

		FOR BHF USE					

LL1

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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.

I. IDPH License ID Number: <u>0040956</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>The Wealshire</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2012</u> to <u>12/31/12</u> 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.	
Address: <u>150 Jamestown Lane</u> <u>Lincolnshire</u> <u>60069</u>			
NumberCityZip Code			
County: <u>Lake</u>			
Telephone Number: <u>(224) 543-7100</u> Fax # <u>(847)883-9028</u>			
HFS ID Number: _____			
Date of Initial License for Current Owners: <u>08/15/1995</u>			
Type of Ownership:			
☐ VOLUNTARY,NON-PROFIT ☐ Charitable Corp. ☐ Trust IRS Exemption Code _____			
☒ PROPRIETARY ☐ Individual ☒ Partnership ☐ Corporation ☐ "Sub-S" Corp. ☐ Limited Liability Co. ☐ Trust ☐ Other _____			
☐ GOVERNMENTAL ☐ State ☐ County ☐ Other _____			
In the event there are further questions about this report, please contact:			
Name: <u>: Mike Brogan</u> Telephone Number: <u>(224)543-7132</u>			
Email Address: _____			
		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) <u>Bruce Harris</u> (Title) <u>Vice President of Financial Operations</u>	
		Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) <u>Larry Templin</u> <u>Partner</u> (Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP</u> <u>P.O. Box 9, Dunlap, IL 61525</u> (Telephone) <u>630-361-2868</u> 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: 1/1/2012 Ending: 12/31/12

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 bedsN/A

	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	<u>144</u>	Skilled (SNF)	<u>144</u>	<u>52,704</u>	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	<u>144</u>	TOTALS	<u>144</u>	<u>52,704</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>2,375</u>	<u>9,671</u>	<u>21,749</u>	<u>33,795</u>	8
9	SNF/PED					9
10	ICF	<u>4,335</u>	<u>7,627</u>		<u>11,962</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>6,710</u>	<u>17,298</u>	<u>21,749</u>	<u>45,757</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 86.82%

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)

None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐NO ☒Non-allowable costs have been
eliminated in Schedule V, Column 7

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 8/14/1995NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐If YES, enter number
of beds certified 100 and days of care provided 17,809Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/12 Fiscal Year: 12/31/12

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

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	322,912	39,754	12,341	375,007		375,007		375,007			1
2	Food Purchase		415,945		415,945		415,945		415,945			2
3	Housekeeping	589,074	46,736		635,810		635,810		635,810			3
4	Laundry	37,966	36,011		73,977		73,977		73,977			4
5	Heat and Other Utilities			207,766	207,766		207,766		207,766			5
6	Maintenance	140,720	66,357	196,008	403,085		403,085		403,085			6
7	Other (specify):* Waste Removal			23,457	23,457		23,457		23,457			7
8	TOTAL General Services	1,090,672	604,803	439,572	2,135,047		2,135,047		2,135,047			8
	B. Health Care and Programs											
9	Medical Director			79,600	79,600		79,600		79,600			9
10	Nursing and Medical Records	5,050,064	267,410	26,414	5,343,888		5,343,888	(4,184)	5,339,704			10
10a	Therapy	61,527	3,338	2,094,873	2,159,738		2,159,738		2,159,738			10a
11	Activities	203,797	9,878	18,846	232,521		232,521	(2,538)	229,983			11
12	Social Services	110,739			110,739		110,739		110,739			12
13	CNA Training											13
14	Program Transportation	18,043		6,491	24,534		24,534	(2,711)	21,823			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	5,444,170	280,626	2,226,224	7,951,020		7,951,020	(9,433)	7,941,587			16
	C. General Administration											
17	Administrative			1,052,797	1,052,797		1,052,797	(958,884)	93,913			17
18	Directors Fees											18
19	Professional Services			134,035	134,035		134,035		134,035			19
20	Dues, Fees, Subscriptions & Promotions			17,551	17,551		17,551	(669)	16,882			20
21	Clerical & General Office Expenses	449,780	53,534	104,692	608,006		608,006	959,560	1,567,566			21
22	Employee Benefits & Payroll Taxes			1,171,264	1,171,264		1,171,264		1,171,264			22
23	Inservice Training & Education			388	388		388		388			23
24	Travel and Seminar			8,337	8,337		8,337		8,337			24
25	Other Admin. Staff Transportation			21,912	21,912		21,912		21,912			25
26	Insurance-Prop.Liab.Malpractice			105,530	105,530		105,530	49,254	154,784			26
27	Other (specify):*											27
28	TOTAL General Administration	449,780	53,534	2,616,506	3,119,820		3,119,820	49,261	3,169,081			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,984,622	938,963	5,282,302	13,205,887		13,205,887	39,828	13,245,715			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.

