

Facility Name & ID Number WESLEY VILLAGE

0022350 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	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 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	2,579	5,295		7,874	8	
9	SNF/PED					9	
10	ICF	7,563	7,381		14,944	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	10,142	12,676		22,818	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.64%

D. How many bed-hold days during this year were paid by the Department? 96 (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/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 4/14/1980

J. 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 983

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: TAX-EXPEMP Fiscal Year: JAN-DEC

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

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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	209,284	15,816	7,253	232,353		232,353		232,353		1
2	Food Purchase		213,097		213,097		213,097	(585)	212,512		2
3	Housekeeping	99,246	12,474	14	111,734	21,785	133,519		133,519		3
4	Laundry	19,495		29,917	49,412		49,412		49,412		4
5	Heat and Other Utilities			78,449	78,449		78,449		78,449		5
6	Maintenance	56,346	19,385	12,599	88,330		88,330		88,330		6
7	Other (specify):*										7
8	TOTAL General Services	384,371	260,772	128,232	773,375	21,785	795,160	(585)	794,575		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	1,347,664	173,288	26,187	1,547,139	(60,249)	1,486,890		1,486,890		10
10a	Therapy			68,108	68,108		68,108		68,108		10a
11	Activities	43,968	15,908	9,624	69,500		69,500	(5,187)	64,313		11
12	Social Services					35,927	35,927		35,927		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,391,632	189,196	103,919	1,684,747	(24,322)	1,660,425	(5,187)	1,655,238		16
	C. General Administration										
17	Administrative	78,764			78,764		78,764		78,764		17
18	Directors Fees										18
19	Professional Services			14,804	14,804		14,804		14,804		19
20	Dues, Fees, Subscriptions & Promotions			13,129	13,129	2,537	15,666		15,666		20
21	Clerical & General Office Expenses	106,668	12,149	14,178	132,995		132,995		132,995		21
22	Employee Benefits & Payroll Taxes			432,349	432,349		432,349		432,349		22
23	Inservice Training & Education										23
24	Travel and Seminar			9,223	9,223		9,223	(410)	8,813		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			24,437	24,437		24,437		24,437		26
27	Other (specify):*										27
28	TOTAL General Administration	185,432	12,149	508,120	705,701	2,537	708,238	(410)	707,828		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,961,435	462,117	740,271	3,163,823		3,163,823	(6,182)	3,157,641		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			199,673	199,673		199,673		199,673			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			149,385	149,385		149,385		149,385			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			349,058	349,058		349,058		349,058			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			40,079	40,079		40,079		40,079			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			40,079	40,079		40,079		40,079			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,961,435	462,117	1,129,408	3,552,960		3,552,960	(6,182)	3,546,778			45

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

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ID# 0022350

Report Period Beginning: 1/1/2009

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
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.

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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

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VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number

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IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1	CITIZENS NATIONAL BANK		X		\$32,178.18		\$ 4,192,000	\$ 4,111,644		5.5000	\$ 149,385	1							
2												2							
3												3							
4												4							
5												5							
Working Capital																			
6												6							
7												7							
8												8							
9	TOTAL Facility Related				\$32,178.18		\$ 4,192,000	\$ 4,111,644			\$ 149,385	9							
B. Non-Facility Related*																			
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$ 4,192,000	\$ 4,111,644			\$ 149,385	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.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and

1. Real Estate Tax accrual used on 2008 report.		\$	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.)		\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	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.		\$	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2004	_____	8
	2005	_____	9
	2006	_____	10
	2007	_____	11
	2008	_____	12
	13	FROM R. E. TAX STATEMENT FOR 2008 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

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

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X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,893 B. General Construction Type: Exterior BRICK Frame PRESTRESSED CONC 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).

