FOR BHF USE

LL1

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

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

I. IDPH License ID Number: 0040956

Facility Name: The Wealshire

Address: 150 Jamestown Lane (Number) | Lincolnshire (City) | 60069 (Zip Code)

County: Lake

Telephone Number: (224) 543-7100 **Fax #** (847) 883-9028

HFS ID Number:

Date of Initial License for Current Owners: 08/15/1995

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Matt Lowe **Telephone Number:** (224) 543-7132
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/1/2010 to 12/31/2010 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Jennifer L. Bebinger
(Title) Administrator

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

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

Facility Name & ID Number The Wealshire # 0040956 Report Period Beginning: 01/1/2010 Ending: 12/31/2010

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 11/06/09

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	144	Skilled (SNF)	144	52,560	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,473	9,851	20,115	32,439	8
9	SNF/PED					9
10	ICF	4,513	7,769		12,282	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,986	17,620	20,115	44,721	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.09%

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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] 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 [X] Date 08/14/1995 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 74 and days of care provided 17,688

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number The Wealshire # 0040956 Report Period Beginning: 01/1/2010 Ending: 12/31/2010

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	304,902	44,900	12,505	362,307		362,307		362,307			1
2	Food Purchase		387,662		387,662		387,662	(98)	387,564			2
3	Housekeeping	529,807	54,015		583,822		583,822		583,822			3
4	Laundry	43,285	31,522		74,807		74,807		74,807			4
5	Heat and Other Utilities			241,261	241,261		241,261		241,261			5
6	Maintenance	154,822	52,474	202,995	410,291		410,291		410,291			6
7	Other (specify):* Waste Removal			29,876	29,876		29,876		29,876			7
8	TOTAL General Services	1,032,816	570,573	486,637	2,090,026		2,090,026	(98)	2,089,928			8
	B. Health Care and Programs											
9	Medical Director			75,600	75,600		75,600		75,600			9
10	Nursing and Medical Records	4,448,504	356,390	11,183	4,816,077		4,816,077		4,816,077			10
10a	Therapy	36,812		1,531,959	1,568,771	(60,256)	1,508,515		1,508,515			10a
11	Activities	281,097	17,197		298,294		298,294		298,294			11
12	Social Services	36,942			36,942		36,942		36,942			12
13	CNA Training											13
14	Program Transportation			670	670		670		670			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,803,355	373,587	1,619,412	6,796,354	(60,256)	6,736,098		6,736,098			16
	C. General Administration											
17	Administrative			983,025	983,025		983,025		983,025			17
18	Directors Fees											18
19	Professional Services			125,286	125,286		125,286		125,286			19
20	Dues, Fees, Subscriptions & Promotions			138,447	138,447		138,447	(133,767)	4,680			20
21	Clerical & General Office Expenses	680,369	42,351	311,120	1,033,840		1,033,840	(186,573)	847,267			21
22	Employee Benefits & Payroll Taxes			950,678	950,678		950,678		950,678			22
23	Inservice Training & Education			324	324	60,256	60,580		60,580			23
24	Travel and Seminar			5,123	5,123		5,123	(5,123)				24
25	Other Admin. Staff Transportation			27,056	27,056		27,056		27,056			25
26	Insurance-Prop.Liab.Malpractice			98,877	98,877		98,877	83,438	182,315			26
27	Other (specify):*											27
28	TOTAL General Administration	680,369	42,351	2,639,936	3,362,656	60,256	3,422,912	(242,025)	3,180,887			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,516,540	986,511	4,745,985	12,249,036		12,249,036	(242,123)	12,006,913			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: 01/1/2010 Ending: 12/31/2010

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			2,793	2,793		2,793	791,580	794,373			30
31	Amortization of Pre-Op. & Org.							13,985	13,985			31
32	Interest			9,799	9,799		9,799	654,652	664,451			32
33	Real Estate Taxes							143,820	143,820			33
34	Rent-Facility & Grounds			1,029,756	1,029,756		1,029,756	(1,029,756)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,042,348	1,042,348		1,042,348	574,281	1,616,629			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			63,525	63,525		63,525		63,525			38
39	Ancillary Service Centers		969,636	71,585	1,041,221		1,041,221		1,041,221			39
40	Barber and Beauty Shops			34,496	34,496		34,496		34,496			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			84,135	84,135		84,135		84,135			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		969,636	253,741	1,223,377		1,223,377		1,223,377			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,516,540	1,956,147	6,042,074	14,514,761		14,514,761	332,158	14,846,919			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: 01/1/2010 Ending: 12/31/2010

