

		FOR BHF USE					

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

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

<p>I. IDPH License ID Number: <u>0005439</u></p> <p>Facility Name: <u>WESLEY PLACE</u></p> <p>Address: <u>1415 WEST FOSTER AVENUE</u> <u>CHICAGO</u> <u>60640</u> <small>Number City Zip Code</small></p> <p>County: <u>COOK</u></p> <p>Telephone Number: <u>(773) 769-5500</u> Fax # <u>(773) 769-6287</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>UNKNOWN</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>501c3</u> </td> <td style="width:33%; border: none;"> <input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Jim Zoros, Chief Financial Officer</u> Telephone Number: <u>(773) 769-5500</u> Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>501c3</u>	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/12</u> to <u>12/31/12</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) <u>William A. Lowe</u> (Title) <u>Chief Executive Officer</u></td> </tr> <tr> <td style="width:20%; padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # ()</td> </tr> </table> <p align="right"> MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630 </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>William A. Lowe</u> (Title) <u>Chief Executive Officer</u>	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # ()
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>501c3</u>	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>William A. Lowe</u> (Title) <u>Chief Executive Officer</u>							
Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # ()							

Facility Name & ID Number WESLEY PLACE

0005439 Report Period Beginning: 01/01/12 Ending: 12/31/12

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed 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	126	Skilled (SNF)	126	46,116	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	126	TOTALS	126	46,116	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	11,086	6,295	6,034	23,415	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,086	6,295	6,034	23,415	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 50.77%

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

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

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 1898

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 126 and days of care provided 5,342

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

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

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	280,106	37,543	174,998	492,647		492,647		492,647		1
2	Food Purchase		239,005		239,005		239,005	(9,321)	229,684		2
3	Housekeeping	152,073	39,683		191,756		191,756		191,756		3
4	Laundry	20,053	7,537		27,590		27,590		27,590		4
5	Heat and Other Utilities			145,815	145,815		145,815		145,815		5
6	Maintenance	123,932	39,103	117,461	280,496		280,496		280,496		6
7	Other (specify):*										7
8	TOTAL General Services	576,164	362,871	438,274	1,377,309		1,377,309	(9,321)	1,367,988		8
	B. Health Care and Programs										
9	Medical Director			63,620	63,620		63,620		63,620		9
10	Nursing and Medical Records	1,670,956	161,100	76,698	1,908,754		1,908,754	(16,326)	1,892,428		10
10a	Therapy	22,447	3,707		26,154		26,154		26,154		10a
11	Activities	41,866	5,482	8,277	55,625		55,625		55,625		11
12	Social Services	119,246	1,745	5,007	125,998		125,998		125,998		12
13	CNA Training										13
14	Program Transportation			10,713	10,713		10,713	(1,204)	9,509		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,854,515	172,034	164,315	2,190,864		2,190,864	(17,530)	2,173,334		16
	C. General Administration										
17	Administrative	138,398			138,398		138,398		138,398		17
18	Directors Fees										18
19	Professional Services			110,728	110,728		110,728		110,728		19
20	Dues, Fees, Subscriptions & Promotions			87,344	87,344		87,344	(50,400)	36,944		20
21	Clerical & General Office Expenses	495,410	50,740	60,018	606,168		606,168	44,394	650,562		21
22	Employee Benefits & Payroll Taxes			738,053	738,053		738,053		738,053		22
23	Inservice Training & Education			134	134		134		134		23
24	Travel and Seminar			11,756	11,756		11,756		11,756		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			99,045	99,045		99,045		99,045		26
27	Other (specify):*										27
28	TOTAL General Administration	633,808	50,740	1,107,078	1,791,626		1,791,626	(6,006)	1,785,620		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,064,487	585,645	1,709,667	5,359,799		5,359,799	(32,857)	5,326,942		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 PLACE

#0005439

Report Period Beginning:

01/01/12

Ending:

12/31/12

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			594,882	594,882	594,882	(120,000)	474,882				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			206,381	206,381	206,381	(4,394)	201,987				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			10,165	10,165	10,165		10,165				35
36	Other (specify):*											36
37	TOTAL Ownership			811,428	811,428	811,428	(124,394)	687,034				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		304,717	680,730	985,447	985,447		985,447				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			178,876	178,876	178,876		178,876				42
43	Other (specify):* Non-Allowable	50,985		2,661,859	2,712,844	2,712,844	(2,712,844)					43
44	TOTAL Special Cost Centers	50,985	304,717	3,521,465	3,877,167	3,877,167	(2,712,844)	1,164,323				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,115,472	890,362	6,042,560	10,048,394	10,048,394	(2,870,095)	7,178,299				45