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	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			117,425	117,425		117,425	600,983	718,408			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			214	214		214	584,925	585,139			32
33	Real Estate Taxes							154,567	154,567			33
34	Rent-Facility & Grounds			1,081,606	1,081,606		1,081,606	(1,081,606)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			1,199,245	1,199,245		1,199,245	258,869	1,458,114			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			28,138	28,138		28,138		28,138			38
39	Ancillary Service Centers		724,729		724,729		724,729		724,729			39
40	Barber and Beauty Shops			24,366	24,366		24,366		24,366			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			79,236	79,236		79,236		79,236			42
43	Other (specify):* Non-allowable Costs	49,190	17,045	320,268	386,503		386,503	(386,503)				43
44	TOTAL Special Cost Centers	49,190	741,774	452,008	1,242,972		1,242,972	(386,503)	856,469			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	7,033,812	1,680,737	6,933,555	15,648,104		15,648,104	(87,806)	15,560,298			45

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

		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				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	(86,255)	30		9
10	Interest and Other Investment Income	(4,881)	32		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	(47,776)	43		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(10,182)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(84,767)	43		24
25	Fund Raising, Advertising and Promotional	(177,169)	43		25
	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 See Page 5A	(101,711)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (512,741)		\$	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)	424,935		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 424,935		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (87,806)		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.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

The Wealshire

ID#

0040956

Report Period Beginning:

1/1/2012

Ending:

12/31/12

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Disallow Laboratory	\$ (28,708)	43	1
2	Disallow X-Rays	(37,901)	43	2
3	Disallow Unidentified Expense	(8,000)	21	3
4	Offset Vendor Rebates Against Expense	(4,184)	10	4
5	Offset Transportation Income Against Expense	(2,538)	11	5
6	Offset Transportation Income Against Expense	(2,711)	14	6
7	Disallow Management Fees on Real Estate Entity	(17,000)	17	7
8	Disallow Chamber of Commerce Dues	(669)	20	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	(101,711)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Wealshire

0040956

Report Period Beginning:

1/1/2012

Ending:

12/31/12

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	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	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	(4,184)	0	0	0	0	0	0	0	0	0	0	(4,184)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(2,538)	0	0	0	0	0	0	0	0	0	0	(2,538)	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	(2,711)	0	0	0	0	0	0	0	0	0	0	(2,711)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(9,433)	0	0	0	0	0	0	0	0	0	0	(9,433)	16
	C. General Administration													
17	Administrative	(17,000)	17,000	(958,884)	0	0	0	0	0	0	0	0	(958,884)	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	(669)	0	0	0	0	0	0	0	0	0	0	(669)	20
21	Clerical & General Office Expenses	(8,000)	8,676	958,884	0	0	0	0	0	0	0	0	959,560	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	49,254	0	0	0	0	0	0	0	0	0	49,254	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(25,669)	74,930	0	0	0	0	0	0	0	0	0	49,261	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(35,102)	74,930	0	0	0	0	0	0	0	0	0	39,828	29

