



Facility Name & ID Number Wesley Village

# 0022350 Report Period Beginning: 1/1/15 Ending: 12/31/15

**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	<u>73</u>	Skilled (SNF)	<u>73</u>	<u>26,645</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>73</u>	TOTALS	<u>73</u>	<u>26,645</u>	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	<u>7,474</u>	<u>14,184</u>	<u>3,377</u>	<u>25,035</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>7,474</u>	<u>14,184</u>	<u>3,377</u>	<u>25,035</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.96%

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

36 (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)

Outpatient Therapy

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES  NO

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 04/14/1980

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 73 and days of care provided 2,097

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-Exempt Fiscal Year: Jan-Dec

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

Facility Name &amp; ID Number

Wesley Village

# 0022350

Report Period Beginning:

1/1/15

Ending:

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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
	<b>A. General Services</b>										
1	Dietary	279,634	20,592	11,875	312,101		312,101		312,101		1
2	Food Purchase		230,339		230,339		230,339	(653)	229,686		2
3	Housekeeping	60,136	8,905		69,041	20,785	89,826		89,826		3
4	Laundry	10,275		41,237	51,512		51,512		51,512		4
5	Heat and Other Utilities			79,818	79,818		79,818		79,818		5
6	Maintenance	46,071	4,405	32,372	82,848		82,848		82,848		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	396,116	264,241	165,302	825,659	20,785	846,444	(653)	845,791		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			7,200	7,200		7,200		7,200		9
10	Nursing and Medical Records	1,743,635	256,783	22,449	2,022,867	(78,442)	1,944,425		1,944,425		10
10a	Therapy			516,813	516,813		516,813		516,813		10a
11	Activities	74,476	8,508	16,927	99,911		99,911	(7,868)	92,043		11
12	Social Services					55,126	55,126		55,126		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,818,111	265,291	563,389	2,646,791	(23,316)	2,623,475	(7,868)	2,615,607		16
	<b>C. General Administration</b>										
17	Administrative	95,950			95,950		95,950		95,950		17
18	Directors Fees										18
19	Professional Services			21,274	21,274		21,274		21,274		19
20	Dues, Fees, Subscriptions & Promotions			7,444	7,444	2,531	9,975		9,975		20
21	Clerical & General Office Expenses	76,202	9,329	14,772	100,303		100,303		100,303		21
22	Employee Benefits & Payroll Taxes			540,334	540,334		540,334		540,334		22
23	Inservice Training & Education										23
24	Travel and Seminar			12,626	12,626		12,626		12,626		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice										26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	172,152	9,329	596,450	777,931	2,531	780,462		780,462		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,386,379	538,861	1,325,141	4,250,381		4,250,381	(8,521)	4,241,860		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.

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#0022350

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1/1/15

Ending:

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## 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	
	<b>D. Ownership</b>											
30	Depreciation			295,723	295,723	295,723		295,723				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			187,103	187,103	187,103		187,103				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			482,826	482,826	482,826		482,826				37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
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			179,201	179,201	179,201		179,201				42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			179,201	179,201	179,201		179,201				44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,386,379	538,861	1,987,168	4,912,408	4,912,408		(8,521)	4,903,887			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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**VI. ADJUSTMENT DETAIL**

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	7,868	LN 11		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	653	LN 2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ 8,521		\$	30

BHF USE ONLY						
48		49		50		51
						52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense	2,058		33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 2,058		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 10,579		37

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

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

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

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Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

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	<b>Total</b>		0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Wesley Village

# 0022350

Report Period Beginning:

1/1/15

Ending:

12/31/15

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	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	0	0	0	0	0	0	0	0	0	0	0	0	8
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	0	0	0	0	0	0	0	0	0	0	0	0	16
	<b>C. General Administration</b>													
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	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	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	<b>TOTAL General Administration</b>	0	0	0	0	0	0	0	0	0	0	0	0	28
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Wesley Village

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Report Period Beginning:

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	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	<b>TOTAL Ownership</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>45</b>

Facility Name & ID Number Wesley Village

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**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

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	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	<b>Total</b>			\$			\$	\$ *	14

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

Facility Name & ID Number

Wesley Village

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Ending:

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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								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

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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