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(98)	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	428,881	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(494)	21		18
19	Entertainment				19
20	Contributions	(21,136)	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	(164,943)	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	(200,357)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 41,853		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	290,305		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 290,305		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 332,158		37

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

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

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

The Wealshire

ID# 0040956

Report Period Beginning: 01/1/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Travel	$ (5,123)	24	1
2	Credit Card and Bank Fees	(35,569)	20	2
3	Marketing and Advertising	(98,198)	20	3
4	Non-Care Depreciation	(61,467)	30	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				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**	(200,357)		49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number The Wealshire **#** 0040956 **Report Period Beginning:** 01/1/2010 **Ending:** 12/31/2010

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	(98)	0	0	0	0	0	0	0	0	0	0	(98)	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**	(98)	0	0	0	0	0	0	0	0	0	0	(98)	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	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(133,767)	0	0	0	0	0	0	0	0	0	0	(133,767)	20
21	Clerical & General Office Expenses	(186,573)	0	0	0	0	0	0	0	0	0	0	(186,573)	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	(5,123)	0	0	0	0	0	0	0	0	0	0	(5,123)	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	83,438	0	0	0	0	0	0	0	0	0	83,438	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(325,463)	83,438	0	0	0	0	0	0	0	0	0	(242,025)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(325,561)	83,438	0	0	0	0	0	0	0	0	0	(242,123)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Wealshire # 0040956 **Report Period Beginning:** 01/1/2010 **Ending:** 12/31/2010

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	367,414	424,166	0	0	0	0	0	0	0	0	0	791,580	30
31	Amortization of Pre-Op. & Org.	0	13,985	0	0	0	0	0	0	0	0	0	13,985	31
32	Interest	0	654,652	0	0	0	0	0	0	0	0	0	654,652	32
33	Real Estate Taxes	0	143,820	0	0	0	0	0	0	0	0	0	143,820	33
34	Rent-Facility & Grounds	0	(1,029,756)	0	0	0	0	0	0	0	0	0	(1,029,756)	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**	367,414	206,867	0	0	0	0	0	0	0	0	0	574,281	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
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	41,853	290,305	0	0	0	0	0	0	0	0	0	332,158	45

Facility Name & ID Number The Wealshire # 0040956 Report Period Beginning: 01/1/2010 Ending: 12/31/2010

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 Propertie	Lincolnshire	Bldg Prtnrshp
The Wealshire Inc.	1.0			Alexander Blake	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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 1,029,756	Lincolnshire Properties, LP		$	$ (1,029,756)	1
2	V	26	Insurance		Lincolnshire Properties, LP		83,438	83,438	2
3	V	33	Real EstateTaxes		Lincolnshire Properties, LP		143,820	143,820	3
4	V	30	Book Depreciation		Lincolnshire Properties, LP		424,166	424,166	4
5	V	31	Amortization		Lincolnshire Properties, LP		13,985	13,985	5
6	V	32	Interest Expense		Lincolnshire Properties, LP		654,801	654,801	6
7	V	32	Interest Income		Lincolnshire Properties, LP		(149)	(149)	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,029,756			$ 1,320,061	$ * 290,305	14

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

Facility Name & ID Number The Wealshire # 0040956 Report Period Beginning: 01/1/2010 Ending: 12/31/2010

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Arnold Goldberg	Owner	Administrative	99.00	None	35	79.20		$ 417,606	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	$ 417,606		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: 01/1/2010 Ending: 2/31/2010

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number The Wealshire # 0040956 Report Period Beginning: 01/1/2010 Ending: 12/31/2010

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	HUD Cambridge Capital		X	Mortgage Loan	$62,944.00	10/18/07	$ 10,746,400	$ 10,361,017	9/18/42	6.2300	$ 654,801	1
2												2
3												3
4												4
5												5
	Working Capital											
6	GE Capital		X	Phone System	$3,314.03	02/09/09	173,195	105,922	01/09/14	9.5000	11,378	6
7												7
8												8
9	TOTAL Facility Related				$66,258.03		$ 10,919,595	$ 10,466,939			$ 666,179	9
	B. Non-Facility Related*											
10	Interest Income		X								(1,728)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,728)	14
15	TOTALS (line 9+line14)						$ 10,919,595	$ 10,466,939			$ 664,451	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 52,552 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.)**

