

Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CENTER# 0022350 Report Period Beginning: 1/1/2007 Ending: 12/31/2007

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	26	Skilled (SNF)	26	9,490	1
2		Skilled Pediatric (SNF/PED)			2
3	47	Intermediate (ICF)	47	17,155	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	73	TOTALS	73	26,645	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 Patient Days by Level of Care and Primary Source of Payment			5		
		Medicaid Recipient	Private Pay	Other			Total
		8	SNF	3,419			5,175
9	SNF/PED					9	
10	ICF	7,895	8,260		16,155	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	11,314	13,435		24,749	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.88%D. How many bed-hold days during this year were paid by the Department? 98 (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)

N/AF. 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 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 4/14/1980J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ NO K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 26 and days of care provided 1,645Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: TAX-EXEMPT Fiscal Year: JAN-DEC

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

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Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CEN # 0022350 Report Period Beginning: 1/1/2007 Ending: 12/31/2007

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

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	223,340	23,661	4,379	251,380		251,380		251,380		1
2	Food Purchase		175,887		175,887		175,887	(308)	175,579		2
3	Housekeeping	95,750	9,622	331	105,703	35,250	140,953		140,953		3
4	Laundry	18,808		34,034	52,842		52,842		52,842		4
5	Heat and Other Utilities			76,406	76,406		76,406		76,406		5
6	Maintenance	42,063	20,627	9,125	71,815		71,815		71,815		6
7	Other (specify):*										7
8	TOTAL General Services	379,961	229,797	124,275	734,033	35,250	769,283	(308)	768,975		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	1,337,284	179,926	145,968	1,663,178	(74,709)	1,588,469		1,588,469		10
10a	Therapy										10a
11	Activities	36,291	12,181	7,992	56,464		56,464	(4,710)	51,754		11
12	Social Services					37,009	37,009		37,009		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,373,575	192,107	153,960	1,719,642	(37,700)	1,681,942	(4,710)	1,677,232		16
	C. General Administration										
17	Administrative	71,302			71,302		71,302		71,302		17
18	Directors Fees										18
19	Professional Services			16,402	16,402		16,402		16,402		19
20	Dues, Fees, Subscriptions & Promotions			12,852	12,852	2,450	15,302		15,302		20
21	Clerical & General Office Expenses	88,223	15,669	10,982	114,874		114,874		114,874		21
22	Employee Benefits & Payroll Taxes			352,037	352,037		352,037		352,037		22
23	Inservice Training & Education										23
24	Travel and Seminar			14,436	14,436		14,436	(1,322)	13,114		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			24,324	24,324		24,324		24,324		26
27	Other (specify):*										27
28	TOTAL General Administration	159,525	15,669	431,033	606,227	2,450	608,677	(1,322)	607,355		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,913,061	437,573	709,268	3,059,902		3,059,902	(6,340)	3,053,562		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 WESLEY VILLAGE HEALTH CARE CENTER #0022350 Report Period Beginning: 1/1/2007 Ending: 12/31/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			157,031	157,031		157,031		157,031			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			158,907	158,907		158,907		158,907			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			315,938	315,938		315,938		315,938			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			39,968	39,968		39,968		39,968			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			39,968	39,968		39,968		39,968			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,913,061	437,573	1,065,174	3,415,808		3,415,808	(6,340)	3,409,468			45

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

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	4,710	LN 11		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	308	LN 2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				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	1,322			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 6,340		\$	30

BHF USE ONLY						
48		49		50		51
						52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense	7,222		33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 7,222		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 13,562		37

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

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

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

STATE OF ILLINOIS
 WESLEY VILLAGE HEALTH CARE CENTER

ID# 0022350
 Report Period Beginning: 1/1/2007
 Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
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				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	0		49

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
		NOT APPLICABLE				

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$	NOT APPLICABLE		\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CEN # 0022350 Report Period Beginning: 1/1/2007 Ending: 12/31/2007

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									\$	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	\$	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 WESLEY VILLAGE HEALTH CARE CENTER # 0022350 Report Period Beginning: 1/1/2007 Ending: 2/31/2007

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CEN # 0022350 Report Period Beginning: 1/1/2007 Ending: 12/31/2007