WESLEY VILLAGE RETIREMENT CENTER - 70 UNITS

WESLEY ESTATES INDEPENDENT LIVING DUPLEXES - 18 UNITS

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: 144,434 2. Number of Years Over Which it is Being Amortized: 20
 3. Current Period Amortization: 7,222 4. Dates Incurred: 2/1/1997 - 1/31/1998

Nature of Costs: BOND ISSUANCE COSTS - 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 Use	2 Square Feet	3 Year Acquired	4 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	TOTALS	235,224		\$ 48,600	3

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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	\$	\$ 770,561	4
5	26	1998	1997	1,934,404	50,214	50	50,214		567,990	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		15			1,054	22
23	Blacktop sealer		1994	1,307	45	15	45		1,307	23
24	Turf & garden mix 38%		1997	322		10			322	24
25	Walking Path 50%		1997	418	10	20	10		130	25
26	Concrete Curbing 38%		1997	562	7	20	7		91	26
27	Walking Path 50%		2000	17,911	896	20	896		8,960	27
28	Alzheimers garden enhancement		2000	4,468	223	20	223		2,230	28
29	Walking Path 50%		2001	15,264	890	10	890		8,010	29
30	Glider Walking Path		2002	1,346	135	10	135		945	30
31	Seal & asphalt drive & parking lot		2003	7,888	367	15	367		2,469	31
32	Landscape Gazebo Area		2003	1,202	120	10	120		400	32
33	Landscaping around wheelchair swing		2004	856	85	10	85		510	33
34	Landscaping south garden area 50%		2004	5,618	562	10	562		3,372	34
35	Landscape HC/SCU signs		2005	519	51	10	51		255	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

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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		1,120	39
40	Wallpaper	1981	2,264		20			2,264	40
41	Entrance signs	1981	5,920	208	30	208		2,888	41
42	Signs	1981	58		12			58	42
43	Intangibles	1981	5,742		20			5,742	43
44	Overhang roof drain	1982	342		20			342	44
45	Remodel bathroom	1982	371	8	50	8		216	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		207	49
50	Wheelchair Ramp	1984	407		10			407	50
51	Remodel showers	1984	501	17	30	17		409	51
52	Install Décor	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		13			4,919	62
63	Elevator Jack	1990	3,780		15			3,780	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		8,793	67
68	Install A/C food Service	1992	866	43	20	43		774	68
69	Roof Repair	1992	8,685		15			8,685	69
70	TOTAL (lines 4 thru 69)		\$ 3,449,976	\$ 80,373		\$ 80,373	\$	\$ 1,516,103	70

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

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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	\$ 80,373		\$ 80,373	\$	\$ 1,516,103	1
2	Redisgn water system	1992	2,385	95	20	95		1,615	2
3	Remodeling	1992	9,845		15			9,845	3
4	Carpeting	1993	851	25	15	25		876	4
5	Remodeling	1993	1,540		10			1,540	5
6	New Entryway	1994	7,888	484	20	484		7,405	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		79	9
10	Roof repairs - west end	1996	385	26	15	26		353	10
11	12 air conditioning units	1996	3,698	247	15	247		3,026	11
12	Shingle east entrance	1997	398	26	15	26		319	12
13	Border resident rooms	1997	484		10			484	13
14	Carpet installations hallway	1997	265	13	20	13		158	14
15	Vinyl floor covering	1997	1,507	75	20	75		900	15
16	Remote annunciator panel	1997	705	34	20	34		426	16
17	Heating/air conditioning units	1997	1,602	80	20	80		967	17
18	3 windows	1997	116	6	20	6		73	18
19	12 window screens	1997	126	6	20	6		132	19
20	Carpet	1997	432	36	20	36		432	20
21	Drainage from SE corner of Building	1997	378	24	15	24		301	21
22	Additional wiring to pass inspection	1998	4,748	237	20	237		2,746	22
23	Window treatments	1998	10,940	547	20	547		6,382	23
24	Mixing valve	1998	2,695	180	15	180		2,010	24
25	Tuckpointing building exterior	1998	4,511	180	20	180		2,010	25
26	Flooring	1998	665	44	15	44		525	26
27	New fire alarms in Health Care	1998	10,468	523	20	523		5,841	27
28	Additional strobes due to inspection	1998	1,381	69	20	69		811	28
29	Roof repairs kitchen & SE section	1998	9,060	362	25	362		3,711	29
30	Alzheimer unit lounge flooring	1999	1,074	54	15	54		594	30
31	Health care lighting upgrade	1999	2,019	202	10	202		2,019	31
32	Fire alarm upgrade	1999	2,814	281	10	281		2,814	32
33	Heating/cooling laundry room & kitchen corridor	2000	9,000	450	20	450		4,500	33
34	TOTAL (lines 1 thru 33)		\$ 3,547,744	\$ 84,685		\$ 84,685	\$	\$ 1,584,669	34