Facility Name & ID Number The Wealshire # 0040956 **Report Period Beginning:** 01/1/2010 **Ending:** 12/31/2010

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 136,000	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.)		$ 139,820	2
3. Under or (over) accrual (line 2 minus line 1).		$ 3,820	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 140,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 143,820	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	116,188	8
	2006	125,379	9
	2007	132,465	10
	2008	135,951	11
	2009	139,820	12

2010 Accrual = $136,000 X 3% = $140,000

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

NOTES:

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

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME 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 Cost**

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

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	15-15-200-062	Skilled Nursing Facility	$ 139,819.97	$ 139,819.97
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 139,819.97	$ 139,819.97

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number The Wealshire # 0040956 Report Period Beginning: 01/1/2010 Ending: 12/31/2010

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 [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

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

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	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: 01/1/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	144			1995	$ 11,521,031	$	20	$ 576,052	$ 576,052	$ 8,856,799	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LINCOLNSHIRE PROPERTIES:										9
10	MUSIC SYSTEM			1999	33,003		20	1,650	1,650	9,687	10
11	SIDEWALK			1999	4,660		20	233	233	2,238	11
12	PATIO			2001	5,200		20	260	260	1,779	12
13	SIDEWALK			2001	2,325		20	116	116	2,441	13
14	CARPTETING			2002	12,473		20	624	624	4,238	14
15	SPRINKLER SYSTEM			2002	6,805		20	340	340	4,067	15
16	REMODELING			2003	20,650		20	1,033	1,033	6,307	16
17	SIGNAGE			2004	6,000		7	857	857	5,540	17
18	REMODELING-WINDOWS PB			2004	9,411		15	627	627	10,612	18
19	REMODELING KITCHEN - CC			2004	34,889		7	4,984	4,984	32,396	19
20	TELEPHONE EQUIPMENT			2006	9,460		7	1,351	1,351	6,756	20
21	LIGHTING			2006	24,655		7	3,522	3,522	17,610	21
22	CARPETS			2006	23,788		5	4,758	4,758	23,789	22
23	ROOF REPAIRS			2008	21,880		15	1,459	1,459	4,377	23
24	BOILER			2008	122,706		27.5	4,462	4,462	13,386	24
25	PAVING			2008	43,663		15	2,911	2,911	8,733	25
26	FLOORING			2009	58,489		15	3,899	3,899	7,798	26
27	Tuscany Kitchen Countertops and Cabinets/new nurses station			2009	71,584		15	4,772	4,772	9,544	27
28	Barcelona Kitchen Countertops and Cabinets/new nurses station			2009	87,759		15	5,851	5,851	11,702	28
29	FLOORING			2009	23,709		15	1,581	1,581	3,162	29
30	PIPING			2009	5,510		15	367	367	734	30
31	Nurses Station Remodel			2010	87,116		20	4,356	4,356	4,356	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: 01/1/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	LEASEHOLD IMPROVEMENTS	1995	$ 34,126	$	20	$ 1,706	$ 1,706	$ 25,043	37
38	LEASEHOLD IMPROVEMENTS	1996	4,059		20	203	203	2,833	38
39	LEASEHOLD IMPROVEMENTS	1998	3,993		20	200	200	4,193	39
40	ALARM SYSTEM	1999	9,183		20	459	459	4,941	40
41	SECURITY SYSTEM	1999	4,427		20	221	221	2,360	41
42	CABLING/WINDOWS/CABINETS/LUMBER/FIRE SAFETY/ETC	2000	23,775		20	1,189	1,189	11,974	42
43	SIGN	2000	1,611		20	81	81	803	43
44	BOILER WORK	2000	871		20	44	44	440	44
45	BEARING & ASSEMBLING	2001	1,136		20	57	57	551	45
46	PUMP W/ MOTOR	2001	704		20	35	35	324	46
47	COMPERSSOR	2001	1,797		20	90	90	863	47
48	BOILER WORK	2001	1,722		20	86	86	853	48
49	BOILER WORK	2001	1,008		20	50	50	496	49
50	ROOF REPAIR	2001	500		20	25	25	222	50
51	PHONE SYSTEM	2001	1,713		20	86	86	809	51
52	BLACKTOP & PATCH	2001	4,799		20	240	240	2,400	52
53	CARPETING	2002	1,158		20	58	58	354	53
54	EXTERIOR DOORS	2002	9,700		20	485	485	3,446	54
55	BOILER REPAIRS	2002	8,124		20	406	406	3,654	55
56	SPRINKLER SYSTEM	2002	950		20	48	48	480	56
57	BALCKTOP REPAIR	2002	2,799		20	140	140	616	57
58	BOILER REPAIRS	2002	1,077		20	54	54	1,174	58
59	PUMP & BOILER REPAIRS	2002	3,376		20	169	169	1,521	59
60	FIRE SAFETY UPGRADES	2003	9,901		20	495	495	5,065	60
61	SEWAGE EJECTORS/DISPOSER/PUMP	2003	12,848		20	642	642	4,157	61
62	BORIS BARBARIC-PAINTING	2003	5,950		5	1,190	1,190	7,140	62
63	TELEPHONE LINES	2003	4,229		20	211	211	1,583	63
64	IRRIGATION SYSTEM BOOSTER PUMP/HEADS	2004	2,109		39	54	54	275	64
65	UPGRADE BOILER CONTROLS	2004	5,530		39	142	142	734	65
66	SIGNAGE	2005	2,788		20	139	139	300	66
67	HANDICAP RAMP	2005	1,700		20	85	85	131	67
68	LANDSCAPE LIGHTING	2005	7,022		20	351	351	466	68
69	CHILLER REPLACEMENT EXCESS	2005	5,000		15	333	333	916	69
70	TOTAL (lines 4 thru 69)		$ 12,416,451	$		$ 635,839	$ 635,839	$ 9,139,168	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: 01/1/2010 Ending: 12/31/2010