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2	3	4	5	6		7	8	9	10	
						Original	Balance					
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO									
	A. Directly Facility Related											
	Long-Term											
1	SUBORDINATED DEBENTURES		X				\$ 323,005	\$ 190,215	VARIOUS	VARIOUS	\$ 10,692	1
2	FIRST FEDERAL BANK		X	MORTGAGE			2,725,000	1,437,355	11/13/2022	5.6000	96,675	2
3	FIRST FEDERAL BANK		X	CAPITAL FINANCING	\$8,600.00		665,450	606,395	4/1/2011	8.5000	51,540	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				\$8,600.00		\$ 3,713,455	\$ 2,233,965			\$ 158,907	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 3,713,455	\$ 2,233,965			\$ 158,907	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #

* 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.)

IMPORTANT NOTICE

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

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

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

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

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WESLEY VILLAGE HEALTH CARE CENTER COUNTY MCDONOUGH

FACILITY IDPH LICENSE NUMBER 0022350

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cos

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

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocation:

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

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

C. Tax Bills

Attach a copy of the original 2006 tax bills which were listed in Section A to this statement. Be sure to use the 20C tax bill which is normally paid during 2007

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

Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CENTER# 0022350

Report Period Beginning:

1/1/2007

Ending:

12/31/2007**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 37,893 B. General Construction Type: Exterior BRICK Frame PRESTRESSED CON Number of Stories 1C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable)

WESLEY VILLAGE RETIREMENT CENTER - 70 UNITSF. 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: 144,434 2. Number of Years Over Which it is Being Amortized: 203. Current Period Amortization: 7,222 4. Dates Incurred: 2/1/1997-1/31/1998Nature of Costs: BOND ISSUANCE EXPENSES - 1998 NEW CONSTRUCTION - SKILLED CARE UNIT

(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>NURSING HOME</u>	<u>235,224</u>	<u>1975</u>	<u>\$ 48,600</u>	<u>1</u>
2					<u>2</u>
3	<u>TOTALS</u>	<u>235,224</u>		<u>\$ 48,600</u>	<u>3</u>

Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CENTER

0022350

Report Period Beginning:

1/1/2007

Ending: 12/31/2007

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	47	1980	1980	\$ 1,304,649	\$ 25,968	50	\$ 25,968		\$ 718,625	4
5	26	1998	1997	1,934,404	50,214	50	50,214		467,562	5
6										6
7										7
8										8
Improvement Type**										
9	LAND IMPROVEMENTS									9
10	Paved parking lot		1981	28,080		15			28,080	10
11	Landscaping		1981	2,943		10			2,943	11
12	Landscaping		1984	227		10			227	12
13	Blacktop driveway		1985	559		10			559	13
14	Landscaping, install cement patio		1982	488		20			488	14
15	Landscaping		1983	681		20			681	15
16	Blacktop driveway		1986	2,668		15			2,668	16
17	Blacktop driveway		1987	15,464		15			15,464	17
18	Improve drainage		1987	1,036		15			1,036	18
19	Landscaping costs		1988	599		10			599	19
20	Improve drainage from roof area		1989	946		15			946	20
21	Blacktop driveway		1990	1,396		15			1,396	21
22	Blacktop sealer		1991	1,054	34	15	34		1,054	22
23	Blacktop sealer		1994	1,307	87	15	87		1,175	23
24	Turf & garden mix 38%		1997	322	13	10	13		143	24
25	Walking path 50%		1997	418	10	20	10		110	25
26	Concrete curbing 38%		1997	562	7	20	7		77	26
27	Walking path 50%		2000	17,911	896	20	896		7,168	27
28	Alzheimers garden enhancement		2000	4,468	223	20	223		1,784	28
29	Walking path 50%		2001	15,264	890	10	890		6,230	29
30	Glider walking path		2002	1,346	135	10	135		675	30
31	Seal & asphalt drive & parking lot		2003	7,888	367	15	367		1,735	31
32	Landscape gazebo area		2003	1,202	120	10	120		160	32
33	Landscaping around wheelchair swing		2004	856	85	10	85		340	33
34	Landscaping south garden area 50%		2004	5,618	562	10	562		2,248	34
35	Landscape HC/SCU signs		2005	519	51	10	51		153	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

