

Facility Name & ID Number The Wealshire

0040956 Report Period Beginning: 01/1/2009 Ending: 12/31/2009

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	43,800	1
2		Skilled Pediatric (SNF/PED)			2
3	22	Intermediate (ICF)	22	8,030	3
4		Intermediate/DD			4
5	2	Sheltered Care (SC)	2	730	5
6		ICF/DD 16 or Less			6
7	144	TOTALS	144	52,560	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	2,269	10,164	17,922	30,355	8
9	SNF/PED					9
10	ICF	4,140	7,719	4	11,863	10
11	ICF/DD					11
12	SC		296		296	12
13	DD 16 OR LESS					13
14	TOTALS	6,409	18,179	17,926	42,514	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.89%

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 08/14/1995

J. Was the facility purchased or leased after January 1, 1978?
 YES Date 08/14/1995 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 Services (Administar Federal)

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/2009

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

Facility Name & ID Number The Wealshire # 0040956 Report Period Beginning: 01/1/2009 Ending: 12/31/2009

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

	Operating Expenses	Costs 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
	A. General Services										
1	Dietary	290,252	34,250	9,489	333,991		333,991		333,991		1
2	Food Purchase		365,763		365,763		365,763	(1,624)	364,139		2
3	Housekeeping	507,018	46,509		553,527		553,527		553,527		3
4	Laundry	45,127	34,712		79,839		79,839		79,839		4
5	Heat and Other Utilities			299,004	299,004		299,004		299,004		5
6	Maintenance	151,343	39,955	236,068	427,366		427,366		427,366		6
7	Other (specify):* Waste Removal			37,810	37,810		37,810		37,810		7
8	TOTAL General Services	993,740	521,189	582,371	2,097,300		2,097,300	(1,624)	2,095,676		8
	B. Health Care and Programs										
9	Medical Director			58,600	58,600		58,600		58,600		9
10	Nursing and Medical Records	4,399,854	254,389	1,780	4,656,023		4,656,023		4,656,023		10
10a	Therapy	27,698		1,432,262	1,459,960	(56,245)	1,403,715		1,403,715		10a
11	Activities	220,570	17,348		237,918		237,918		237,918		11
12	Social Services	43,329			43,329		43,329		43,329		12
13	CNA Training										13
14	Program Transportation			1,454	1,454		1,454		1,454		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	4,691,451	271,737	1,494,096	6,457,284	(56,245)	6,401,039		6,401,039		16
	C. General Administration										
17	Administrative			826,979	826,979		826,979		826,979		17
18	Directors Fees										18
19	Professional Services			96,983	96,983		96,983	(22,291)	74,692		19
20	Dues, Fees, Subscriptions & Promotions			115,269	115,269		115,269	(84,200)	31,069		20
21	Clerical & General Office Expenses	571,591	32,693	221,805	826,089		826,089	(87,019)	739,070		21
22	Employee Benefits & Payroll Taxes			954,742	954,742		954,742		954,742		22
23	Inservice Training & Education			398	398	56,245	56,643		56,643		23
24	Travel and Seminar			668	668		668		668		24
25	Other Admin. Staff Transportation			19,650	19,650		19,650		19,650		25
26	Insurance-Prop.Liab.Malpractice			106,409	106,409		106,409	85,644	192,053		26
27	Other (specify):*										27
28	TOTAL General Administration	571,591	32,693	2,342,903	2,947,187	56,245	3,003,432	(107,866)	2,895,566		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,256,782	825,619	4,419,370	11,501,771		11,501,771	(109,490)	11,392,281		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:

01/1/2009

Ending:

12/31/2009

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			61,110	61,110		61,110	729,416	790,526			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			13,681	13,681		13,681	661,673	675,354			32
33	Real Estate Taxes							141,951	141,951			33
34	Rent-Facility & Grounds			1,032,756	1,032,756		1,032,756	(1,032,756)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			1,107,547	1,107,547		1,107,547	500,284	1,607,831			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			55,270	55,270		55,270		55,270			38
39	Ancillary Service Centers		928,473	63,008	991,481		991,481		991,481			39
40	Barber and Beauty Shops			28,610	28,610		28,610		28,610			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			75,927	75,927		75,927		75,927			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		928,473	222,815	1,151,288		1,151,288		1,151,288			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,256,782	1,754,092	5,749,732	13,760,606		13,760,606	390,794	14,151,400			45