Summary B

12/31/12

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as 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 Properties	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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	\$ 1,081,606	Lincolnshire Properties, LP	0.00%	\$	\$ (1,081,606)	1
2	V	17	Management Fees		Lincolnshire Properties, LP	0.00%	17,000	17,000	2
3	V	21	Bank Charges		Lincolnshire Properties, LP	0.00%	676	676	3
4	V	21	Miscellaneous		Lincolnshire Properties, LP	0.00%	8,000	8,000	4
5	V	26	Insurance		Lincolnshire Properties, LP	0.00%	49,254	49,254	5
6	V	33	Real Estate Taxes		Lincolnshire Properties, LP	0.00%	154,567	154,567	6
7	V	30	Book Depreciation		Lincolnshire Properties, LP	0.00%	687,238	687,238	7
8	V	32	Interest Expense		Lincolnshire Properties, LP	0.00%	589,806	589,806	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,081,606			\$ 1,506,541	\$ * 424,935	14

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

VII. RELATED PARTIES (continued)

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)	
15	V	17	Management Fees	\$ 1,052,797	Alexander Blake Company	0.00%	\$	(1,052,797)	15
16	V	17	Administrator Salaries		Alexander Blake Company	0.00%	93,913	93,913	16
17	V	21	Administrative Salaries		Alexander Blake Company	0.00%	958,660	958,660	17
18	V	21	Other Administrative Expenses		Alexander Blake Company	0.00%	224	224	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 1,052,797			\$ 1,052,797	\$ *	39

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

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	Salary	\$ 631,270	L17, C3	1
2	Josh Goldberg	Administrator	Administrative	0.00	None	40	100.00	Salary	93,913	L17, C3	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 725,183		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

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**		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		X	Mortgage Loan	\$62,944.00	10/18/07	\$ 10,746,400	\$ 10,245,854	9/18/42	0.0250	\$ 589,806	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	Omnicare		X	Working Capital	\$14,560.00	3/15/11	435,521	130,066	12/15/13	0.0510	214	6	
7												7	
8												8	
9	TOTAL Facility Related				\$77,504.00		\$ 11,181,921	\$ 10,375,920			\$ 590,020	9	
	B. Non-Facility Related*												
10												10	
11							Interest income offset				(4,881)	11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (4,881)	14	
15	TOTALS (line 9+line14)						\$ 11,181,921	\$ 10,375,920			\$ 585,139	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 49,404 Line # 26

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2011 report.			\$	145,000	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.)		2011	\$	154,567	2
3. Under or (over) accrual (line 2 minus line 1).			\$	9,567	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	145,000	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.			\$	154,567	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007	132,465	8	
		2008	135,951	9	
		2009	139,820	10	
		2010	144,496	11	
		2011	154,567	12	
Accrual based on prior year tax bill.					

		FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	\$		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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

The Wealshire

COUNTY

Lake

FACILITY IDPH LICENSE NUMBER

0040956

CONTACT PERSON REGARDING THIS REPORT :

Mike Brogan

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 2011 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 2011.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	15-15-200-262	Skilled Nursing Facility	\$ 154,566.92	\$ 154,566.92
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 154,566.92	\$ 154,566.92

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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.**

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).
The Ponds of Wealshire

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: N/A 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	1995	\$ 11,521,031	\$	20	\$ 576,052	\$ 576,052	\$ 10,008,903
5										
6										
7										
8										
	Improvement Type**									
9	Lincolnshire Properties:									
10	Music System			1999	33,003		20	1,650	1,650	12,987
11	Sidewalk			1999	4,660		20	233	233	2,704
12	Patio			2001	5,200		20	260	260	2,299
13	Sidewalk			2001	2,325		20			2,325
14	Carpeting			2002	12,473		20			4,862
15	Sprinkler System			2002	6,805		20	340	340	4,747
16	Remodeling			2003	20,650		20	1,033	1,033	8,373
17	Signage			2004	6,000		7			6,000
18	Remodeling-Windows PB			2004	9,411		15			9,411
19	Remodeling Kitchen -CC			2004	34,889		7			34,889
20	Telephone Equipment			2006	9,460		7	1,351	1,351	9,458
21	Lighting			2006	24,655		7	3,522	3,522	24,654
22	Carpets			2006	23,788		5			23,788
23	Roof Repairs			2008	21,880		15	1,459	1,459	7,295
24	Boiler			2008	122,706		27.5	4,462	4,462	22,310
25	Paving			2008	43,663		15	2,911	2,911	14,555
26	Flooring			2009	58,489		15	3,899	3,899	15,596
27	Tuscany Kitchen Countertops & Cabinets/new nurses station			2009	71,584		15	4,772	4,772	19,088
28	Barcelona Kitchen Countertops & Cabinets/new nurses station			2009	87,759		15	5,851	5,851	23,404
29	Flooring			2009	23,709		15	1,581	1,581	6,324
30	Piping			2009	5,510		15	367	367	1,468
31	Nurses Station Remodel			2010	87,116		20	4,356	4,356	13,068
32										
33										
34										
35										
36										