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

Facility Name & ID Number **WESLEY PLACE**

0005439

Report Period Beginning: **01/01/12**

Ending: **12/31/12**

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	(9,321)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,420)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(4,394)	32		10
11	Discounts, Allowances, Rebates & Refunds	(13,232)	10		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				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	49,743	21		24
25	Fund Raising, Advertising and Promotional	(49,501)	20		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(899)	20		28
29	Other-Attach Schedule	(2,840,071)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (2,870,095)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (2,870,095)		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.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

WESLEY PLACE

ID# 0005439

Report Period Beginning: 01/01/12

Ending: 12/31/12

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Marketing Salaries	\$ (50,985)	43	1
2	Marketing Travel	(3,762)	43	2
3	Resident Transportation Revenue	(1,204)	14	3
4	Miscellaneous Resident Revenue	(3,094)	10	4
5	Misc Income - Other	(2,929)	21	5
6	Non-Nursing Home Expenses	(2,658,097)	43	6
7	Depreciation on Non-Care Asset	(120,000)	30	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	(2,840,071)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WESLEY PLACE# 0005439

Report Period Beginning:

01/01/12

Ending:

12/31/12

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(9,321)	0	0	0	0	0	0	0	0	0	0	(9,321)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(9,321)	0	(9,321)	8									
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(16,326)	0	0	0	0	0	0	0	0	0	0	(16,326)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(1,204)	0	0	0	0	0	0	0	0	0	0	(1,204)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(17,530)	0	(17,530)	16									
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(50,400)	0	0	0	0	0	0	0	0	0	0	(50,400)	20
21	Clerical & General Office Expenses	44,394	0	0	0	0	0	0	0	0	0	0	44,394	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(6,006)	0	(6,006)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(32,857)	0	(32,857)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WESLEY PLACE

0005439

Report Period Beginning:

01/01/12

Ending:

12/31/12

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(120,000)	0	0	0	0	0	0	0	0	0	0	(120,000)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,394)	0	0	0	0	0	0	0	0	0	0	(4,394)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(124,394)	0	(124,394)	37									
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(2,712,844)	0	0	0	0	0	0	0	0	0	0	(2,712,844)	43
44	TOTAL Special Cost Centers	(2,712,844)	0	(2,712,844)	44									
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(2,870,095)	0	0	0	0	0	0	0	0	0	0	(2,870,095)	45

Facility Name & ID Number WESLEY PLACE

0005439

Report Period Beginning:

01/01/12

Ending:

12/31/12

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
UNITED METHODIST HOMES & SERVIC	100%			NAPER VALLEY CO	CHICAGO	SR HOME IMPROV
				UMH&S FOUNDATI	CHICAGO	FOUNDATION
				WINWOOD APARTM	CHICAGO	ELDERLY HOUSIN
				UNITED NURSING S	CHICAGO	NURSE RECRUTE

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		\$			\$	\$	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.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0	\$ *

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

Facility Name & ID Number

WESLEY PLACE

0005439

Report Period Beginning:

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VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2	Maurlea Babb	BOD						2
3	Thomas Burkle	BOD						3
4	John Callen	BOD						4
5	Noel DeBacker	BOD						5
6	Leslie Desmond	BOD						6
7	Michael Dudley	BOD						7
8	Kathleen West	BOD						8
9	J. Herbert Landon	BOD						9
10	Larry Loecker	BOD						10
11	William A. Lowe	BOD						11
12	Cletus Moll	BOD						12
13	J. Christian Slusher	BOD						13
14	Martha Strong	BOD						14
15	Samuel Witwer	BOD						15
16	M. Richard Wright	BOD						16
17	Lawrence Zydowsky	BOD						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

Facility Name & ID Number WESLEY PLACE # 0005439 Report Period Beginning: 01/01/12 Ending: 12/31/12

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	N/A								\$		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 PLACE

0005439 Report Period Beginning: 01/01/12 Ending: 12/31/12

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 PLACE

0005439

Report Period Beginning:

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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	Name of Lender	2		3	4	5	6		8	9	10	11						
		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	Axis Capital		X	DIRECTV Satellite Dish -	\$415.00	05/01/07	\$ 20,604	\$	05/01/2012	0.0800	\$ 163	1						
2				for resident television service								2						
3												3						
4	Illinois Finance Authority		X	Revenue Bonds, Series 2012		03/01/12	4,834,400	4,834,400	03/01/2042	Variable	206,218	4						
5				Facility Renovations								5						
Working Capital																		
6												6						
7												7						
8							Interest Income Offset				(4,394)	8						
9	TOTAL Facility Related				\$415.00		\$ 4,855,004	\$ 4,834,400			\$ 201,987	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 4,855,004	\$ 4,834,400			\$ 201,987	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 bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2011 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 2012 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:	2007 _____	8	FOR BHF USE ONLY			
	2008 _____	9				
	2009 _____	10				
	2010 _____	11				
	2011 _____	12				
N/A - Facility is not subject to real estate taxes			13	FROM R. E. TAX STATEMENT FOR 2011	\$	13
			14	PLUS APPEAL COST FROM LINE 5	\$	14
			15	LESS REFUND FROM LINE 6	\$	15
			16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WESLEY PLACE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0005439

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2011.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>N/A - Facility is not subject to real estate taxes</u>	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number WESLEY PLACE

0005439 Report Period Beginning:

01/01/12 Ending:

12/31/12

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 68,281 B. General Construction Type: Exterior BRICK Frame CONCRETE BLOCK Number of Stories 5

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).

Related business entities are identified on page 6, Schedule VII - Related Parties. Specific facilities located adjacent to Wesley Place are

Winwood Apartments, Inc. - 1406 W. Winona - a 31 unit HUD subsidized apartment building for very low income adults

Glenwood Apartments - 5027 N. Glenwood - a 13 unit apartment complex for very low income adults

Foster Apartments - 1433 W. Foster - 2 flat - intergenerational housing.

Wellness Center Building - 1355 W. Foster - contains offices of United Methodist Homes & Services, UMH&S Foundation, and Home Care

Hiram Property - 1351 W. Foster - storage and parking for the organization.

The costs for these entities are segregated and not included as part of the financial information presented on this report for Wesley Place

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	HEALTH CARE	39,375	1898-1950	\$ 25,000	1
2	HEALTH CARE - Market Value Write Up		2010	1,975,000	2
3	TOTALS	39,375		\$ 2,000,000	3

Facility Name & ID Number WESLEY PLACE

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	42		1922	\$ 214,000	\$		\$	\$	\$ 214,000	4
5	48		1951	297,000					297,000	5
6			1972	941,207					941,207	6
7	8		1973	541,942					541,942	7
8	28		1974	479,275					479,275	8
Improvement Type**										
9	Additions - 1975		1975	898,240					898,240	9
10	Additions - 1976		1976	1,203					1,203	10
11	Additions - 1980		1980	1,300					1,306	11
12	Additions - 1983		1983	215					215	12
13	Additions - 1984		1984	1,188					1,188	13
14	Additions - 1985		1985	7,958					7,958	14
15	Additions - 1986		1986	31,965					31,965	15
16	Additions - 1987		1987	3,680					3,680	16
17	Additions - 1988		1988	41,556					41,556	17
18	Additions - 1989		1989	123,634					123,634	18
19	Additions - 1990		1990	81,482					81,555	19
20	Additions - 1991		1991	155,195					154,296	20
21	Additions - 1992		1992	276,411					271,528	21
22	Additions - 1993		1993	226,117					219,587	22
23	Additions - 1994		1994	261,289	312		312		257,006	23
24	Additions - 1995		1995	162,755	14		14		162,650	24
25	Additions - 1996		1996	281,475	7,177		7,177		220,463	25
26	Additions - 1997		1997	55,643	716		716		63,339	26
27	Additions - 1998		1998	110,213	15		15		110,066	27
28	Additions - 1999		1999	34,124	240		240		31,355	28
29	Additions - 2000		2000	136,254	1,967		1,967		121,342	29
30	Additions - 2001		2001	101,321	546		546		93,953	30
31	Additions - 2002		2002	245,777	12,152		12,152		243,416	31
32	Additions - 2003		2003	230,162	21,417		21,417		204,810	32
33	Additions - 2004		2004	84,046	5,642		5,642		73,151	33
34	Additions - 2005		2005	244,694	24,125		24,125		180,937	34
35										35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number WESLEY PLACE