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

Facility Name & ID Number WESLEY VILLAGE

0022350

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,547,744	\$ 84,685		\$ 84,685	\$	\$ 1,584,669	1
2	Sewer line	2000	8,868	355	25	355		3,550	2
3	Smoking patio	2000	2,590	130	20	130		1,300	3
4	Decorate Health Care dining room	2001	7,887	307	15	307		2,763	4
5	A/C Compressor Health Care core	2001	9,076	202	15	202		1,818	5
6	Wallguards Health Care dining room	2001	970	32	15	32		288	6
7	Kitchen walk-in cooler compressor	2001	1,769		7			1,769	7
8	Generator Health Care	2001	989		7			989	8
9	Alzheimer water system	2001	14,079	469	20	469		4,221	9
10	Glider walking path	2002	1,346	135	10	135		1,080	10
11	Storage shed - cement work	2002	9,357	468	20	468		3,744	11
12	Health care center core area roof	2002	8,800	440	20	440		3,520	12
13	Outside door - Health care center hall	2003	5,600	560	10	560		3,920	13
14	Health Care center shower room tile	2003	1,475	147	10	147		1,029	14
15	Health Care center core area remodeling	2003	1,000	100	10	100		600	15
16	Water softening system	2003	12,470	1,247	10	1,247		8,729	16
17	Garage/storage	2003	17,861	893	20	893		6,251	17
18	Health Care center dining room remodeling	2004	27,065	1,804	15	1,804		10,824	18
19	Health Care center core area floor plans	2004	7,414	494	15	494		2,964	19
20	Garage/Storage 50%	2004	1,737	87	20	87		522	20
21	Carpet - 7 rooms health care	2004	3,910	260	15	260		1,560	21
22	Health care center activity room remodeling	2005	2,606	261	15	261		2,085	22
23	Food service department drain	2005	2,655	265	10	265		1,325	23
24	Health Care center door locks	2005	529	53	10	53		265	24
25	Health care center doors	2005	4,395	440	10	440		2,200	25
26	A/C Units	2005	5,291	529	10	529		2,645	26
27	Garage/Workshop 50%	2005	927	46	20	46		230	27
28	Outdoor electrical	2005	1,464	98	15	98		490	28
29	Resurfacing driveway and parking lot	2005	65,430	4,492	15	4,492		16,021	29
30	Health Care center remodeling	2006	2,783	185	15	185		648	30
31	Health Care center carpet	2006	468	23	20	23		87	31
32	Garage door opener	2006	433	43	10	43		143	32
33	Health Care center electrical panel	2006	2,340	156	15	156		481	33
34	TOTAL (lines 1 thru 33)		\$ 3,781,328	\$ 99,406		\$ 99,406	\$	\$ 1,672,730	34