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number The Wealshire

0040956

Report Period Beginning:

1/1/2012

Ending:

12/31/12

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Leasehold Improvements	1995	\$ 34,126	\$	20	\$ 1,706	\$ 1,706	\$ 28,455	37
38	Leasehold Improvements	1996	4,059		20	203	203	3,239	38
39	Leasehold Improvements	1998	3,993		20			3,993	39
40	Alarm System	1999	9,183		20	459	459	5,859	40
41	Security System	1999	4,427		20	221	221	2,802	41
42	Cabling/Windows/Cabinets/Lumber/Fire Safety/Etc/	2000	23,775		20	1,189	1,189	14,352	42
43	Sign	2000	1,611		20	81	81	242	43
44	Boiler Work	2000	871		20	44	44	528	44
45	Bearing & Assembling	2001	1,136		20	57	57	665	45
46	Pump w/ Motor	2001	704		20	35	35	394	46
47	Comperssor	2001	1,797		20	90	90	1,043	47
48	Boiler Work	2001	1,722		20	86	86	1,025	48
49	Boiler Work	2001	1,008		20	50	50	596	49
50	Roof Repair	2001	500		20	25	25	272	50
51	Phone System	2001	1,713		20	86	86	981	51
52	Blacktop & Patch	2001	4,799		20	240	240	2,880	52
53	Carpeting	2002	1,158		20	58	58	470	53
54	Exterior Doors	2002	9,700		20	485	485	4,416	54
55	Boiler Repairs	2002	8,124		20	406	406	4,466	55
56	Sprinkler System	2002	950		20	48	48	576	56
57	Blacktop Repair	2002	2,799		20	140	140	896	57
58	Boiler Repairs	2002	1,077		20			1,077	58
59	Pump & Boiler Repairs	2002	3,376		20	169	169	1,859	59
60	Fire Safety Upgrades	2003	9,901		20	495	495	6,055	60
61	Sewage Ejectors/Disposer/Pump	2003	12,848		20	642	642	5,441	61
62	Boris Barbaric - Painting	2003	5,950		5			5,950	62
63	Telephone Lines	2003	4,229		20	211	211	2,005	63
64	Irrigation System Booster Pump/Heads	2004	2,109		39	54	54	383	64
65	Upgrade Boiler Controls	2004	5,530		39	142	142	1,018	65
66	Signage	2005	2,788		20	139	139	578	66
67	Handicap Ramp	2005	1,700		20	85	85	301	67
68	Landscape Lighting	2005	7,022		20	351	351	1,168	68
69	Chiller Replacement Excess	2005	5,000		15	333	333	1,582	69
70	TOTAL (lines 4 thru 69)		\$ 12,416,451	\$		\$ 622,429	\$ 622,429	\$ 10,384,075	70