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		$ 12,416,451	$		$ 635,839	$ 635,839	$ 9,139,168	1
2	NEW HVAC COIL	2006	7,128		10	713	713	3,208	2
3	NEW HVAC COIL	2006	6,414		10	641	641	3,420	3
4	SIGNAGE	2006	2,274		10	227	227	852	4
5	CAPITALIZED TELEPHONE SYSTEM	2008	173,195		20	8,660	8,660	18,763	5
6	DOORS	2009	10,284		15	343	343	686	6
7	FOUNTAIN	2009	38,500		15	428	428	856	7
8	CONCRETE PAD	2009	17,394		39	74	74	148	8
9	BACKSPLASH	2009	15,305		15	85	85	170	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	Book Depreciation			156,557			(156,557)		33
34	TOTAL (lines 1 thru 33)		$ 12,686,945	$ 156,557		$ 647,011	$ 490,454	$ 9,167,272	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: 01/1/2010 Ending: 12/31/2010

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	$ 1,701,677	$ 12,303	$ 37,561	$ 25,258	3-20 yrs	$	71
72	Current Year Purchases	94,794	6,239	9,480	3,241	10 yrs	9,480	72
73	Fully Depreciated Assets	303,261						73
74	Lincolnshire Properties	1,206,068	186,958	94,357	(92,601)	3-20 yrs		74
75	TOTALS	$ 3,305,800	$ 205,500	$ 141,398	$ (64,102)		$ 9,480	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	Maintenance	2007 Chevy	2007	$ 29,820	$ 3,435	$ 5,964	$ 2,529	5	$ 23,856	76
77										77
78										78
79										79
80	TOTALS			$ 29,820	$ 3,435	$ 5,964	$ 2,529		$ 23,856	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)	$ 16,993,490	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 365,492	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 794,373	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 428,881	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 9,200,608	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	21,682	87
88	LANDSCAPING	68,503	4,242	43,557	88
89	BUILDING 1997 SECT 754	4,185,474	55,734	1,159,610	89
90					90
91	TOTALS	$ 4,312,138	$ 61,467	$ 1,224,849	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number The Wealshire # 0040956 Report Period Beginning: 01/1/2010 Ending: 12/31/2010

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	1996/1997	144	1997	1,029,756			4
5								5
6								6
7	TOTAL		144		$ 1,029,756 **			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 ☒ X NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2011	$
13.	/2012	$
14.	/2013	$

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

15. Is Movable equipment rental included in building rental? ☒ X 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

* 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.