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

Facility Name & ID Number WESLEY VILLAGE

0022350

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 3,781,328	\$ 99,406		\$ 99,406	\$	\$ 1,672,730	1
2	Retirement center PTAC units	2006	12,849	856	15	856		2,996	2
3	Elevator upgrade	2006	4,980	332	15	332		1,218	3
4	Health Care center plumbing replacement	2006	70,249	1,756	40	1,756		5,414	4
5	Health Care center replace bathroom floor	2006	10,299	257	40	257		814	5
6	Upgrade sprinkler system	2006	1,632	109	15	109		354	6
7	Food service fire system	2006	3,479	497	7	497		1,947	7
8	Generator upgrade	2006	965	115	7	115		460	8
9	Air conditioning P-TAC units	2006	1,601	107	15	107		339	9
10	Food service laundry water heater upgrade	2006	2,921	195	15	195		764	10
11	Food service booster heater	2006	1,982	132	15	132		462	11
12	Health Care center spa bath	2006	24,334	1,622	15	1,622		4,866	12
13	Generator 1000KW	2006	387,059	15,482	25	15,482		61,798	13
14	Health Care Center remodeling architect fees	2007	32,169	1,608	20	1,608		4,155	14
15	Breakroom floor tile paint counter	2007	3,293	220	15	220		641	15
16	Replace Kitchen wall	2007	3,709	185	20	185		510	16
17	Health care center plumbing project	2007	3,990	133	30	133		399	17
18	Major repairs to water heaters	2007	6,919	346	20	346		893	18
19	Rehab signing	2008	510	102	5	102		204	19
20	health car remodel flooring lighting ceilings demo	2008	434,525	21,726	20	21,726		21,726	20
21	New parking lot/sidewalk/railing	2008	57,631	2,882	20	2,882		3,123	21
22	A/C Heat in Health Care Center	2008	54,566	2,728	20	2,728		4,320	22
23	Nurse call system	2008	16,690	2,384	7	2,384		2,426	23
24	Fire Door - HCC office	2008	724	36	20	36		63	24
25	Rehab roof	2008	10,418	521	20	521		825	25
26	HCC Hallway Remodeling	2008	2,353	118	20	118		196	26
27	Maintenance Building	2008	66,103	1,653	40	1,653		1,653	27
28	HCC Entrance Canopies	2008	3,770	186	20	186		186	28
29	Rehab new flooring at nurses station	2008	3,239	162	20	162		162	29
30	Garage lighting	2008	2,337	117	20	117		117	30
31	water heaters	2008	102,723	5,136	20	5,136		5,136	31
32	Health Care center Remodeling flooring, paint, wallpaper	2009	181,019	3,771	20	3,771		3,771	32
33	Maintenance Building	2009	16,473	34	40	34		34	33
34	TOTAL (lines 1 thru 33)		\$ 5,306,839	\$ 164,915		\$ 164,915	\$	\$ 1,804,703	34

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

XI. OWNERSHIP COSTS (continued)

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

1	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		\$ 5,306,839	\$ 164,915		\$ 164,915	\$	\$ 1,804,703	1
2	2009	38,550	482		482		482	2
3	2009	2,923	110		110		110	3
4	2009	6,030	25		25		25	4
5	2009	3,076	64		64		64	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		\$ 5,357,418	\$ 165,596		\$ 165,596	\$	\$ 1,805,384	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 908,405	\$ 20,835	\$ 20,835	\$		\$ 257,629	71
72	Current Year Purchases	49,671	3,569	3,569			3,569	72
73	Fully Depreciated Assets	27,509					27,509	73
74								74
75	TOTALS	\$ 985,585	\$ 24,404	\$ 24,404	\$		\$ 288,707	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	14 passenger bus with lift	Chevy 2008 model	2008	\$ 48,364	\$ 9,673	\$ 9,673	\$	5	\$ 12,897	76
77										77
78										78
79										79
80	TOTALS			\$ 48,364	\$ 9,673	\$ 9,673	\$		\$ 12,897	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)	\$ 6,439,967	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 199,673	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 199,673	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)	\$ 2,106,988	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

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

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

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

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

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

YES NO

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

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		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	Other (specify):									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.