0005439

Report Period Beginning:

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Ending:

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Resident Room - Painting, Sinks, Toilets, Grab Bars, Window Cove	2006	\$ 40,854	\$ 4,085	10	\$ 4,085	\$	\$ 26,553	37
38	Lobby/Entrance/Utility Room - Vinyl Flooring, Intallation of new I	2006	91,208	9,121	10	9,121		59,286	38
39	Roofing for The Methodist Home	2006	2,000	200	10	200		1,300	39
40	Lower Level - Rehab Areas, Painting, Flooring, Electrical, Gym In	2006	44,794	4,479	10	4,479		29,115	40
41	2nd Floor - Swift Corridor - New Doors & Frames, Painting	2006	3,565	357	10	357		2,319	41
42	4th Floor Dining Room - Wall Protection, Handrails, Windows Cov	2006	2,588	259	10	259		1,683	42
43	Fire Alarm Smoke Detector/Sprinkler System	2006	70,839	7,084	10	7,084		46,046	43
44	Building Water Cooler	2006	860	43	20	43		279	44
45	Carpeting - Resident Rooms #281, #282, #283, Lower Level-Bush H	2006	16,209		5			16,209	45
46	Lawn Sprinkler System	2006	10,200	1,020	10	1,020		6,630	46
47	Perimeter Fence Upgrade Installed	2006	5,500	550	10	550		3,575	47
48	Landscaping -Trees & Shrubs for The Methodist Home	2006	6,300	630	10	630		4,095	48
49									49
50	1st Floor Nursing Station/Utility Room - Plumbing, Carpentrv, Des	2007	56,005	5,600	10	5,600		30,800	50
51	Chimney Replacement - The Methodist Home Roof	2007	53,190	5,319	10	5,319		29,255	51
52	Bathrooms - 2nd Floor/LL - Replaced Walls, Tubs, Toilets, Shower	2007	28,572	2,857	10	2,857		15,714	52
53	Resident Room - Painting - Rms 79, 459, 461, 466, 477, 268, 457, 26	2007	18,377	1,838	10	1,838		10,108	53
54	Painting - 2nd Floor - Bush Hall & 4th Floor Dayroom/Hallway/Dc	2007	5,440	544	10	544		2,992	54
55	Fire Alarm System Sprinklers - 1st Floor - Miller & Swift Hallway	2007	5,240	524	10	524		2,882	55
56	Smoke Dampers & Co2 Exhaust- 2nd Floor Resident Dining Room	2007	7,519	376	20	376		2,068	56
57	New Feed Pump Assembly - Boiler Room - The Methodist Home	2007	15,990	640	25	640		3,520	57
58	Carpeting/Flooring - 2nd Floor - Bush Hall - Common Areas and N	2007	28,509	2,850	5	2,850		28,509	58
59	Repaving of Parking Lot - The Methodist Home	2007	2,471	247	10	247		1,359	59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,787,551	\$ 122,946		\$ 122,946	\$	\$ 6,398,120	70