STATE OF ILLINOIS

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Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CENTER

0022350

Report Period Beginning:

1/1/2007

Ending:

12/31/2007

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	BUILDING IMPROVEMENTS									37
38	Screen & doors	1981	4,500		10			4,500		38
39	Constructed carports	1981	2,000	40	50	40		1,040		39
40	Wallpaper	1981	2,264		20			2,264		40
41	Entrance signs	1981	5,920	208	30	208		2,472		41
42	Signs	1981	58		12			58		42
43	Intangibles	1981	5,742		20			5,742		43
44	Overhang roof drain	1982	342		20			343		44
45	Remodel bathroom	1982	371	8	50	8		200		45
46	Exhaust fans & lights	1982	426		20			426		46
47	Carpet	1983	169		5			169		47
48	Install satellite system	1983	4,122		15			4,122		48
49	Remodeling	1983	389	8	50	8		191		49
50	Wheelchair ramp	1984	407		10			407		50
51	Remodel showers	1984	501	17	30	17		375		51
52	Install decoder	1985	450		15			450		52
53	Redecorate resident rooms	1985	10,126		15			10,126		53
54	Install tornado siren	1986	3,056		15			3,056		54
55	Carpet	1987	538		5			538		55
56	Install TV filter	1987	68		15			68		56
57	Redecorate resident rooms	1987	7,274		15			7,274		57
58	Remodeling hallway	1988	68		15			68		58
59	Roof repair	1989	3,704		15			3,704		59
60	Emergency light	1989	35		10			35		60
61	Redecorating	1989	13,802		15			13,802		61
62	Nurse call system	1990	4,919	315	13	315		4,868		62
63	Elevator jack	1990	3,780	240	15	240		624		63
64	Solid core door	1990	735		10			735		64
65	Water system repairs	1991	1,410		10			1,410		65
66	Water heater repairs	1991	1,323		10			1,323		66
67	Replace window panes	1991	9,051	476	20	476		7,841		67
68	Install A/C food service	1992	866	43	20	43		688		68
69	Roof repair	1992	8,685		15			8,685		69
70	TOTAL (lines 4 thru 69)		\$ 3,449,976	\$ 81,017		\$ 81,017	\$	\$ 1,351,930		70

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

Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CENTER

0022350

Report Period Beginning:

1/1/2007

Ending:

12/31/2007

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,449,976	\$ 81,017		\$ 81,017	\$	\$ 1,351,930	1
2	Redesign water system	1992	2,385	95	20	95		1,425	2
3	Remodeling	1992	9,845	661	15	661		9,845	3
4	Carpeting	1993	851	57	15	57		826	4
5	Remodeling	1993	1,540		10			1,540	5
6	New entryway	1994	7,888	484	20	484		6,437	6
7	Remodeling	1994	3,216		10			3,216	7
8	Painting entryway & carpet	1995	2,456		10			2,456	8
9	Dining room floor	1996	116	6	20	6		67	9
10	Roof repairs - west end	1996	385	26	15	26		301	10
11	12 air conditioning units	1996	3,698	247	15	247		2,532	11
12	Shingle east entrance	1997	398	26	15	26		267	12
13	Border resident rooms	1997	484	25	10	25		254	13
14	Carpet installations hallway	1997	265	13	20	13		132	14
15	Vinyl floor covering	1997	1,507	75	20	75		750	15
16	Remote annunciator panel	1997	705	34	20	34		358	16
17	Heating/air conditioning units	1997	1,602	80	20	80		807	17
18	3 windows	1997	116	6	20	6		61	18
19	12 window screens	1997	126	6	20	6		63	19
20	Carpet	1997	432	36	20	36		360	20
21	Drainage from SE corner of building	1997	378	24	15	24		253	21
22	Additional wiring to pass inspection	1998	4,748	237	20	237		2,272	22
23	Window treatments	1998	10,940	547	20	547		5,288	23
24	Mixing valve	1998	2,695	180	15	180		1,650	24
25	Tuckpointing building exterior	1998	4,511	180	20	180		1,650	25
26	Flooring	1998	665	44	15	44		437	26
27	New fire alarms in Health Care	1998	10,468	523	20	523		4,795	27
28	Additional strobes due to inspection	1998	1,381	69	20	69		673	28
29	Roof repairs kitchen & SE section	1998	9,060	362	25	362		2,987	29
30	Alzheimer unit lounge flooring	1999	1,074	54	15	54		486	30
31	Health care lighting upgrade	1999	2,019	135	10	135		1,215	31
32	Fire alarm upgrade	1999	2,814	164	10	164		1,476	32
33	Heating/cooling laundry room & kitchen corridor	2000	9,000	450	20	450		3,600	33
34	TOTAL (lines 1 thru 33)		\$ 3,547,744	\$ 85,863		\$ 85,863	\$	\$ 1,410,409	34