Facility Name & ID Number WESLEY VILLAGE# 0022350Report Period Beginning: 1/1/2009Ending: 12/31/2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2009

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 179,272	\$ 749,876	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	279,965	304,467	3
4	Supply Inventory (priced at)	25,133	76,162	4
5	Short-Term Investments		873,932	5
6	Prepaid Insurance	20,562	41,124	6
7	Other Prepaid Expenses	61,064	122,129	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Wesley Estates Investment</u>		180,000	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 565,996	\$ 2,347,690	10
B. Long-Term Assets				
11	Long-Term Notes Receivable		569,255	11
12	Long-Term Investments		458,103	12
13	Land	48,600	180,000	13
14	Buildings, at Historical Cost	5,357,418	9,809,463	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,033,949	2,148,148	16
17	Accumulated Depreciation (book methods)	(2,106,988)	(5,795,817)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe <u>annuities</u>)		9,746	22
23	Other(specify): <u>land improvements</u>		445,892	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,332,979	\$ 7,824,790	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,898,975	\$ 10,172,480	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 105,709	\$ 114,902	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	84,889	106,111	29
30	Accrued Salaries Payable	63,791	75,049	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		67,559	32
33	Accrued Interest Payable	12,306	15,383	33
34	Deferred Compensation	5,950	7,000	34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Accrued expenses</u>	113,409	133,422	36
37	<u>Member fee, apt deposit</u>	206,744	413,488	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 592,798	\$ 932,914	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	4,026,755	5,033,444	39
40	Mortgage Payable			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)	\$ 4,026,755	\$ 5,033,444	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,619,553	\$ 5,966,358	46
47	TOTAL EQUITY(page 18, line 24)	\$ 279,422	\$ 4,206,122	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,898,975	\$ 10,172,480	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 483,571	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 483,571	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(204,149)	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)	\$ (204,149)	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)	\$ 279,422	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number WESLEY VILLAGE

0022350

Report Period Beginning: 1/1/2009

Ending: 12/31/2009

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,181,270	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,181,270	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	167,541	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 167,541	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)	\$ 3,348,811	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	773,375	31
32	Health Care	1,684,747	32
33	General Administration	705,701	33
B. Capital Expense			
34	Ownership	349,058	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	40,079	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,552,960	40
41	Income before Income Taxes (line 30 minus line 40)**	(204,149)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (204,149)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A 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**

0022350

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,852	2,080	\$ 56,139	\$ 26.99	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,985	6,350	143,197	22.55	3
4	Licensed Practical Nurses	15,875	16,752	327,198	19.53	4
5	CNAs & Orderlies	51,153	56,287	683,911	12.15	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,817	2,080	30,309	14.57	9
10	Activity Assistants	1,346	1,500	13,659	9.11	10
11	Social Service Workers	1,911	2,080	35,927	17.27	11
12	Dietician					12
13	Food Service Supervisor	1,799	2,080	39,397	18.94	13
14	Head Cook	1,803	2,080	22,345	10.74	14
15	Cook Helpers/Assistants	11,630	12,567	119,806	9.53	15
16	Dishwashers	3,250	3,467	27,736	8.00	16
17	Maintenance Workers	3,350	3,500	56,346	16.10	17
18	Housekeepers	11,393	11,750	99,246	8.45	18
19	Laundry	1,944	2,000	19,495	9.75	19
20	Administrator	1,800	2,080	78,764	37.87	20
21	Assistant Administrator					21
22	Other Administrative	1,856	2,080	28,000	13.46	22
23	Office Manager					23
24	Clerical	5,792	6,478	78,668	12.14	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	4,297	4,747	100,731	21.22	31
32	Other Health Care(specify)	62	62	561	9.05	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	128,915	140,020	\$ 1,961,435 *	\$ 14.01	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	131	\$ 4,211	LN 1 COL 3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	24	3,600	LN 10 COL 3	39
40	Physical Therapy Consultant	22	1,290	LN 10 COL 3	40
41	Occupational Therapy Consultant	3	165	LN 10 COL 3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	3	150	LN 10 COL 3	43
44	Activity Consultant	22	1,547	LN 11 COL 3	44
45	Social Service Consultant	22	1,547	LN 10 COL 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	226	\$ 12,510		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

Facility Name & ID Number WESLEY VILLAGE

0022350

Report Period Beginning: 1/1/2009

Ending: 12/31/2009

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. Life Services Network
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? 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? 10YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 22,447 Line 10 COL 3
- (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. \$ 40,079
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. \$ 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 LLP
- (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.