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

Facility Name & ID Number WESLEY PLACE

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 6,787,551	\$ 122,946		\$ 122,946	\$	\$ 6,398,120	1
2									2
3	Resident Room Painting - #'s 66, 72, 79	2008	6,704	671	10	671		3,020	3
4	Painting - Ground Floor - Dining Room/Common Areas/Bathroom	2008	7,815	782	10	782		3,518	4
5	Installed Fire Sprinkler Pumps and Wiring - Utility Room	2008	3,143	314	10	314		1,413	5
6	Painting and Interior Design - 1st Floor - Foyer/Common Hallways	2008	16,403	1,640	10	1,640		7,380	6
7	Design and Schematics for Day Room and Foyer/Hallways	2008	2,800	280	10	280		1,260	7
8	Construction/Countertop Installation - 3rd Floor Nursing Station	2008	5,272	527	10	527		2,372	8
9	Emergency Power/Lighting Upgrade - North Entrance/2nd Floor N	2008	11,552	577	20	577		2,598	9
10	Hot and Cold Circulating Pumps and Bearing Assemblies	2008	2,112	106	20	106		476	10
11	Boiler Room - Steam Trap/Condensate Pump/Control Switch Insta	2008	6,640	265	25	265		1,193	11
12	Resident Room - HVAC Fan Motor Replacement	2008	2,503	100	25	100		450	12
13	Chiller/Boiler Room - New Feed Pump, Thermostat & Flush Gun	2008	3,668	147	25	147		661	13
14	Boiler - Retube - Complete	2008	17,282	691	25	691		3,110	14
15	Cooling Tower Replacement	2008	17,644	706	25	706		3,177	15
16	Carpeting/Flooring - 2nd Floor - Bush Hall - 1st Floor Hallways/At	2008	46,410	9,282	5	9,282		41,769	16
17									17
18	Fifth Floor - Masonry/Brick Replacement	2009	9,175	917	10	917		3,209	18
19	Construction of New Nursing Stations - 1st/3rd Floors - Laminate	2009	5,054	505	10	505		1,768	19
20	Third Floor Hallways - Installed ADA Door Closers and Painted H	2009	7,550	755	10	755		2,643	20
21	Fire Smoke Dampers/Sprinkler Heads installed on 1st, 4th Floors,	2009	12,585	1,259	10	1,259		4,406	21
22	Fourth Floor Hallway/Day Room - Installed New Vinyl Flooring ar	2009	12,831	1,283	10	1,283		4,491	22
23	Resident Rooms - New Plank and Amtico Flooring - Rooms #55,56,	2009	21,055	2,106	10	2,106		7,371	23
24	Front & Rear Elevators - New Power Supply, Transformer, and Sv	2009	4,242	424	10	424		1,484	24
25	Hydraulic Freight Lift - Receiving Dock	2009	3,820	191	20	191		669	25
26	New Fire Stop Actuators and Ductwork	2009	6,600	264	25	264		924	26
27	Resident Rooms - New Ceiling Fan Coil Motors	2009	2,503	100	25	100		350	27
28	Boiler Room - Replacement of Pnuematic Control System, Gas Val	2009	6,737	269	25	269		942	28
29	Chiller Room - HVAC - Replacement of Main Control Board, Cold	2009	23,092	924	25	924		3,234	29
30	Carpeting - Resident Rooms #75, #77, #80; 3rd & 4th Floor Hallwa	2009	24,602	4,920	5	4,920		17,219	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,077,345	\$ 152,951		\$ 152,951	\$	\$ 6,519,227	34

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

Facility Name & ID Number WESLEY PLACE

0005439

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 7,077,345	\$ 152,951		\$ 152,951	\$	\$ 6,519,227	1
2									2
3	Hot Water Heater Circulating Pump Motor & Seals	2010	4,150	166	25	166		415	3
4	Boiler Fire Tube, Solenoid Strainer Valve, and Controller	2010	4,475	179	25	179		448	4
5	Chiller Room Ventilation Motor, Actuator and Thermostats	2010	4,488	180	25	180		449	5
6	Fire Pump Check Valve, Sprinkler Heads - Ground Floor	2010	8,376	838	10	838		2,094	6
7	Refinish Fire Escape Stairways	2010	7,800	780	10	780		1,950	7
8	1st, 2nd, & 3rd Floors - Drinking Fountains, Sinks, Lockers	2010	3,958	396	10	396		991	8
9	Construction of Built-In Laminate Counter Tops, Door - Med Recc	2010	2,960	296	10	296		740	9
10	Fire Sprinkler Annunciator Panel - 2nd Floor Nursing Station	2010	5,340	534	10	534		1,335	10
11	Exterior Tuckpointing, Brickwork, Flashing, Wall Caps, Weeps	2010	10,480	1,048	10	1,048		2,620	11
12	Goulds Ejector Pump - Dietary Storage Room	2010	3,465	346	10	346		865	12
13									13
14	HVAC - New Controller, Chilled Water Sensors, Heater Circuit &	2011	7,441	298	25	298		447	14
15	Main Sewer Line Replacement	2011	15,000	1,500	10	1,500		2,250	15
16	Exterior Masonry, Paving - Main Entrance Area	2011	55,349	5,535	10	5,535		8,302	16
17	Life Safety - New Emergency Generator, Vertical Shafts, Elevator	2011	465,050	23,253	20	23,253		34,879	17
18	1st Fl-Locker Room Renovation- Install Tile Floor, Ceiling, Paintin	2011	16,735	1,672	10	1,672		2,508	18
19	3rd, 4th Floor Resident Bathroom Renovation - Flooring, Painting,	2011	66,570	6,658	10	6,658		9,987	19
20	3rd, 4th Floor Resident Room Renovations - Flooring, Blinds, Pain	2011	101,732	10,174	10	10,174		15,261	20
21	3rd, 4th Floor - Install Handrails on Hallway Walls	2011	8,110	812	10	812		1,218	21
22	Exterior - Tuckpointing, Brickwork, Chemical Treatment	2011	26,404	2,640	10	2,640		3,960	22
23	3rd, 4th, & 5th Floors - Install Nurse Call/Wander System	2011	95,715	9,572	10	9,572		14,358	23
24	Ground Floor - Sewage Ejector Pump	2011	3,367	336	10	336		504	24
25	Boiler Room - Pnuematic Controls for Hot Water & Fire Pump Pr	2011	3,403	340	10	340		510	25
26	Architect and General Contractor Fees	2011	195,567	19,556	10	19,556		29,334	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,193,280	\$ 240,060		\$ 240,060	\$	\$ 6,654,652	34