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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(87)	2		4
5	Telephone, TV & Radio in Resident Rooms	(1,606)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	225,283	30		9
10	Interest and Other Investment Income	1,741	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,537)	2		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	(16,874)	21		18
19	Entertainment				19
20	Contributions	(2,439)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(26,991)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(67,898)	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	(27,859)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 81,733		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	367,202		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 367,202		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 448,935		37

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

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

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

BHF USE ONLY

48		49		50		51		52	
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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Credit Card Fees	\$ (24,617)	20	1
2	Chamber of Commerce Dues	(305)	20	2
3	Collections Costs	(1,800)	19	3
4	Internal Marketing	(17,214)	20	4
5	Marketing Referral Services	(1,810)	20	5
6	Marketing Incentives	(9,334)	20	6
7	Marketing Supplies	(8,927)	20	7
8	Promotion & Events	(15,080)	20	8
9	Advertising and Brochures	(6,913)	20	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	Total	(86,000)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Wealshire# 0040956

Report Period Beginning:

01/1/2009

Ending:

12/31/2009

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,624)	0	0	0	0	0	0	0	0	0	0	(1,624)	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	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,624)	0	0	0	0	0	0	0	0	0	0	(1,624)	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	(28,791)	6,500	0	0	0	0	0	0	0	0	0	(22,291)	19
20	Fees, Subscriptions & Promotions	(84,200)	0	0	0	0	0	0	0	0	0	0	(84,200)	20
21	Clerical & General Office Expenses	(88,817)	1,798	0	0	0	0	0	0	0	0	0	(87,019)	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	85,644	0	0	0	0	0	0	0	0	0	85,644	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(201,808)	93,942	0	(107,866)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(203,432)	93,942	0	(109,490)	29								

STATE OF ILLINOIS

Facility Name & ID Number The Wealshire# 0040956

Report Period Beginning:

01/1/2009 Ending:

Summary B

12/31/2009

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	225,283	504,133	0	0	0	0	0	0	0	0	0	729,416	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	1,741	659,932	0	0	0	0	0	0	0	0	0	661,673	32
33	Real Estate Taxes	0	141,951	0	0	0	0	0	0	0	0	0	141,951	33
34	Rent-Facility & Grounds	0	(1,032,756)	0	0	0	0	0	0	0	0	0	(1,032,756)	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	227,024	273,260	0	500,284	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)	23,592	367,202	0	0	0	0	0	0	0	0	0	390,794	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
<u>Arnold Goldberg</u>	<u>99.0</u>	<u>The Ponds of Wealshire</u>	<u>Lincolnshire</u>	<u>Lincolnshire Propertie</u>	<u>Lincolnshire</u>	<u>Bldg Prtnrshp</u>
<u>The Wealshire Inc.</u>	<u>1.0</u>			<u>Alexander Blake</u>	<u>Northbrook</u>	<u>Mgmt Co.</u>

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	<u>34 Rent</u>	\$ <u>1,032,756</u>	<u>Lincolnshire Properties, LP</u>		\$	<u>(1,032,756)</u>	1
2	V	<u>26 Insurance</u>		<u>Lincolnshire Properties, LP</u>		<u>85,644</u>	<u>85,644</u>	2
3	V	<u>21 Office Expenses</u>		<u>Lincolnshire Properties, LP</u>		<u>1,798</u>	<u>1,798</u>	3
4	V	<u>33 Real Estate Taxes</u>		<u>Lincolnshire Properties, LP</u>		<u>141,951</u>	<u>141,951</u>	4
5	V	<u>30 Book Depreciation</u>		<u>Lincolnshire Properties, LP</u>		<u>490,148</u>	<u>490,148</u>	5
6	V	<u>30 Amortization</u>		<u>Lincolnshire Properties, LP</u>		<u>13,985</u>	<u>13,985</u>	6
7	V	<u>32 Interest Expense</u>		<u>Lincolnshire Properties, LP</u>		<u>660,244</u>	<u>660,244</u>	7
8	V	<u>32 Interest Income</u>		<u>Lincolnshire Properties, LP</u>		<u>(312)</u>	<u>(312)</u>	8
9	V	<u>19 Professional Fees</u>		<u>Lincolnshire Properties, LP</u>		<u>6,500</u>	<u>6,500</u>	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ <u>1,032,756</u>			\$ <u>1,399,958</u>	\$ * <u>367,202</u>	14