Facility Name & ID Number The Wealshire # 0040956 Report Period Beginning: 01/1/2010 Ending: 12/31/2010

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number The Wealshire

STATE OF ILLINOIS
0040956 Report Period Beginning: 01/1/2010 Ending: 12/31/2010

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10-3	hrs	$	39,236	$ 599,965	$	39,236	$ 599,965	1
2	Licensed Speech and Language Development Therapist	10-1, 10-3	736 hrs	36,812				736	36,812	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10-3	hrs		61,241	931,994		61,241	931,994	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$ 36,812	100,477	$ 1,531,959	$	101,213	$ 1,568,771	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

Facility Name & ID Number The Wealshire # 0040956 **Report Period Beginning:** 01/1/2010 **Ending:** 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2010 (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	$ 819,460	$ 822,040	1
2	Cash-Patient Deposits	9,274	9,274	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 97,693)	1,933,415	1,933,415	3
4	Supply Inventory (priced at)	17,660	17,660	4
5	Short-Term Investments			5
6	Prepaid Insurance	67,205	136,240	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	1,682,255	3,066,264	8
9	Other(specify):	(3,085)	72,794	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,526,184	$ 6,057,687	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	203,768	816,613	15
16	Equipment, at Historical Cost	912,773	2,200,200	16
17	Accumulated Depreciation (book methods)	(856,412)	(10,557,154)	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**		146,146	22
23	Other(specify): Unamortized Loan Fees		444,015	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 260,129	$ 13,353,720	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,786,313	$ 19,411,407	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,029,739	$ 2,097,868	26
27	Officer's Accounts Payable	(144)	(144)	27
28	Accounts Payable-Patient Deposits	10,274	10,274	28
29	Short-Term Notes Payable		94,466	29
30	Accrued Salaries Payable	349,955	349,955	30
31	Accrued Taxes Payable (excluding real estate taxes)	34,834	34,834	31
32	Accrued Real Estate Taxes(Sch.IX-B)		140,000	32
33	Accrued Interest Payable		22,574	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Management Fees	539,005	539,005	36
37	Due to Affiliates	1,376,009	1,612,653	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,339,672	$ 4,901,485	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		10,361,017	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Trade Payable	69,155	69,155	43
44	Long Term Capital Lease	72,237	72,237	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 141,392	$ 10,502,409	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,481,064	$ 15,403,894	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 305,249	$ 4,007,513	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,786,313	$ 19,411,407	48

***(See instructions.)**

Facility Name & ID Number The Wealshire # 0040956 **Report Period Beginning:** 01/1/2010 **Ending:** 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 251,175	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 251,175	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	650,176	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	(596,102)	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)**	$ 54,074	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)**	$ 305,249	24 *

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

Facility Name & ID Number The Wealshire # 0040956 Report Period Beginning: 01/1/2010 Ending: 12/31/2010

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

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 15,079,418	1
2	Discounts and Allowances for all Levels	(378,420)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 14,700,998	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	364,221	6
7	Oxygen	3,693	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 367,914	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	40,208	13
14	Non-Patient Meals	98	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)**	$ 40,306	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	6,861	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 6,861	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Ancillary Income	48,858	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 48,858	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 15,164,937	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,090,026	31
32	Health Care	6,796,354	32
33	General Administration	3,362,656	33
	B. Capital Expense		
34	Ownership	1,042,348	34
	C. Ancillary Expense		
35	Special Cost Centers	1,139,242	35
36	Provider Participation Fee	84,135	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 14,514,761	40
41	**Income before Income Taxes (line 30 minus line 40)****	650,176	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 650,176	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: 01/1/2010 Ending: 12/31/2010