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

Facility Name & ID Number WESLEY PLACE

0005439

Report Period Beginning:

01/01/12

Ending:

12/31/12

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 8,193,280	\$ 240,060		\$ 240,060	\$	\$ 6,654,652	1
2									2
3	<u>HVAC - New Fan Coil Units, Duct Detectors, Compressor, Pneuma</u>	2012	35,367	707	25	707		707	3
4	<u>Carpeting/Flooring - Admission Office, Business Office - 1st Floor</u>	2012	8,762	876	5	876		876	4
5	<u>Life Safety - Fire Protection, Vertical Shafts, Elevator Recall, Eme</u>	2012	258,870	6,472	20	6,472		6,472	5
6	<u>Parking Lot Excavation, Sewer Replacement, Paving, and Canopy/</u>	2012	178,074	8,904	10	8,904		8,904	6
7	<u>*Architect, General Contractor Fees</u>	2012	2,018,871	100,943	10	100,943		100,943	7
8	<u>Rooftop EMR Wireless Installation</u>	2012	6,981	349	10	349		349	8
9	<u>Interior, exterior signs and signage</u>	2012	41,881	2,094	10	2,094		2,094	9
10	<u>Exterior Brickwork and Roof Drainage</u>	2012	26,902	1,345	10	1,345		1,345	10
11	<u>2nd, 3rd, 4th Floor Resident Rooms - Lighting, Electrical, Painting</u>	2012	153,754	7,688	10	7,688		7,688	11
12	<u>2nd, 3rd, 4th Floor - Hallway Handrails, Wall Protection, Nurse C</u>	2012	81,092	4,055	10	4,055		4,055	12
13	<u>Flooring - Stairwell and 2nd Floor Hallways</u>	2012	42,700	2,135	10	2,135		2,135	13
14	<u>Ground Floor - New Entrance Door, Flooring/Painting - Women's</u>	2012	21,857	1,093	10	1,093		1,093	14
15	<u>1st Floor - Ceiling Tile, Painting, Dietary Sewage Pump Installati</u>	2012	16,703	835	10	835		835	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26	*Note - Architect and General Contractor Fees are for a major renovation project being done at Wesley Place. The project includes								
27	interior, exterior, and life safety work. Interior work includes resident room remodeling with new flooring, windows, lighting, paint, bathroom								
28	fixtures, carpentry, hallway painting and handrails, and nurse call/wander system. Exterior work includes masonry, brickwork, fencing, signage,								
29	and electrical. Life Safety includes a new emergency generator, installation of vertical shafts, and an elevator recall.								
30	The invoices paid to the architect and general contractor are not broken out on an item by item basis.								
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,085,094	\$ 377,556		\$ 377,556	\$	\$ 6,792,148	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,196,363	\$ 77,299	\$ 77,299	\$		\$ 830,233	71
72	Current Year Purchases	320,556	16,027	16,027			16,027	72
73	Fully Depreciated Assets	1,132,682					1,132,682	73
74								74
75	TOTALS	\$ 2,649,601	\$ 93,326	\$ 93,326	\$		\$ 1,978,942	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	Ford Eldorado Passenger Bus, 20	2007	\$ 7,000	\$	\$	\$		\$ 7,000	76
77	Patient Transportation	Nissan Quest Minivan, 2007	2011	16,000	4,000	4,000			6,000	77
78										78
79										79
80	TOTALS			\$ 23,000	\$ 4,000	\$ 4,000	\$		\$ 13,000	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)	\$ 15,757,695	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 474,882	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 474,882	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)	\$ 8,784,090	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	Non-Nursing Home Assets/2006-2011	\$ 1,088,931	\$ 16,466	\$ 35,912	86
87	2010 NH Bldg Mkt Value Write Up	3,000,000	120,000	180,000	87
88					88
89					89
90					90
91	TOTALS	\$ 4,088,931	\$ 136,466	\$ 215,912	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: N/A