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

Facility Name & ID Number

The Wealshire

0040956

Report Period Beginning:

01/1/2009

Ending:

12/31/2009

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		\$ 479,006	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	\$ 479,006		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:

01/1/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number

The Wealshire

0040956

Report Period Beginning:

01/1/2009

Ending:

12/31/2009

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1	HUD Cambridge Capital		Mortgage Loan Lincolnshire Pr	\$62,944.00	10/18/07	\$ 10,746,400	\$ 10,556,007	9/18/42	6.2300	\$ 660,244	1								
2	HUD Cambridge Capital		Mortgage Loan Fees Linc Prop	Amortize	10/18/07	489,466	458,000			13,985	2								
3											3								
4											4								
5											5								
Working Capital																			
6											6								
7											7								
8											8								
9	TOTAL Facility Related			\$62,944.00		\$ 11,235,866	\$ 11,014,007			\$ 674,229	9								
B. Non-Facility Related*																			
10											10								
11											11								
12											12								
13											13								
14	TOTAL Non-Facility Related					\$	\$			\$	14								
15	TOTALS (line 9+line14)					\$ 11,235,866	\$ 11,014,007			\$ 674,229	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 41,644 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

1. Real Estate Tax accrual used on 2008 report.		\$	<u>130,000</u>	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.)		\$	<u>135,951</u>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>5,951</u>	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>136,000</u>	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.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<u>141,951</u>	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2004	<u>128,852</u>	8	
	2005	<u>116,188</u>	9	
	2006	<u>125,379</u>	10	
	2007	<u>132,465</u>	11	
	2008	<u>135,951</u>	12	
				FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2008	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

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.

Facility Name & ID Number The Wealshire

0040956

Report Period Beginning:

01/1/2009 Ending:

12/31/2009

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 62,477 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>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 The Wealshire

0040956

Report Period Beginning:

01/1/2009

Ending:

12/31/2009

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	144			1995	\$ 11,521,031	\$ 130,276	20	\$ 576,052	\$ 445,776	\$ 8,280,747	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LINCOLNSHIRE PROPERTIES:										
10				1999	33,003	846	20	1,650	804	8,037	9
11				1999	4,660	275	20	233	(42)	2,005	11
12				2001	5,200	307	20	260	(47)	1,519	12
13				2001	2,325	137	20	116	(21)	2,325	13
14				2002	12,473	1,194	20	624	(570)	3,614	14
15				2002	6,805	401	20	340	(61)	3,727	15
16				2003	20,650	2,028	20	1,033	(996)	5,274	16
17				2004	6,000	535	7	857	322	4,683	17
18				2004	9,411	586	15	627	41	9,985	18
19				2004	34,889	3,112	7	4,984	1,872	27,412	19
20				2006	9,460	1,352	7	1,351	(1)	5,405	20
21				2006	24,655	3,522	7	3,522	0	14,088	21
22				2006	23,788	3,398	5	4,758	1,360	19,031	22
23				2008	21,880	2,079	15	1,459	(620)	2,918	23
24				2008	122,706	4,462	27.5	4,462	0	8,924	24
25				2008	43,663	4,148	15	2,911	(1,237)	5,822	25
26				2009	58,489	2,924	15	3,899	975	3,899	26
27				2009	71,584	3,579	15	4,772	1,193	4,772	27
28				2009	87,759	4,388	15	5,851	1,463	5,851	28
29				2009	23,709	1,185	15	1,581	396	1,581	29
30				2009	5,510	276	15	367	91	367	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 The Wealshire

0040956

Report Period Beginning:

01/1/2009

Ending:

12/31/2009

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	\$ 23,337	37
38	LEASEHOLD IMPROVEMENTS	1996	4,059	104	20	203	99	2,630	38
39	LEASEHOLD IMPROVEMENTS	1998	3,993		20	200	200	3,993	39
40	ALARM SYSTEM	1999	9,183	235	20	459	224	4,482	40
41	SECURITY SYSTEM	1999	4,427	114	20	221	107	2,139	41
42	CABLING/WINDOWS/CABINETS/LUMBER/FIRE SAFETY/ETC	2000	23,775	610	20	1,189	579	10,785	42
43	SIGN	2000	1,611	41	20	81	40	722	43
44	BOILER WORK	2000	871		20	44	44	396	44
45	BEARING & ASSEMBLING	2001	1,136		20	57	57	494	45
46	PUMP W/ MOTOR	2001	704		20	35	35	289	46
47	COMPRESSOR	2001	1,797		20	90	90	773	47
48	BOILER WORK	2001	1,722		20	86	86	767	48
49	BOILER WORK	2001	1,008		20	50	50	446	49
50	ROOF REPAIR	2001	500	13	20	25	12	197	50
51	PHONE SYSTEM	2001	1,713	44	20	86	42	723	51
52	BLACKTOP & PATCH	2001	4,799		20	240	240	2,160	52
53	CARPETING	2002	1,158	83	20	58	(25)	296	53
54	EXTERIOR DOORS	2002	9,700	485	20	485		2,961	54
55	BOILER REPAIRS	2002	8,124		20	406	406	3,248	55
56	SPRINKLER SYSTEM	2002	950		20	48	48	432	56
57	BLACKTOP REPAIR	2002	2,799		20	140	140	476	57
58	BOILER REPAIRS	2002	1,077		20	54	54	1,120	58
59	PUMP & BOILER REPAIRS	2002	3,376		20	169	169	1,352	59
60	FIRE SAFETY UPGRADES	2003	9,901		20	495	495	4,570	60
61	SEWAGE EJECTORS/DISPOSER/PUMP	2003	12,848	329	20	642	313	3,515	61
62	BORIS BARBARIC-PAINTING	2003	5,950		5	1,190	1,190	5,950	62
63	TELEPHONE LINES	2003	4,229	276	20	211	(65)	1,372	63
64	IRRIGATION SYSTEM BOOSTER PUMP/HEADS	2004	2,109	54	39	54	0	221	64
65	UPGRADE BOILER CONTROLS	2004	5,530	142	39	142	(0)	592	65
66	SIGNAGE	2005	2,788	249	20	139	(110)	161	66
67	HANDICAP RAMP	2005	1,700	196	20	85	(111)	46	67
68	LANDSCAPE LIGHTING	2005	7,022	809	20	351	(458)	115	68
69	CHILLER REPLACEMENT EXCESS	2005	5,000	447	15	333	(114)	583	69
70	TOTAL (lines 4 thru 69)		\$ 12,329,335	\$ 176,116		\$ 631,483	\$ 455,367	\$ 8,503,329	70

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 12,329,335	\$ 176,116		\$ 631,483	\$ 455,367	\$ 8,503,329	1
2	NEW HVAC COIL	2006	7,128		10	713	713	2,495	2
3	NEW HVAC COIL	2006	6,414		10	641	641	2,779	3
4	SIGNAGE	2006	2,274		10	227	227	625	4
5	CAPITALIZED TELEPHONE SYSTEM	2008	173,195		20	8,660	8,660	10,103	5
6	DOORS	2009	10,284	321	15	343	22	343	6
7	FOUNTAIN	2009	38,500	241	15	428	187	428	7
8	CONCRETE PAD	2009	17,394	93	39	74	(19)	74	8
9	BACKSPLASH	2009	15,305	96	15	85	(11)	85	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)		\$ 12,599,829	\$ 176,867		\$ 642,655	\$ 465,788	\$ 8,520,261	34

**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:

01/1/2009

Ending:

12/31/2009

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	\$ 1,681,571	\$ 235,560	\$ 35,074	\$ (200,486)	3-20 yr	\$ 1,792,477	71
72	Current Year Purchases	20,106	2,436	2,487	51	5-7 yr	2,487	72
73	Fully Depreciated Assets	303,261						73
74	<u>LINCOLNSHIRE PROPERTIES</u>	<u>1,197,272</u>	<u>134,226</u>	<u>93,917</u>	<u>(40,309)</u>	<u>3-20 yr</u>		74
75	TOTALS	\$ 3,202,210	\$ 372,222	\$ 131,478	\$ (240,744)		\$ 1,794,964	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	<u>Maintenance</u>	<u>2007 CHEVY</u>	<u>2007</u>	\$ 29,820	\$ 5,725	\$ 5,964	\$ 239	5	\$ 17,892	76
77										77
78										78
79										79
80	TOTALS			\$ 29,820	\$ 5,725	\$ 5,964	\$ 239		\$ 17,892	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 16,802,784	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 554,814	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 780,097	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 225,283	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 10,333,117	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	<u>LINCOLNSHIRE PROPERTIES</u>	\$	\$	\$	86
87	<u>COMPLETION OF BLDG 1996</u>	58,161	1,491	20,191	87
88	<u>LANDSCAPING</u>	68,503	4,238	39,315	88
89	<u>BUILDING 1997 SECT 754</u>	4,185,474	55,734	1,103,876	89
90					90
91	TOTALS	\$ 4,312,138	\$ 61,463	\$ 1,163,382	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>1,032,756</u>			4
5								5
6								6
7	TOTAL		<u>144</u>		\$ <u>1,032,756</u>			7

8. List separately any amortization of lease expense included on page 4, line 34. _____

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____
Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2010</u>	\$ _____
13.	<u>/2011</u>	\$ _____
14.	<u>/2012</u>	\$ _____

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

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

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10-3	hrs	\$	34,454	\$ 526,836	\$	34,454	\$ 526,836	1
2	Licensed Speech and Language Development Therapist	10-1, 10-3	554 hrs	27,698				554	27,698	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10-3	hrs		59,495	905,426		59,495	905,426	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	TOTAL			\$ 27,698	93,949	\$ 1,432,262	\$	94,503	\$ 1,459,960	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.

Facility Name & ID Number The Wealshire# 0040956Report Period Beginning: 01/1/2009Ending: 12/31/2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2009

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 430,425	\$ 444,431	1
2	Cash-Patient Deposits	472	472	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>27,056</u>)	1,767,928	1,767,928	3
4	Supply Inventory (priced at)	17,660	17,660	4
5	Short-Term Investments			5
6	Prepaid Insurance	105,939	173,991	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	1,895,222	3,274,231	8
9	Other(specify):	(18,596)	55,613	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,199,050	\$ 5,734,326	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		3,302,521	13
14	Buildings, at Historical Cost		17,001,379	14
15	Leasehold Improvements, at Historical Cost	211,873	737,602	15
16	Equipment, at Historical Cost	809,974	2,103,766	16
17	Accumulated Depreciation (book methods)	(853,619)	(10,139,355)	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 (spe Reserves)		142,412	22
23	Other(specify): <u>Unamort Loan Fees</u>		458,000	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 168,228	\$ 13,606,325	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,367,278	\$ 19,340,651	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,505,194	\$ 1,509,195	26
27	Officer's Accounts Payable	126,633	126,633	27
28	Accounts Payable-Patient Deposits	3,905	3,905	28
29	Short-Term Notes Payable		94,466	29
30	Accrued Salaries Payable	306,040	306,040	30
31	Accrued Taxes Payable (excluding real estate taxes)	32,929	32,929	31
32	Accrued Real Estate Taxes(Sch.IX-B)		136,000	32
33	Accrued Interest Payable		22,574	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>	1,376,009	1,619,014	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,889,715	\$ 4,389,761	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		10,461,540	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Trade Payable</u>	122,941	122,941	43
44	<u>Long Term Capital Lease</u>	103,447	103,447	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 226,388	\$ 10,687,928	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,116,103	\$ 15,077,689	46
47	TOTAL EQUITY(page 18, line 24)	\$ 251,175	\$ 4,262,962	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,367,278	\$ 19,340,651	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 870,548	1
2	Restatements (describe):		2
3	Book Depreciation Adjustments	(238,816)	3
4	Reducion of Accrued Vacation & Related Payroll Taxes	108,661	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 740,393	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,180	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	(491,398)	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)	\$ (489,218)	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)	\$ 251,175	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number The Wealshire