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	\$		\$ 622,429	\$ 622,429	\$ 10,384,075	1
2	New HVAC Coil	2006	7,128		10	713	713	4,634	2
3	New HVAC Coil	2006	6,414		10	641	641	4,702	3
4	Signage	2006	2,274		10	227	227	1,306	4
5	Capitalized Telephone System	2008	173,195		20	8,660	8,660	36,083	5
6	Doors	2009	10,284		15	343	343	1,372	6
7	Fountain	2009	38,500		15	428	428	1,712	7
8	Concrete Pad	2009	17,394		39	74	74	296	8
9	Backsplash	2009	15,305		15	85	85	340	9
10	Roof Repairs	2011	11,360		20	568	568	1,136	10
11	Tile for 4 bathroom remodels	2011	18,300		15	1,220	1,220	2,440	11
12	Kitchen Backsplash	2011	5,000		15	333	333	666	12
13	Privacy Screens	2011	8,161		15	544	544	1,088	13
14	Closets for patients	2011	3,840		15	256	256	512	14
15	Sidewalk and retaining wall repairs	2012	16,800		15	560	560	560	15
16	Shower Remodel (Tiling, drain repair, etc.)	2012	52,969		15	1,766	1,766	1,766	16
17	Unit Remodel-Melbourne Household	2012	33,469		15	1,116	1,116	1,116	17
18	Boiler repair	2012	10,840		15	361	361	361	18
19	Tiling (Entrances and Elevators)	2012	5,700		15	190	190	190	19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29	Book Depreciation			81,524			(81,524)		29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 12,853,384	\$ 81,524		\$ 640,514	\$ 558,990	\$ 10,444,355	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 1,911,794	\$ 24,023	\$ 58,573	\$ 34,550	3-20 yrs	\$ 1,653,403	71
72	Current Year Purchases	118,912	5,946	5,946		10 yrs	5,946	72
73	Fully Depreciated Assets	303,261					303,261	73
74	Lincolnshire Properties							74
75	TOTALS	\$ 2,333,967	\$ 29,969	\$ 64,519	\$ 34,550		\$ 1,962,610	75

D. Vehicle Costs. (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	2011 Chevy Silverdo	2011	\$ 35,594	\$ 5,932	\$ 5,932	\$	5	\$ 35,594	76
77	Resident Transportation	2012 Ford E-250	2012	46,950	7,443	7,443		5	7,443	77
78										78
79										79
80	TOTALS			\$ 82,544	\$ 13,375	\$ 13,375	\$		\$ 43,037	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)	\$ 16,240,820	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 124,868	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 718,408	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 593,540	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 12,450,002	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	24,664	87
88	LANDSCAPING	68,503	4,242	52,041	88
89	BUILDING 1997 SECT 754	4,185,474	55,734	1,271,078	89
90					90
91	TOTALS	\$ 4,312,138	\$ 61,467	\$ 1,347,783	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		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: N/A
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							4
5								5
6								6
7	TOTAL				\$			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: N/A
(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	N/A				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. /2013 \$
13. /2014 \$
14. /2015 \$

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

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

It is the policy of this facility to only hire certified nurses aides.
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

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		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)	\$			

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.)

	1	2	3	4	5	6	7	8		
	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	10A(3)	hrs	\$	15,628	\$ 882,354	\$	15,628	\$ 882,354	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		4,245	230,616		4,245	230,616	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		18,208	981,398	3,338	18,208	984,736	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				724,729		724,729	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Rehabilitation Nurse</u>		1995 hrs	61,527				1,995	61,527	12
13	Other (specify): <u>Massage Therapy</u>				10	505		10	505	13
14	TOTAL			\$ 61,527	38,090	\$ 2,094,873	\$ 728,067	40,085	\$ 2,884,467	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.