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

If NO, see instructions. YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2013 \$ _____

13. _____ /2014 \$ _____

14. _____ /2015 \$ _____

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: \$ 10,165 Description: Copiers - Leased - \$8,812; Dishwasher - Leased - \$1,353

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number WESLEY PLACE # 0005439 Report Period Beginning: 01/01/12 Ending: 12/31/12
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?</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	2	3	
		Drop-outs	Completed	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)	\$			

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	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	L39, C3	hrs	\$	4,308	\$ 258,340	\$	4,308	\$ 258,340	1	
2	Licensed Speech and Language Development Therapist	L39, C3	hrs		1,871	103,390		1,871	103,390	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	L39, C3	hrs		5,122	274,454		5,122	274,454	4	
5	Physician Care		visits							5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy	L39, C2	# of prescripts				255,642		255,642	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify):									12	
13	Other (specify): <u>Med Suppl, Lab, X-Ra</u>	L39, C2, C3				44,546	49,075		93,621	13	
14	TOTAL			\$	11,301	\$ 680,730	\$ 304,717	11,301	\$ 985,447	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 PLACE# 0005439Report Period Beginning: 01/01/12

Ending:

12/31/12

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/12

(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	\$ 821,860	\$	1
2	Cash-Patient Deposits	20,630		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>280,647</u>)	788,525		3
4	Supply Inventory (priced at)	25,976		4
5	Short-Term Investments			5
6	Prepaid Insurance	2,636		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	81,597		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,741,224	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	35,000		12
13	Land	2,800,000		13
14	Buildings, at Historical Cost	14,304,978		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,741,648		16
17	Accumulated Depreciation (book methods)	(9,000,002)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spec <u>Goodwill</u>)	1,000,000		22
23	Other(specify): <u>Unamortized Financing Costs</u>	100,859		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 11,982,483	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 13,723,707	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 263,067	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	67,357		28
29	Short-Term Notes Payable	240,000		29
30	Accrued Salaries Payable	628,790		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	144,740		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Unexpended Restricted Gifts</u>	38,718		36
37	<u>Due to Third-Party Payor</u>	141,268		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,523,940	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	5,611,700		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)	\$ 5,611,700	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,135,640	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 6,588,067	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 13,723,707	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 8,475,808	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 8,475,808	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(1,342,476)	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)	\$ (1,342,476)	17
B. Transfers (Itemize):			
18	Equity Transfer to Parent Corporation	(545,265)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (545,265)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 6,588,067	24 *

* This must agree with page 17, line 47.

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	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,960,650	1
2	Discounts and Allowances for all Levels	(1,543,139)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,417,511	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,292,603	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,292,603	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	9,321	14
15	Telephone, Television and Radio	2,420	15
16	Rental of Facility Space		16
17	Sale of Drugs	245,520	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	20,782	19
20	Radiology and X-Ray	7,171	20
21	Other Medical Services	106,772	21
22	Laundry	5,868	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 397,854	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,662	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,662	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	<u>Other - See attached schedule</u>	2,596,288	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,596,288	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,705,918	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,377,309	31
32	Health Care	2,190,864	32
33	General Administration	1,791,626	33
B. Capital Expense			
34	Ownership	811,428	34
C. Ancillary Expense			
35	Special Cost Centers	3,698,291	35
36	Provider Participation Fee	178,876	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,048,394	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,342,476)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,342,476)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,395,777	44
45	Private Pay - Net Inpatient Revenue	1,312,745	45
46	Medicare - Net Inpatient Revenue	1,618,473	46
47	Other-(specify) <u>Managed Care</u>	90,516	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,417,511	49