0040956

Report Period Beginning: 01/1/2009

Ending: 12/31/2009

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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 13,285,023	1
2	Discounts and Allowances for all Levels	(648,188)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,636,835	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,079,817	6
7	Oxygen	2,581	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,082,398	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	36,922	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 36,922	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	6,631	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 6,631	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,762,786	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,097,300	31
32	Health Care	6,457,284	32
33	General Administration	2,947,187	33
B. Capital Expense			
34	Ownership	1,107,547	34
C. Ancillary Expense			
35	Special Cost Centers	1,075,361	35
36	Provider Participation Fee	75,927	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,760,606	40
41	Income before Income Taxes (line 30 minus line 40)**	2,180	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,180	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

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

Facility Name & ID Number The Wealshire

0040956

Report Period Beginning:

01/1/2009

Ending:

12/31/2009

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	1,704	2,004	\$ 100,782	\$ 50.29	1
2	Assistant Director of Nursing					2
3	Registered Nurses	28,938	31,678	923,767	29.16	3
4	Licensed Practical Nurses	34,498	37,884	999,940	26.39	4
5	CNAs & Orderlies	156,138	173,343	2,023,114	11.67	5
6	CNA Trainees					6
7	Licensed Therapist	554	554	27,698	50.00	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,986	2,142	52,576	24.55	9
10	Activity Assistants	11,950	13,334	167,994	12.60	10
11	Social Service Workers	2,000	2,154	43,329	20.12	11
12	Dietician	249	251	3,977	15.84	12
13	Food Service Supervisor	1,262	1,554	48,129	30.97	13
14	Head Cook	1,425	1,675	27,810	16.60	14
15	Cook Helpers/Assistants	10,140	11,278	114,166	10.12	15
16	Dishwashers	11,047	11,620	96,170	8.28	16
17	Maintenance Workers	6,782	7,468	151,343	20.27	17
18	Housekeepers	48,739	53,621	507,018	9.46	18
19	Laundry	4,057	4,717	45,127	9.57	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	12,595	14,258	369,220	25.90	22
23	Office Manager	1,870	2,128	41,448	19.48	23
24	Clerical	7,553	7,879	82,953	10.53	24
25	Vocational Instruction	1,558	1,866	56,245	30.14	25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,899	2,100	74,707	35.57	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,873	4,255	58,062	13.65	31
32	Other Health Care(specify)	5,616	6,399	163,237	25.51	32
33	Other(specify)	2,468	2,632	77,970	29.62	33
34	TOTAL (lines 1 - 33)	358,901	396,794	\$ 6,256,782 *	\$ 15.77	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	\$ 9,489	1-3	35
36	Medical Director	58,600	9-3	36
37	Medical Records Consultant			37
38	Nurse Consultant	1,780	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) <u>Unemployment</u>	1,092	19-3	46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 70,961		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		
<u>Incurring in management Fee</u>	<u>Administrator</u>	<u>0</u>	<u>\$ 0</u>	<u>Workers' Compensation Insurance</u>	<u>\$ 223,532</u>	<u>IDPH License Fee</u>	<u>\$ 1,990</u>		
	<u>Asst. Administrator</u>	<u>0</u>	<u>0</u>	<u>Unemployment Compensation Insurance</u>	<u>58,717</u>	<u>Advertising: Employee Recruitment</u>	<u>5,594</u>		
				<u>FICA Taxes</u>	<u>453,661</u>	<u>Health Care Worker Background Check</u>	<u>1,568</u>		
				<u>Employee Health Insurance</u>	<u>163,125</u>	(Indicate # of checks performed _____)			
				<u>Employee Meals</u>	<u>19,574</u>	<u>Patient Background Checks</u>			
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Chamber of Commerce Dues</u>	<u>305</u>		
				<u>401(k) Employer Contributions</u>	<u>27,374</u>	<u>Credit Card Fees</u>	<u>24,617</u>		
TOTAL (agree to Schedule V, line 17, col. 1)				<u>Employee Relations (Awards, Holiday and Awards celebrations Holiday gifts)</u>	<u>6,909</u>	<u>Marketing & Promotion</u>	<u>59,278</u>		
(List each licensed administrator separately.)			\$ _____	<u>Employee Education</u>	<u>1,850</u>	<u>MISC. OTHER</u>	<u>21,917</u>		
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 954,742			\$ 31,069		
Description				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**	
Amount				Description		Line #		Amount	
<u>Management Fee for Jennifer Bebinger</u>								<u>Out-of-State Travel</u>	
<u>\$ 151,653</u>								<u>\$ _____</u>	
<u>Management Fee for Shari Floss</u>								<u>In-State Travel</u>	
<u>33,547</u>								<u>668</u>	
<u>Balance Management Fee</u>								<u>Seminar Expense</u>	
<u>641,779</u>								<u>_____</u>	
TOTAL (agree to Schedule V, line 17, col. 3)				TOTAL		\$ _____		<u>Entertainment Expense</u>	
(Attach a copy of any management service agreement)								<u>(agree to Sch. V, line 24, col. 8)</u>	
\$ 826,979								\$ 668	
C. Professional Services				F. Dues, Fees, Subscriptions and Promotions					
Vendor/Payee		Type		Amount		Description		Amount	
<u>Personal Planners</u>		<u>Unemployment Consulting</u>		<u>\$ 1,092</u>					
<u>Lerman, Boudart & Assoc.</u>		<u>Accounting Services</u>		<u>3,299</u>					
<u>Frost, Ruttenburg & Rottblatt</u>		<u>Accounting Services</u>		<u>17,830</u>					
<u>Law Office of Eugene K. Hollander</u>		<u>Employee lawsuits</u>		<u>7,960</u>					
<u>Ash, Anos, Freedman & Logal</u>		<u>Miscellaneous Issues</u>		<u>22,450</u>					
<u>Socialwork Consultation Group, Inc</u>				<u>165</u>					
<u>Polsinelli Shalton Flanigan</u>		<u>Medicaid Issues</u>		<u>11,964</u>					
<u>Law Offices Segal & Segal</u>		<u>Collections</u>		<u>24,028</u>					
<u>Marshall, Gerstein & Borun</u>		<u>Trademark Registration</u>		<u>450</u>					
<u>AmerAssist</u>		<u>Collections</u>		<u>1,260</u>					
<u>Richard Peelo & Associates</u>		<u>Medicare Cost Report</u>		<u>3,750</u>					
<u>From Page 24</u>				<u>2,735</u>					
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL				\$ _____	
(If total legal fees exceed \$5,000, attach copy of invoices.)				\$ 96,983					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number The Wealshire# 0040956Report Period Beginning: 01/1/2009Ending: 12/31/2009**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 action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? _____ 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 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 51,602 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. \$ 75,927
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 benefits on Schedule V. \$ _____ Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (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? _____
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: _____
- (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.