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	\$ 2,559,658	\$ 2,664,372	1
2	Cash-Patient Deposits	57,020	57,020	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>None</u>)	2,225,130	2,225,130	3
4	Supply Inventory (priced at <u>Cost</u>)	17,660	17,660	4
5	Short-Term Investments			5
6	Prepaid Insurance	128,386	197,421	6
7	Other Prepaid Expenses	45,010	53,010	7
8	Accounts Receivable (owners or related parties)	372,513	1,765,821	8
9	Other(specify): <u>Employee Loans</u>	700	791,299	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,406,077	\$ 7,771,733	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		970,925	13
14	Buildings, at Historical Cost	24,380	11,461,964	14
15	Leasehold Improvements, at Historical Cost	341,642	954,487	15
16	Equipment, at Historical Cost	1,064,369	2,416,511	16
17	Accumulated Depreciation (book methods)	(880,038)	(12,450,002)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):		495,560	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 550,353	\$ 3,849,445	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,956,430	\$ 11,621,178	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,828,813	\$ 1,896,944	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	108,020	108,020	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	104,914	104,914	30
31	Accrued Taxes Payable (excluding real estate taxes)	79,096	79,096	31
32	Accrued Real Estate Taxes(Sch.IX-B)		145,000	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>	546,437	546,437	36
37	<u>Due to Affiliates</u>	1,376,009	1,376,009	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,043,289	\$ 4,278,994	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	130,066	130,066	39
40	Mortgage Payable		10,245,854	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Deferred Revenue</u>	13,900	13,900	43
44	<u>Long Term Capital Lease</u>	32,694	32,694	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 176,660	\$ 10,422,514	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,219,949	\$ 14,701,508	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,736,481	\$ (3,080,330)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,956,430	\$ 11,621,178	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,369,752	1
2	Restatements (describe):		2
3	Prior Period Adjustments	(21,889)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,347,863	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,054,094	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	(1,665,476)	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)	\$ (611,382)	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)	\$ 1,736,481	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number The Wealshire# 0040956Report Period Beginning: 1/1/2012Ending: 12/31/12

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		2
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 13,990,717	1
2	Discounts and Allowances for all Levels	(3,101,500)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,889,217	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,352,366	6
7	Oxygen	840	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,353,206	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	20,070	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	873,959	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	179,351	19
20	Radiology and X-Ray	29,372	20
21	Other Medical Services	340,909	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,443,661	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,881	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,881	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28		9,433	28
28a		1,800	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 11,233	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 16,702,198	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,135,047	31
32	Health Care	7,951,020	32
33	General Administration	3,119,820	33
	B. Capital Expense		
34	Ownership	1,199,245	34
	C. Ancillary Expense		
35	Special Cost Centers	1,163,736	35
36	Provider Participation Fee	79,236	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 15,648,104	40
41	Income before Income Taxes (line 30 minus line 40)**	1,054,094	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,054,094	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,063,239	44
45	Private Pay - Net Inpatient Revenue	3,935,520	45
46	Medicare - Net Inpatient Revenue	5,205,101	46
47	Other-(specify) <u>Insurance</u>	685,357	47
48	Other-(specify) _____		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 10,889,217	49

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

** Does this agree with taxable income (loss) per Federal Income

Tax Return? Yes 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.

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	2,000	2,080	\$ 113,000	\$ 54.33	1
2	Assistant Director of Nursing					2
3	Registered Nurses	74,936	89,373	2,350,363	26.30	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies	163,612	196,248	2,260,899	11.52	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,648	1,995	61,527	30.84	8
9	Activity Director					9
10	Activity Assistants	12,893	14,006	203,797	14.55	10
11	Social Service Workers	5,467	5,681	110,739	19.49	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,120	23,418	322,912	13.79	15
16	Dishwashers					16
17	Maintenance Workers	6,045	6,455	140,720	21.80	17
18	Housekeepers	48,967	53,355	589,074	11.04	18
19	Laundry	3,191	3,593	37,966	10.57	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,492	16,623	334,911	20.15	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,621	2,779	63,805	22.96	31
32	Other Health Care(specify)					32
33	Other(specify) See Sch 20A	13,844	14,511	444,099	30.60	33
34	TOTAL (lines 1 - 33)	372,836	430,117	\$ 7,033,812 *	\$ 16.35	34

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	Monthly	\$ 12,341	L1, C3	35
36	Medical Director	Monthly	79,600	L9, C3	36
37	Medical Records Consultant	Monthly	627	L10, C3	37
38	Nurse Consultant	Monthly	9,561	L10, C3	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)		\$ 102,129		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	N/A			51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