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	<b>TOTALS</b>				\$	\$		\$	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	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
<b>A. Directly Facility Related</b>																
<b>Long-Term</b>																
1	Citizens National Bank, a division of N	X		Refinance & New Projects	\$32,630.57		\$ 6,250,000	\$ 5,936,850		4.6900	\$ 176,550					
2																
3																
4																
5																
<b>Working Capital</b>																
6																
7																
8																
9	<b>TOTAL Facility Related</b>				\$32,630.57		\$ 6,250,000	\$ 5,936,850			\$ 176,550					
<b>B. Non-Facility Related*</b>																
10																
11																
12																
13																
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$					
15	<b>TOTALS (line 9+line14)</b>						\$ 6,250,000	\$ 5,936,850			\$ 176,550					

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**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>				
1. Real Estate Tax accrual used on 2014 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 2015 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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$			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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$			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:	2010	_____	8	<b>FOR BHF USE ONLY</b>		
	2011	_____	9			
	2012	_____	10			
	2013	_____	11			
	2014	_____	12			
				13	FROM R. E. TAX STATEMENT FOR 2014 \$	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.**

## 2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Wesley Village COUNTY McDonough

FACILITY IDPH LICENSE NUMBER 0022350

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 2014 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 2014.

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

**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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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

Facility Name & ID Number Wesley Village

# 0022350 Report Period Beginning:

1/1/15 Ending:

12/31/15

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 39,393 B. General Construction Type: Exterior Brick Frame Prestressed Concrete 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 - 69 units

Wesley Estates Independent Living Duplexes - 32 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: 58,242 2. Number of Years Over Which it is Being Amortized: 25  
 3. Current Period Amortization: 2,058 4. Dates Incurred: November 2012

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

**XI. OWNERSHIP COSTS:**

A. Land.	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
	<u>Nursing Home</u>	<u>235,224</u>	<u>1975</u>	<u>\$ 48,600</u>	<u>1</u>
					<u>2</u>
	<b>TOTALS</b>	<b>235,224</b>		<b>\$ 48,600</b>	<b>3</b>

**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	47	1980	1980	\$ 1,304,649	\$ 25,968	50	\$ 25,968		\$ 926,369	4
5	26	1998	1997	1,934,404	50,214	50	50,214		869,274	5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	<b>LAND IMPROVEMENTS</b>									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			448	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		15			1,307	23
24	Turf & garden mix 38%		1997	322		10			322	24
25	Walking path 50%		1997	418	10	20	10		190	25
26	Concrete curbing 38%		1997	562	28	20	28		223	26
27	Walking path 50%		2000	17,911	896	20	896		14,336	27
28	Alzheimers garden enhancement		2000	4,468	223	20	223		3,568	28
29	Walking path 50%		2001	15,264		10			15,264	29
30	Glider walking path		2002	1,346		10			1,346	30
31	Seal & Asphalt drive and parking lot		2003	7,888		15			7,888	31
32	Landscape gazebo area		2003	1,202		10			1,202	32
33	Landscaping around wheelchair swing		2001	856		10			856	33
34	Landscaping south garden area 50%		2004	5,618		10			5,618	34
35	Landscape HC/SCU signs		2005	519	30	10	30		519	35
36	Parking Lot Striping - 50%		2010	360	120	5	120		360	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 &amp; ID Number Wesley Village

# 0022350

Report Period Beginning:

1/1/15

Ending:

12/31/15

**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	Loading Dock Resurface	2012	\$ 8,350	\$ 835	10	\$ 835	\$	\$ 2,853	37
38	HCC Parking Lot Expansion	2013	2,570	171	15	171		413	38
39	HCC Sidewalk	2013	1,500	100	15	100		217	39
40	Rehab/HCC Entrance Landscaping	2014	8,497	425	10	425		850	40
41									41
42	<b>BUILDING IMPROVEMENTS</b>								42
43	Screen Doors	1981	4,500		10			4,500	43
44	Constructed Carports	1981	2,000	40	50	40		1,360	44
45	Wallpaper	1981	2,264		20			2,264	45
46	Entrance signs	1981	5,920		30			5,920	46
47	Signs	1981	58		12			58	47
48	Intangibles	1981	5,742		20			5,742	48
49	Overhang roof Drain	1982	342		20			342	49
50	Remodel bathroom	1982	371	8	50	8		264	50
51	Exhaust fans & lights	1982	426		20			426	51
52	Carpet	1983	169		5			169	52
53	Install Satellite system	1983	4,122		15			4,122	53
54	Remodeling	1983	389	8	50	8		255	54
55	Wheelchair ramp	1984	407		10			407	55
56	Remodel showers	1986	501		30			501	56
57	install décor	1985	450		15			450	57
58	Redecorate resident rooms	1985	10,126		15			10,126	58
59	install tornado siren	1986	3,056		15			3,056	59
60	Carpet	1987	538		5			538	60
61	Install TV Filter	1987	68		15			68	61
62	Redecorate resident rooms	1987	7,274		15			7,274	62
63	remodeling hallway	1988	68		15			68	63
64	roof repair	1989	3,704		15			3,704	64
65	emergency light	1989	35		10			35	65
66	redecorating	1989	13,802		15			13,802	66
67	nurse call system	1990	4,919		13			4,919	67
68	elevator jack	1990	3,780		15			3,780	68
69	solid core door	1990	735		10			735	69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 3,449,918	\$ 79,076		\$ 79,076	\$	\$ 1,983,961	70