XIX. SUPPORT SCHEDULES (cont'd)

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
				Workers' Compensation Insurance	\$	IDPH License Fee	\$	
				Unemployment Compensation Insurance		Advertising: Employee Recruitment		
				FICA Taxes		Health Care Worker Background Check		
				Employee Health Insurance		(Indicate # of checks performed _____)		
				Employee Meals				
				Illinois Municipal Retirement Fund (IMRF)*				
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$					
B. Administrative - Other								
Description			Amount			Less: Public Relations Expense	()	
			\$			Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$	TOTAL (agree to Sch. V, line 20, col. 8)	\$	
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
SCI	Property Inspection		\$ 1,500			\$	Out-of-State Travel	\$
Kathleen M. Black	Activity Consultant		700					
Alerus Financial	401(k) processing		535				In-State Travel	
							Seminar Expense	
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (brought forward to page 21)			\$ 2,735	TOTAL		\$	TOTAL	\$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number

The Wealshire

0040956

Report Period Beginning:

01/1/2009

Ending:

12/31/2009

Book to Tax Reconciliation**Amount**

Net Income per books		2,181
Nondeductible expenses for tax:		
Bad Debts Allowances	27,056	
Fines and Penalties	<u>16,874</u>	
Total Nondeductible expenses		43,930
Expenses for tax but not book:		
Amortization of Section 754 Assets		31,669
Tax income		<u><u>14,442</u></u>