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,747	1,984	$ 102,560	$ 51.69	1
2	Assistant Director of Nursing					2
3	Registered Nurses	30,187	33,659	963,359	28.62	3
4	Licensed Practical Nurses	35,526	39,611	1,063,769	26.86	4
5	CNAs & Orderlies	150,329	167,617	1,988,997	11.87	5
6	CNA Trainees					6
7	Licensed Therapist	736	736	36,812	50.02	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,045	2,375	73,931	31.13	9
10	Activity Assistants	13,357	14,812	207,166	13.99	10
11	Social Service Workers	1,620	1,970	36,942	18.75	11
12	Dietician	524	524	8,382	16.00	12
13	Food Service Supervisor	1,252	1,466	48,737	33.24	13
14	Head Cook	1,337	1,564	26,658	17.04	14
15	Cook Helpers/Assistants	10,228	11,419	122,055	10.69	15
16	Dishwashers	11,136	11,746	99,070	8.43	16
17	Maintenance Workers	7,037	8,118	154,822	19.07	17
18	Housekeepers	48,561	54,299	529,807	9.76	18
19	Laundry	3,980	4,460	43,285	9.71	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	13,936	15,701	447,504	28.50	22
23	Office Manager	1,720	1,945	39,404	20.26	23
24	Clerical	7,556	7,927	88,356	11.15	24
25	Vocational Instruction	1,650	2,060	60,256	29.25	25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,523	2,839	92,985	32.75	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,578	5,238	70,271	13.42	31
32	Other Health Care(specify)	3,490	3,971	106,307	26.77	32
33	Other(specify) Marketing	2,910	3,119	105,105	33.70	33
34	TOTAL (lines 1 - 33)	357,965	399,160	$ 6,516,540 *	$ 16.33	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 12,505	1-3	35
36	Medical Director		75,600	9-3	36
37	Medical Records Consultant		3,226	10-3	37
38	Nurse Consultant		7,957	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)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 99,288		49

C. CONTRACT NURSES

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

Facility Name & ID Number The Wealshire # 0040956 Report Period Beginning: 01/1/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Incurred in management fees	Administrator	0	$ 0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
Management Fee for Jennifer Bebinger	$ 164,454
Balance Management Fee	818,571
TOTAL (agree to Schedule V, line 17, col. 3)	$ 983,025
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Alerus Financial	401K Processing	$ 714
Amer Assist	Collections	177
Ash, Anos, Freedman & Logan	Miscellaneous Issues	31,083
Behles & Behles	Architect Fees	11,676
Callero & Callero LLP	401k Audit	8,500
CT Corporation System	Annual Fee	950
Miscellaneous		296
Executive Synergies	Executive Profiles	4,500
Frost, Ruttenberg & Rothblatt	Accounting Services	905
Kathleen M. Black	Activity Consultant	280
Kristine Geggie	Interior Design	2,640
From Page 24		63,565
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 125,286

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 182,521
Unemployment Compensation Insurance	44,661
FICA Taxes	471,847
Employee Health Insurance	160,324
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Employer Contributions	45,907
Employee Education	5,964
Employee Relations (Awards, Holiday and Awards celebrations Holiday gifts)	39,454
TOTAL (agree to Schedule V, line 22, col.8)	$ 950,678

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,605
Health Care Worker Background Check	245
(Indicate # of checks performed)	
Patient Background Checks	
Dues Subscriptions and Fees	(170)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,680

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number The Wealshire # 0040956 Report Period Beginning: 01/1/2010 Ending: 12/31/2010

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number The Wealshire **#** 0040956 **Report Period Beginning:** 01/1/2010 **Ending:** 12/31/2010

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. $ **54,523** 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. $ **84,135**
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.

Facility Name & ID Number The Wealshire # 0040956 Report Period Beginning: 01/1/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$

TOTAL (agree to Schedule V, line 17, col. 1) $
(List each licensed administrator separately.)

B. Administrative - Other

Description	Amount
	$

TOTAL (agree to Schedule V, line 17, col. 3) $
(Attach a copy of any management service agreement)

C. Professional Services

Vendor/Payee	Type	Amount
Law Office of Eugene Hollander	Legal Fees	7,889
Law Offices Segal & Segal	Collections	18,874
Posinelli Shugart	Medicaid Issues	22,738
Rehab Management Systems	MDS Therapy Consultant	7,500
Richard Peelo & Associates	Medicare Cost Report	3,750
RSM McGladrey	401k Audit	1,630
Personnel Planners	Unemployment Consulting	1,184

TOTAL (agree to Schedule V, line 19, column 3) $ 63,565
(If total legal fees exceed $5,000, attach copy of invoices.)

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	

TOTAL (agree to Schedule V, line 22, col.8) $

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

Description	Line #	Amount
		$

TOTAL $

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )

TOTAL (agree to Sch. V, line 20, col. 8) $

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )

TOTAL (agree to Sch. V, line 24, col. 8) $

**See instructions.

Book to Tax Reconciliation		Amount
Net Income per books		650,176
Nondeductibe expenses for tax:		
Bad Debts Allowances	70,637	
Total Nondeductible expenses		70,637
Expenses for tax but not book:		
Amortization of Section 754 Assets		(31,669)
Tax income		689,144