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

Facility Name &amp; ID Number Wesley Village

# 0022350

Report Period Beginning:

1/1/15

Ending:

12/31/15

**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	<b>Totals from Page 12A, Carried Forward</b>		\$ 3,449,918	\$ 79,076		\$ 79,076	\$	\$ 1,983,961	1
2	Water system repairs	1991	1,410		10			1,410	2
3	Water heater repairs	1991	1,323		10			1,323	3
4	replace window panes	1991	9,051		20			9,051	4
5	install A/C food service	1992	866		20			866	5
6	roof repair	1992	8,685		15			8,685	6
7	redesign water system	1992	2,385		20			2,385	7
8	remodeling	1992	9,845		15			9,845	8
9	carpeting	1993	851		15			851	9
10	remodeling	1993	1,540		10			1,540	10
11	new entryway	1994	7,888		20			7,888	11
12	remodeling	1994	3,216		10			3,216	12
13	painting entryway & carpet	1995	2,456		10			2,456	13
14	diningroom floor	1996	116	6	20	6		115	14
15	roof repairs - west end	1996	385		15			385	15
16	12 air conditioning units	1996	3,698		15			3,698	16
17	shingle east entrance	1997	398		15			398	17
18	border resident rooms	1997	484		10			484	18
19	carpet installment hallway	1997	265	13	20	13		236	19
20	vinyl flooring covering	1997	1,507	75	20	75		1,350	20
21	remote annunciator panel	1997	705	34	20	34		630	21
22	heating/air conditioning units	1997	1,602	80	20	80		1,447	22
23	3 windows	1997	116	6	20	6		109	23
24	12 window screens	1997	126		20			126	24
25	Carpet	1997	432		20			432	25
26	drainage from SE corner of building	1997	378		15			378	26
27	additional wiring to pass inspection	1998	4,748	237	20	237		4,168	27
28	window treatments	1998	10,940	547	20	547		9,664	28
29	mixing valve	1998	2,695		15			2,695	29
30	tuckpointing building exterior	1998	4,511	180	20	180		3,090	30
31	flooring	1998	665		15			665	31
32	new mfire alarms in health care	1998	10,468	523	20	523		8,979	32
33	additional strobesdue to inspection	1998	1,381	69	20	69		1,225	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,545,054	\$ 80,846		\$ 80,846	\$	\$ 2,073,751	34

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

Facility Name &amp; ID Number Wesley Village

# 0022350

Report Period Beginning:

1/1/15

Ending:

12/31/15

**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	<b>Totals from Page 12B, Carried Forward</b>		\$ 3,545,054	\$ 80,846		\$ 80,846	\$	\$ 2,073,751	1
2	Roof repairs kitchen & SE section	1998	9,060	362	25	362		5,883	2
3	Alzheimer unit lounge flooring	1999	1,074		15			1,074	3
4	Health care lighting upgrade	1999	2,019		10			2,019	4
5	fire alarm upgrade	1999	2,814		10			2,814	5
6	Heating/cooling laundry room & kitchen corridor	2000	9,000	450	20	450		7,200	6
7	Sewer line	2000	8,868	355	25	355		5,680	7
8	smoking patio	2000	2,590	130	20	130		2,080	8
9	decorate healthcare diningroom	2001	7,887	307	15	307		4,605	9
10	A/C compressor healthcare diningroom	2001	9,076	202	15	202		3,030	10
11	Wallguards healthcare diningroom	2001	970	32	15	32		480	11
12	Kitchen walk-in cooler compressor	2001	1,769		7			1,769	12
13	Generator healthcare	2001	989		7			989	13
14	Alzheimers water system	2001	14,079	704	20	704		7,505	14
15	Glider walking path	2002	1,346		10			134	15
16	storage shed-cement work	2002	9,357	469	20	469		6,555	16
17	healthcare center core area roof	2002	8,800	440	20	440		6,160	17
18	Outside door - healthcare center hall	2003	5,600		10			5,600	18
19	Healthcare center shower room tile	2003	1,475		10			1,475	19
20	Healthcare center core area remodeling	2003	1,000		10			1,000	20
21	water softening system	2003	12,470		10			12,470	21
22	Garage/storage	2003	17,861	893	20	893		11,609	22
23	Healthcare center diningroom remodeling	2004	27,065	1,804	15	1,804		21,648	23
24	Healthcare center core area floor plans	2004	7,414	494	15	494		5,928	24
25	Garage Storage 50%	2004	1,737	87	20	87		1,044	25
26	Carpet - 7 healthcare rooms	2004	3,910	260	15	260		3,120	26
27	Healthcare center activity room remodeling	2005	2,606		15			2,606	27
28	Food service department drain	2005	2,655	5	10	5		2,655	28
29	Healthcare center door locks	2005	529		10			529	29
30	Healthcare center doors	2005	4,395		10			4,395	30
31	A/C units	2005	5,291	1	10	1		5,291	31
32	Garage/workshop 50%	2005	927	46	20	46		506	32
33	Outdoor electrical	2005	1,464	98	15	98		1,078	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,731,151	\$ 87,985		\$ 87,985	\$	\$ 2,212,682	34

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

Facility Name &amp; ID Number Wesley Village

**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	<b>Totals from Page 12C, Carried Forward</b>		\$ 3,731,151	\$ 87,985		\$ 87,985	\$	\$ 2,212,682	1
2	Resurface driveway and parking lot	2005	65,430	4,492	15	4,492		42,973	2
3	Healthcare center remodeling	2006	2,783	185	15	185		1,758	3
4	Healthcare center carpet	2006	468	23	20	23		225	4
5	garage door opener	2006	433	43	10	43		401	5
6	Healthcare center electrical panel	2006	2,340	156	15	156		1,417	6
7	PTAC units	2006	12,849	856	15	856		8,132	7
8	Elevator upgrade	2006	4,980	332	15	332		3,210	8
9	Healthcare center plumbing replacement	2006	70,249	1,756	40	1,756		15,950	9
10	Healthcare center replace bathroom floor	2006	10,299	257	40	257		2,356	10
11	Upgrade sprinkler system	2006	1,632	109	15	109		1,008	11
12	Food service fire system	2006	3,479		7			3,479	12
13	generator upgrade	2006	965		7			965	13
14	Air conditioning PTAC units	2006	1,601	107	15	107		981	14
15	Food service/laundry water heater	2006	2,921	195	15	195		1,934	15
16	Food Service booster heater	2006	1,982	132	15	132		1,254	16
17	Healthcare center spa bath	2006	24,334	1,622	15	1,622		14,598	17
18	Generator 1000KW	2006	387,059	15,482	25	15,482		154,690	18
19	Healthcare center remodeling architect fees	2007	32,169	1,608	20	1,608		13,803	19
20	Breakroom floore tile paint counter	2007	3,293	220	15	220		1,961	20
21	Replace kitchen wall	2007	3,709	185	20	185		1,620	21
22	Healthcare center plumbing project	2007	3,990	133	30	133		1,197	22
23	Major repairs water heaters	2007	6,919	346	20	346		2,969	23
24	rehab signing	2008	510		5			510	24
25	healthcare center remodel flooring lighting ceilings demo	2008	434,525	21,726	20	21,726		152,082	25
26	New parking lot/sidewalk/railing	2008	57,631	2,882	20	2,882		20,415	26
27	A/C heat in Healthcare center	2008	54,566	2,728	20	2,728		20,688	27
28	Nurse call system	2008	16,690	2,344	7	2,344		16,690	28
29	fire door - HCC office	2008	724	36	20	36		279	29
30	Rehab roof	2008	10,418	521	20	521		3,951	30
31	HC halway remodeling	2008	2,353	118	20	118		904	31
32	Maintenance building	2008	66,103	1,653	40	1,653		11,571	32
33	HC entrance canopies	2008	3,770	186	20	186		1,302	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 5,022,325	\$ 148,418		\$ 148,418	\$	\$ 2,717,955	34