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

Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CENTER

0022350

Report Period Beginning:

1/1/2007

Ending:

12/31/2007

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12B, Carried Forward	\$ 3,547,744	\$ 85,863		\$ 85,863	\$	\$ 1,410,409		1
2	Sewer line	2000 8,868	355	25	355		2,840		2
3	Smoking patio	2000 2,590	130	20	130		1,040		3
4	Decorate Health Care dining room	2001 7,887	307	15	307		2,149		4
5	A/C Compressor Health Care core	2001 9,076	202	15	202		1,414		5
6	Wallguards Health Care dining room	2001 970	32	15	32		224		6
7	Kitchen walk-in cooler compressor	2001 1,769	253	7	253		1,771		7
8	Generator health care	2001 989	845	7	845		989		8
9	Alzheimer water system	2001 14,079	469	20	469		3,283		9
10	Glider walking path	2002 1,346	135	10	135		810		10
11	Storage shed - cement work	2002 9,357	468	20	468		2,808		11
12	Health care center core area roof	2002 8,800	440	20	440		2,640		12
13	Outside door - Health care center hall	2003 5,600	560	10	560		2,800		13
14	Health Care center shower room tile	2003 1,475	147	10	147		735		14
15	Health care center core area remodeling	2003 1,000	100	10	100		400		15
16	Water softening system	2003 12,470	1,247	10	1,247		6,235		16
17	Garage/storage	2003 17,861	893	20	893		4,465		17
18	Health care center dining room remodeling	2004 27,065	1,804	15	1,804		7,216		18
19	Health care center core area floor plans	2004 7,414	494	15	494		1,976		19
20	Garage/storage 50%	2004 1,737	87	20	87		348		20
21	Carpet - 7 rooms health care	2004 3,910	260	15	260		1,040		21
22	Health care center activity room remodeling	2005 2,606	261	15	261		1,563		22
23	Food service department drain	2005 2,655	265	10	265		795		23
24	Health care center door locks	2005 529	53	10	53		159		24
25	Health care center doors	2005 4,395	440	10	440		1,320		25
26	A/C Units	2005 5,291	529	10	529		1,587		26
27	Garage/Workshop 50%	2005 927	46	20	46		138		27
28	Outdoor electrical	2005 1,464	98	15	98		294		28
29	Resurfacing driveway and parking lot	2005 65,430	4,492	15	4,492		7,037		29
30	Health care center remodeling	2006 2,783	185	15	185		278		30
31	Health care center carpet	2006 468	23	20	23		41		31
32	Garage door opener	2006 433	43	10	43		57		32
33	Health care center electrical panel	2006 2,340	156	15	156		169		33
34	TOTAL (lines 1 thru 33)	\$ 3,781,328	\$ 101,682		\$ 101,682	\$	\$ 1,469,030		34

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

Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CENTER

0022350

Report Period Beginning:

1/1/2007

Ending:

12/31/2007

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12C, Carried Forward	\$ 3,781,328	\$ 101,682		\$ 101,682		\$ 1,469,030		1
2	Retirement center P-TAC units	2006 12,849	856	15	856		1,284		2
3	Elevator upgrade	2006 4,980	332	15	332		554		3
4	Health care center plumbing replacement	2006 70,249	1,756	40	1,756		1,902		4
5	Health care center replace bathroom floor	2006 10,299	257	40	257		300		5
6	Upgrade sprinkler system	2006 1,632	109	15	109		136		6
7	Food service fire system	2006 3,479	497	7	497		953		7
8	Generator upgrade	2006 965	115	7	115		230		8
9	Air conditioning P-TAC units	2006 1,601	107	15	107		125		9
10	Food service laundry water heater upgrade	2006 2,921	195	15	195		374		10
11	Food service booster heater	2006 1,982	132	15	132		198		11
12	Health care center Spa bath	2006 24,334	1,622	15	1,622		1,622		12
13	Generator 1000KW	2006 387,059	15,482	25	15,482		30,834		13
14	Health care center remodeling architect fees	2007 32,169	938	20	938		938		14
15	Breakroom floor tile, paint, counter	2007 3,293	201	15	201		201		15
16	Replace kitchen wall	2007 3,709	139	20	139		139		16
17	Health care center plumbing project	2007 3,990	133	30	133		133		17
18	Major repairs to water heaters	2007 6,919	202	20	202		202		18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 4,353,758	\$ 124,755		\$ 124,755		\$ 1,509,155		34

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

Facility Name & ID Number **WESLEY VILLAGE HEALTH CARE CENTER** # **0022350** Report Period Beginning: **1/1/2007** Ending: **12/31/2007**

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	\$ 744,911	\$ 28,523	\$ 28,523	\$		\$ 210,632	71
72	Current Year Purchases	37,529	3,753	3,753			3,753	72
73	Fully Depreciated Assets	27,509					27,509	73
74								74
75	TOTALS	\$ 809,949	\$ 32,276	\$ 32,276	\$		\$ 241,894	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 5,212,307	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 157,031	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 157,031	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,751,049	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		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:
 Beginning _____
 Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	_____/2008	\$ _____
13.	_____/2009	\$ _____
14.	_____/2010	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.
 This amount was calculated by dividing the total amount to be amortized
 by the length of the lease _____.

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

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

15. Is Movable equipment rental included in building rental? YES NO

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

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

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

C. Vehicle Rental (See instructions.)

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost						
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist		hrs	\$		\$								1
2	Licensed Speech and Language Development Therapist		hrs											2
3	Licensed Recreational Therapist		hrs											3
4	Licensed Physical Therapist		hrs											4
5	Physician Care		visits											5
6	Dental Care		visits											6
7	Work Related Program		hrs											7
8	Habilitation		hrs											8
9	Pharmacy		# of prescripts											9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs											10
11	Academic Education		hrs											11
12	Exceptional Care Program													12
13	Other (specify):													13
14	TOTAL			\$		\$		\$		\$		\$		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 **WESLEY VILLAGE HEALTH CARE CENTER** # **0022350** Report Period Beginning: **1/1/2007** Ending: **12/31/2007**
 XV. BALANCE SHEET - Unrestricted Operating Fund. As of **12/31/2007** (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 37,933	\$ 189,663	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	323,248	411,810	3
4	Supply Inventory (priced at)	13,803	55,210	4
5	Short-Term Investments		957,971	5
6	Prepaid Insurance	12,414	24,828	6
7	Other Prepaid Expenses		36,061	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Wesley Estates-Inv		180,000	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 387,398	\$ 1,855,543	10
B. Long-Term Assets				
11	Long-Term Notes Receivable		732,177	11
12	Long-Term Investments		389,142	12
13	Land	48,600	180,000	13
14	Buildings, at Historical Cost	4,353,758	8,330,206	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	809,949	1,897,737	16
17	Accumulated Depreciation (book methods)	(1,751,049)	(5,066,502)	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):		19,716	22
23	Other(specify):		377,890	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,461,258	\$ 6,860,366	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,848,656	\$ 8,715,909	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 45,138	\$ 61,833	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	182,829	182,829	29
30	Accrued Salaries Payable	38,596	52,871	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,953	4,045	31
32	Accrued Real Estate Taxes(Sch.IX-B)		56,000	32
33	Accrued Interest Payable	16,960	23,233	33
34	Deferred Compensation	7,300	10,000	34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	ACCRUED EXPENSES	91,534	91,534	36
37	MEMBER FEE,APT DEPOTIST, ANNU	452,023	512,734	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 837,333	\$ 995,079	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	190,215	1,244,711	39
40	Mortgage Payable	2,043,750	1,907,500	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,233,965	\$ 3,152,211	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,071,298	\$ 4,147,290	46
47	TOTAL EQUITY(page 18, line 24)	\$ 777,358	\$ 4,568,619	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,848,656	\$ 8,715,909	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 940,980	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 940,980	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(163,622)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (163,622)	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)	\$ 777,358	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CENTER # 0022350 Report Period Beginning: 1/1/2007