* 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 PLACE**

0005439

Report Period Beginning:

01/01/12

Ending:

12/31/12

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	1,000	1,086	\$ 51,346	\$ 47.28	1
2	Assistant Director of Nursing					2
3	Registered Nurses	26,334	29,155	831,330	28.51	3
4	Licensed Practical Nurses	4,859	5,138	132,764	25.84	4
5	CNAs & Orderlies	55,419	59,103	615,012	10.41	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,864	2,079	22,447	10.80	8
9	Activity Director					9
10	Activity Assistants	3,613	3,716	41,866	11.27	10
11	Social Service Workers	5,353	5,809	119,246	20.53	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	4,022	4,374	50,458	11.54	14
15	Cook Helpers/Assistants	13,387	14,692	158,485	10.79	15
16	Dishwashers	6,975	7,688	71,163	9.26	16
17	Maintenance Workers	4,505	4,945	123,932	25.06	17
18	Housekeepers	12,598	13,847	152,073	10.98	18
19	Laundry	2,085	2,241	20,053	8.95	19
20	Administrator	2,337	2,564	138,398	53.98	20
21	Assistant Administrator					21
22	Other Administrative	1,792	2,301	51,361	22.32	22
23	Office Manager					23
24	Clerical	17,332	18,379	444,049	24.16	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	936	1,006	16,723	16.62	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Suppl Sched.</u>	3,337	3,753	74,766	19.92	33
34	TOTAL (lines 1 - 33)	167,748	181,876	\$ 3,115,472 *	\$ 17.13	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			35	
36	Medical Director	664	63,620	L9, C3	36
37	Medical Records Consultant	96	4,512	L10, C3	37
38	Nurse Consultant	1,111	45,219	L10, C3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	40	2,200	L11, C3	44
45	Social Service Consultant	48	3,247	L12, C3	45
46	Other(specify)				46
47	<u>Dietary Management Fees</u>	Monthly	172,319	L1, C3	47
48					48
49	TOTAL (lines 35 - 48)	1,959	\$ 291,117		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership %	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function				Description	Amount	Description	Amount	
E.D. Barnett	Administrator		\$ 58,621	Workers' Compensation Insurance	\$ 86,130	IDPH License Fee	\$		
William Lowe	CEO		79,777	Unemployment Compensation Insurance	56,161	Advertising: Employee Recruitment		13,553	
				FICA Taxes	234,302	Health Care Worker Background Check		1,220	
				Employee Health Insurance	352,340	(Indicate # of checks performed <u>84</u>)			
				Employee Meals		Patient Background Checks	<u>194</u>	1,940	
				Illinois Municipal Retirement Fund (IMRF)*		Books & Subscriptions		11,086	
				Employee Recognition	8,349	Membership Fees & Fees		7,565	
				Employee Wellness	771	Resident Relations		1,580	
						Advertising		50,400	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 138,398			Less: Public Relations Expense	(
B. Administrative - Other						Non-allowable advertising		(49,501)	
Description			Amount			Yellow page advertising		(899)	
			\$						
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$		TOTAL (agree to Schedule V, line 22, col.8)	\$ 738,053		TOTAL (agree to Sch. V, line 20, col. 8)	\$ 36,944
C. Professional Services					E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
Frost Ruttenberg & Rothblatt	Audit		\$ 19,439			\$	Out-of-State Travel	\$	
FR&R Consulting	Accounting/Consulting		7,155						
Medifax	Data Processing		420						
KPMG	Data Processing		495				In-State Travel	1,664	
IVANS	Data Processing		3,040						
Richard Olson	Data Processing		300				Seminar Expense	10,092	
Legal - See Attached Schedule			7,058						
Coporate Allocation -	Data Processing		48,868				Entertainment Expense	(
Coporate Allocation -	Consulting		23,953				(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 110,728	TOTAL		\$	TOTAL	\$ 11,756	

* Attach copy of IMRF notifications

**See instructions.

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

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

Facility Name & ID Number WESLEY PLACE

0005439

Report Period Beginning:

01/01/12

Ending:

12/31/12

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 of IL - \$2,819
- (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? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 36,908 Line L10, C2
- (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. \$ 178,876
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? N/A
- (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? YES Indicate the amount. \$ 9,321
- (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? 100% of L14.
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? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: FROST, RUTTENBERG & ROTHBLATT, P.C.
- (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.