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

Facility Name &amp; ID Number Wesley Village

# 0022350

Report Period Beginning:

1/1/15

Ending:

12/31/15

**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	<b>Totals from Page 12D, Carried Forward</b>		\$ 5,022,325	\$ 148,418		\$ 148,418	\$	\$ 2,717,955	1
2	Rehab new flooring at nurses station	2008	3,239	162	20	162		1,134	2
3	Garage lighting	2008	2,337	117	20	117		819	3
4	Water heaters	2008	102,723	5,136	20	5,136		35,962	4
5	Healthcare center remodeling, flooring, paint & Wallpaper	2009	181,019	9,051	20	9,051		58,077	5
6	Maintenance building	2009	16,473	412	40	412		2,506	6
7	Elevator renovation - upgrade to new standards	2009	38,550	1,928	20	1,928		12,050	7
8	Rehab lobby remodel	2009	2,923	146	20	146		986	8
9	HC entrance canopies	2009	6,030	302	20	302		1,840	9
10	Kitchen receiving wall replacement	2009	3,076	154	20	154		988	10
11	elevator upgrade	2010	1,932	97	20	97		566	11
12	Kitchen ceiling 50%	2011	423	28	15	28		140	12
13	HC windows	2011	50,789	2,540	20	2,540		11,218	13
14	HC Shower room - flooring, paint, furniture, plumbing	2011	7,616	508	15	508		2,244	14
15	Rehab remodel - flooring, paint, furniture, wallpaper	2011	52,178	2,609	20	2,609		10,653	15
16	Kitchen, lounge, HC roof - 50%	2011	6,418	642	10	642		2,889	16
17	HC diningroom - flooring, wallpaper, paint, tables, & chairs	2012	14,098	940	15	940		3,290	17
18	Rehab diningroom - flooring, wallpaper, paint, tables, chairs	2012	40,167	2,678	15	2,678		8,704	18
19	Utility room remodel - flooring & plumbing	2012	718	479	15	479		1,477	19
20	Breakroom 50% - move to basement, plumbing, cabinets, vending	2012	9,322	621	15	621		2,122	20
21	PTAC units - painting & patching holes on buildings	2012	1,321	132	10	132		418	21
22	Therapy addition - flooring, furniture, equipment	2013	723,946	18,099	40	18,099		37,706	22
23	Tuckpointing of brick around HC	2013	127,994	4,266	30	4,266		9,599	23
24	Chiller & boiler - 50%	2013	534	107	5	107		241	24
25	Rehab unit roof	2013	805	161	5	161		389	25
26	HC roof recoat	2013	4,350	870	5	870		1,958	26
27	HC Hallway flooring	2013	911	183	5	183		412	27
28	Therapy addition - doors, alarms, wallpaper	2014	5,336	267	20	267		356	28
29	HCC Room 1 flooring, paint, wallpaper	2014	3,333	222	15	222		333	29
30	RHU Roof Recoating	2014	11,752	1,175	10	1,175		1,763	30
31	Therpay pool project	2014	4,685	312	15	312		442	31
32	HCC Room 2 flooring, paint, wallpaper	2014	3,129	209	15	209		226	32
33	Rehab Unit Electronic Keypad for door	2015	720	132	5	132		132	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,451,172	\$ 203,103		\$ 203,103	\$	\$ 2,929,595	34