Ending: 12/31/2007

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,077,724	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,077,724	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	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		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions	168,122	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 168,122	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,245,846	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	768,975	31
32	Health Care	1,677,232	32
33	General Administration	607,355	33
B. Capital Expense			
34	Ownership	315,938	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	39,968	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,409,468	40
41	Income before Income Taxes (line 30 minus line 40)**	(163,622)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (163,622)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

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

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

Facility Name & ID Number WESLEY VILLAGE HEALTH CARE CENTER

0022350

Report Period Beginning: 1/1/2007

Ending: 12/31/2007

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,825	2,080	\$ 54,098	\$ 26.01	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,041	9,200	195,165	21.21	3
4	Licensed Practical Nurses	15,070	16,800	321,354	19.13	4
5	CNAs & Orderlies	56,000	62,000	615,848	9.93	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,800	2,080	24,960	12.00	9
10	Activity Assistants	1,080	1,240	11,331	9.14	10
11	Social Service Workers	1,863	2,080	37,009	17.79	11
12	Dietician					12
13	Food Service Supervisor	1,852	2,080	37,500	18.03	13
14	Head Cook	1,920	2,080	21,005	10.10	14
15	Cook Helpers/Assistants	14,020	14,825	126,969	8.56	15
16	Dishwashers	4,600	5,215	37,866	7.26	16
17	Maintenance Workers	2,800	2,920	42,063	14.41	17
18	Housekeepers	11,250	11,758	95,750	8.14	18
19	Laundry	2,250	2,400	18,808	7.84	19
20	Administrator	1,900	2,080	71,302	34.28	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,760	6,080	88,223	14.51	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	5,105	5,500	78,560	14.28	31
32	Other Health Care(specify)	4,000	4,344	35,250	8.11	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	142,136	154,762	\$ 1,913,061 *	\$ 12.36	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	125	\$ 3,594	LN 1 COL3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	24	3,600	LN 10 COL3	39
40	Physical Therapy Consultant	11	660	LN10 COL3	40
41	Occupational Therapy Consultant	8	495	LN10 COL3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	19	1,334	LN 11 COL3	44
45	Social Service Consultant	19	1,333	LN 10 COL3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	206	\$ 11,016		49

C. CONTRACT NURSES

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

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? YES
If YES, give association name and amount. LIFE SERVICES NETWORK
- (3) Did the nursing home make political contributions or payments to a political organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (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 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 27,720 Line 10COL3
- (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. \$ 39,968
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ N/A 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? 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. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: CLIFTON GUNDERSON & CO The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? NO If no, please explain. FINAL COPY NOT RECEIVED YET
- (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.