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

** See instructions.

The Wealshire

Period Beginning	<u>1/1/2012</u>
Period End	<u>12/31/12</u>

Schedule 20A

XVIII. Staffing and Salary Costs

			Reporting Period Total Salaries, Wages	Average Hourly Wage
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued		
Care Plan Coordinator	3,504	3,754	146,029	38.90
Nursing Supervisor	3,978	4,196	115,968	27.64
Transportation	1,475	1,569	18,043	11.50
Admissions	3,653	3,744	114,869	30.68
Marketing	1,234	1,248	49,190	39.42
TOTAL	<u>13,844</u>	<u>14,511</u>	<u>444,099</u>	

XIX. SUPPORT SCHEDULES

A. Administrative Salaries					
Name	Function	% Ownership	Amount		
Josh Goldberg	Administrator	0%	\$93,913		
(Included in Allocation from Mgmt Co.)					
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$93,913		
B. Administrative - Other					
Description			Amount		
Management Fee (Eliminated in Column 7)			\$1,052,797		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$1,052,797		
C. Professional Services					
Vendor/Payee	Type		Amount		
Polsinelli Shugart	Legal Fees		\$360		
Ash, Anos, Freedman & Logan	Legal Fees		6,332		
Duane Morris, LLP	Legal Fees		14,379		
Law Offices Segal & Segal	Legal Fees		14,114		
Law Offices of Eugene Hollander	Legal Fees		756		
Kristine Geggie	Interior Design		5,363		
ADP	Payroll Processing		15,755		
Frost, Ruttenberg & Rothblatt	Accountants		3,510		
Behles & Behles	Architect Fees		490		
Rehab Management Systems	Reimbursement Consultant		31,200		
Callero & Callero LLP	401k Audit		6,800		
See Attached P 21 A			34,976		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$134,035		
D. Employee Benefits and Payroll Taxes					
Description			Amount		
Workers' Compensation Insurance			\$225,846		
Unemployment Compensation Insurance			75,193		
FICA Taxes			580,869		
Employee Health Insurance			149,899		
Employee Meals					
Illinois Municipal Retirement Fund (IMRF)* 401(k) Employer Contributions					
Life Insurance			101,704		
Employee Relations (Awards, Holiday and Awards celebrations Holiday gifts)			36,972		
Employee Physicals			781		
TOTAL (agree to Schedule V, line 22, col.8)			\$1,171,264		
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			5,105		
Health Care Worker Background Check (Indicate # of checks performed)	27		270		
Patient Background Checks	640		3,053		
Licenses			4,718		
Dues and Subscriptions			4,405		
Total (agree to Sch. V, line 20, col. 8)			\$16,882		
G. Schedule of Travel and Seminar**					
Description			Amount		
Out-of-State Travel			\$		
In-State Travel					
Seminar Expense			8,337		
Entertainment Expense			()		
TOTAL (agree to Sch. V, line 24, col. 8)			\$8,337		

*** Attach copy of IMRF notifications**

****See instructions.**

The Wealshire
0040956
Period Beginning 1/1/2012
Period End 12/31/12

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Personnel Planners	Unemployment Consultant	1,405
Howard, Wershbale & Co	Computer Consulting	6,464
NF and Associates, Inc	Health Benefit Consulting	2,180
Michigan Peer Review Organization	Survey Consulting	6,460
Benetech, Inc	Benefit Plan Administration	3,775
KPMG LLP	Computer Services	505
Leonard Manewith	Accountant	6,625
Computriton Inc	Computer Consulting	112
Osman Consulting	Survey Consulting	5,000
Jennifer Spino	REAC Inspection	2,450
Total		<u>34,976</u>

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	N/A												
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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. N/A

(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? N/A

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 52,165 Line 10

(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. N/A

(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. \$ 79,236
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. \$ 0 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A

(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. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 53%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A

(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 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.