSHIRE

# 0040956

Report Period Beginning: 01/1/2008

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**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	\$ 13,071,947	1
2	Discounts and Allowances for all Levels	(287,518)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 12,784,429	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	770,521	6
7	Oxygen	5,524	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 776,045	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	40,227	13
14	Non-Patient Meals	433	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	750	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>	\$ 41,410	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	3,103	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 3,103	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>	3,890	27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 3,890	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 13,608,877	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	2,145,949	31
32	Health Care	7,174,946	32
33	General Administration	2,878,854	33
<b>B. Capital Expense</b>			
34	Ownership	1,037,136	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	77,958	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 13,314,843	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	294,034	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 294,034	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 &amp; ID Number THE WEALSHIRE

# 0040956

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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	1,984	2,240	\$ 100,283	\$ 44.77	1
2	Assistant Director of Nursing					2
3	Registered Nurses	41,212	45,016	1,406,682	31.25	3
4	Licensed Practical Nurses	20,080	21,914	548,856	25.05	4
5	CNAs & Orderlies	155,213	170,897	2,004,985	11.73	5
6	CNA Trainees					6
7	Licensed Therapist	599	599	28,383	47.38	7
8	Rehab/Therapy Aides	674	780	11,466	14.70	8
9	Activity Director	1,904	2,162	47,192	21.83	9
10	Activity Assistants	11,711	12,500	144,791	11.58	10
11	Social Service Workers	1,984	2,168	40,173	18.53	11
12	Dietician					12
13	Food Service Supervisor	1,968	2,258	63,592	28.16	13
14	Head Cook	2,119	2,403	40,765	16.96	14
15	Cook Helpers/Assistants	27,694	29,418	176,211	5.99	15
16	Dishwashers					16
17	Maintenance Workers	6,354	7,020	99,466	14.17	17
18	Housekeepers	45,198	49,753	499,135	10.03	18
19	Laundry	5,480	6,122	38,210	6.24	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	11,765	13,200	270,576	20.50	22
23	Office Manager					23
24	Clerical	9,205	9,641	160,137	16.61	24
25	Vocational Instruction	1,976	2,238	54,954	24.55	25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,609	2,834	81,884	28.89	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,872	4,210	64,979	15.43	31
32	Other Health Care Nurse Supervisor	3,818	4,187	101,038	24.13	32
33	Other(specify) Marketing	1,952	2,288	63,604	27.80	33
34	TOTAL (lines 1 - 33)	359,371	393,848	\$ 6,047,362 *	\$ 15.35	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	\$ 9,773	1-3	35
36	Medical Director	67,400	9-3	36
37	Medical Records Consultant			37
38	Nurse Consultant	1,093	10-3	38
39	Pharmacist Consultant			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	1,208	19-3	46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 79,474		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

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	
Incurring in management Fee	Administrator	0	0	Workers' Compensation Insurance	\$ 265,460	IDPH License Fee	\$ 696	
	Asst. Administrator	0	0	Unemployment Compensation Insurance	110,732	Advertising: Employee Recruitment	7,666	
				FICA Taxes	426,828	Health Care Worker Background Check	3,010	
				Employee Health Insurance	221,671	(Indicate # of checks performed _____)		
				Employee Meals	25,029	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Chamber of Commerce Dues	528	
				Employee Relations ( Awards, Holiday and Awards celebrations Holiday gifts)	47,295	Credit Card Fees	35,936	
						Marketing & Promotion	54,101	
						MISC. OTHER	2,930	
						less Non allowable credi card fees/COC dues	(36,464)	
						Less: Public Relations Expense	(54,101)	
						Non-allowable advertising (		
						Yellow page advertising (		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 1,097,015	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 14,302	
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 Fee for Jennifer Bebinger			\$ 145,313				Out-of-State Travel	\$ 1,384
Management Fee for Shari Floss			57,882					
Balance Management Fee			504,884				In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 708,079				Seminar Expense	
							Entertainment Expense (	
							(agree to Sch. V, line 24, col. 8)	\$ 1,384
C. Professional Services				TOTAL				
Vendor/Payee	Type		Amount			\$		
Personal Planners	Unemployment Consulting		\$ 1,208					
Lerman, Boudart & Assoc.	Accounting Services		7,939					
Frost, Ruttenburg & Rottblatt	Accounting Services		12,180					
Foley & Lardner LP	licensure & Other Corporate ssu		1,733					
Ash, Anos, Freedman & Logal	IRS issues		21,100					
Ashman Law Offices	licensure & Other Corporate ssu		3,350					
Polsinelli Shalton Flanigan	IRS issues		5,149					
Law Offices Segal & Segal	Collections		7,375					
CT Corporation	Collections		335					
Omnicare	Medical records		2,253					
PEL/VIP Medical Staffing	Staffing Services		9,626					
Behles & Behles	Interior Design Fee		11,987					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 84,234					

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name &amp; ID Number THE WEALSHIRE

# 0040956

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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? NO 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. \$ 52,238 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. \$ 77,997  
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. \$ 8,000 Has any meal income been offset against related costs? YES Indicate the amount. \$ 149
- (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? NO  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use?  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?  
g. Does the facility transport residents to and from day training? NO  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ \_\_\_\_\_
- (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.