Wesley Village
Travel and Seminars
Detail of Schedule V, Line 24

Employee	Training	Cost
1/6/2007 Shana Wiley, LPN; Gina Porumbeanu, LPN,	IV Therapy Course Lincoln Land Community College Springfield, IL	\$ 500.00
1/6/2007 Shana Wiley, LPN; Gina Porumbeanu, LPN,	Hotel accomodations for above	\$ 154.00
2/15/2007 Myron Sinnett, Director of Environmental Svcs	Employment law from A to Z in Illinois Lorman Educational Services, Peoria, IL	\$ 309.00
	Transportation & meals included	\$ 49.66
2/22/2007 Myron Sinnett, Director of Environmental Svcs Amber Carden, Director of Food Service Jeanne Jones, Director of Nursing	Building Profitable Relationships Spoon River College, Macomb, IL	\$ 80.00
3/8/2008 Karen Schoonover, C.N.A.	Restorative Nursing Assistant Training Azer Clinic, Galesburg, IL	\$ 120.00
	Transportation	\$ 67.20
3/21/2007 Mercy Rayburn, Cook, Amy Sikas, Cook, Sheryl Friday, Cook,	Waugh Food Show Peoria, IL	\$ 16.24
3/28-3/30/08 Shelly Ward, Administrator, MyronSinnett, Director of Environmental Svcs, Jeanne Jones, Director of Nursing, Debbie Hetzel, Director of Activities, Peggy Eddington, Social Services, Amber Carden Director of Food Service, Melanie Beans, MDS Coordinator	Life Services Network Annual Conference Chicago, IL	\$ 1,329.99
	Lodging and Transportation	\$ 3,330.92
4/6/2008 Amber Carden, Director of Food Service	Sanitation Instructor Seminar Peoria, IL	\$ 94.56
5/9/2007 Jeanne Jones, Director of Nursing	Workmen's Compensation Insurance Seminar, Life Services Network	\$ 85.44
5/16/2007 Jeanne Jones, Director of Nursing, Melanies Beans, MDS Coordinator,	Amazing Medicaid Race Seminar Life Services Network Springfield, IL	\$ 198.00
Jun-07 Myron Sinnett, Director of Environmental Svcs	Transportation Introduction to Long Term Care Administration College of DuPage	\$ 83.52
5-Jul-07 Shelly Ward, Administrator	EAGLE Accreditation Meeting Moline, IL	\$ 65.00
18-Jul-07 Debbie Hetzel, Director of Activities Amber Carden, Director of Food Service	Food Service Sanitation-Insightful Food Safety, Macomb, IL	\$ 145.04
Jul-07 Myron Sinnett, Director of Environmental Svcs	Introduction to Long Term Care Administration DuPage, IL	\$ 178.00
8/1/2007 Amber Carden, Director of Food Service Mercy Rayburn, Cook	Waugh Foods Show Peoria, IL	\$ 525.00
8/6/2007 Nursing staff	American Red Cross - CPR training	\$ 84.96
8/29/2007 Melanie Beans, MDS Coordinator, Teresa Rexroat, Restorative Nurse	New Standards for F323, Accident Supervision, IDPH, Springfield, IL	\$ 437.49
	Transportation	\$ 150.00
9/11/2007 Shelly Ward, Administrator	Illinois Great Rivers Conference Committee Meeting Springfield, IL	\$ 102.24
9/13/2007 Cindy Cressy, RN, Karen Schoonover, C.N.A.,	Western Illinois Area Agency on Aging Conference, Moline, IL	\$ 50.40
	Transportation	\$ 80.00
9/19/2007 Shelly Ward, Administrator, Jeanne Jones, Director of Nursing	Senior Living Conference, Life Services Network Hinsdale, IL	\$ 79.68
10/9/2007 Amber Carden, Director of Food Service	Waugh Food Shows	\$ 2,262.61
10/12/2007 Mary Jane Shyrack, Administrative Asst Myron Sinnett, Environmental Svcs Jeanne Jones, Director of Nursing	Macomb Area Chamber of Commerce Annual meeting luncheon Macomb, IL	\$ 79.20
11/6/2007 Shelly Ward, Administrator Jeanne Jones, Director of Nursing	Annual Convention and Trade Show Illinois Nursing Home Association Springfield, IL	\$ 60.00
11/16/2007 Jeanne Jones, Director of Nursing Melanie Beans, MDS Coordinator	What is Immediate Jeopardy? Life Services Network, Peoria, IL	\$ 1,214.90
11/13/2007 Debbie Hetzel, Director of Activities Peggy Eddington, Social Services	Therapy Training Program Ramirez Consulting Group Moline, IL	\$ 237.56
12/13/2007 Amber Carden, Director of Food Service	Community Leadership Training Macomb Chamber of Commerce Macomb, IL	\$ 333.90
11/29/2007 Nursing Staff	Life Techniques and Equipment Azer Clinic, Galesburg, IL	\$ 200.00
12/5/2007 Shelly Ward, Administrator	Immediate Jeopardy in the Real World Audio Seminar Life Services Network	\$ 210.00
		\$ 199.00
		\$ 13,113.51