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

Facility Name & ID Number Wesley Village

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3	4	5	6	7	8	9	
		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12E, Carried Forward</b>		\$ 6,451,172	\$ 203,103		\$ 203,103	\$	\$ 2,929,595	1
2	Healthcare Center Electrical outlets	2015	8,433	151	15	151		151	2
3	Rehab Center Electrical outlets	2015	1,580	97	15	97		97	3
4	HCC/Rehab Center Corridor Wallpaper	2015	688	57	10	57		57	4
5	HCC Room 10: Paint, wall covering, Flooring	2015	643	25	15	25		25	5
6	HCC Room 13: paint, wall covering, flooring	2015	1,847	31	15	31		31	6
7	HCC Room 14: paint, wall covering, Flooring	2015	2,273	38	15	38		38	7
8	Rehab unit entrance Door	2015	920	10	15	10		10	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,467,556	\$ 203,512		\$ 203,512	\$	\$ 2,930,004	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	\$ 1,243,358	\$ 73,240	\$ 73,240	\$ (0)		\$ 554,003	71
72	Current Year Purchases	63,950	2,341	2,341	0		2,341	72
73	Fully Depreciated Assets	27,509					27,509	73
74								74
75	TOTALS	\$ 1,334,817	\$ 75,581	\$ 75,581	\$ (0)		\$ 583,853	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	14 passenger bus with lift	Chevy 2008 Model	2008	\$ 48,364	\$	\$	\$	5	\$ 48,364	76
77	White wheelchair van	Dodge 2010 Model	2010	37,632	6,901	6,901		5	37,632	77
78	2006 Lincoln	Lincoln 2006 Model	2011	14,750	2,950	2,950		5	14,750	78
79	Blue Wheelchari van	Dodge 2010 Model	2014	33,895	6,779	6,779		5	8,191	79
80	TOTALS			\$ 134,641	\$ 16,630	\$ 16,630	\$		\$ 108,937	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)	\$ 7,985,614	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 295,723	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 295,723	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (0)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,622,794	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	<b>TOTAL</b>				\$			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. \_\_\_\_\_ /2016                      \$ \_\_\_\_\_

13. \_\_\_\_\_ /2017                      \$ \_\_\_\_\_

14. \_\_\_\_\_ /2018                      \$ \_\_\_\_\_

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	<b>TOTAL</b>		\$	\$	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.

**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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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	<b>TOTALS</b>	\$	\$	\$	\$
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**

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

- (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		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 prescrpts							9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify):									12	
13	Other (specify):									13	
14	<b>TOTAL</b>			\$		\$	\$		\$	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 # 0022350 Report Period Beginning: 1/1/15 Ending: 12/31/15  
 XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/15 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 213,157	\$ 256,816	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>10,701</u> )	567,999	687,703	3
4	Supply Inventory (priced at )	37,527	68,513	4
5	Short-Term Investments	50	145	5
6	Prepaid Insurance	396	1,364	6
7	Other Prepaid Expenses	145	500	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>WE Investment &amp; Beq. Rec</u>		279,142	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 819,274	\$ 1,294,183	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable		257,148	11
12	Long-Term Investments	516,879	3,296,766	12
13	Land	48,600	424,160	13
14	Buildings, at Historical Cost	6,332,457	12,184,791	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,469,458	2,913,270	16
17	Accumulated Depreciation (book methods)	(3,622,794)	(8,604,214)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		58,242	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(6,344)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spec <u>Land Improv.</u>	135,099	622,881	22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 4,879,699	\$ 11,146,700	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 5,698,973	\$ 12,440,883	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 312,291	\$ 376,254	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	356,033	398,170	29
30	Accrued Salaries Payable	36,796	57,343	30
31	Accrued Taxes Payable (excluding real estate taxes)	33,039	51,624	31
32	Accrued Real Estate Taxes(Sch.IX-B)		84,400	32
33	Accrued Interest Payable	11,230	12,618	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Accrued Expenses</u>	223,682	250,764	36
37	<u>Membership Fees &amp; Deposits</u>	74,011	741,595	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,047,082	\$ 1,972,768	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,612,098	5,825,963	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 3,612,098	\$ 5,825,963	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 4,659,180	\$ 7,798,731	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,039,793	\$ 4,642,152	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 5,698,973	\$ 12,440,883	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 936,238	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 936,238	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	103,555	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)	\$ 103,555	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)		23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,039,793	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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,959,898	1
2	Discounts and Allowances for all Levels	(10,701)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 4,949,197</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions	66,766	24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 66,766</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 5,015,963</b>	<b>30</b>

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	825,659	31
32	Health Care	2,646,791	32
33	General Administration	777,931	33
<b>B. Capital Expense</b>			
34	Ownership	482,826	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	179,201	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 4,912,408</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>103,555</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 103,555</b>	<b>43</b>

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 935,713	44
45	Private Pay - Net Inpatient Revenue	2,465,745	45
46	Medicare - Net Inpatient Revenue	1,094,029	46
47	Other-(specify) <u>Skilled Stay Insurance</u>	453,710	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$ 4,949,197</b>	<b>49</b>

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

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

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

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

Facility Name & ID Number Wesley Village

# 0022350

Report Period Beginning:

1/1/15

Ending:

12/31/15

**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	1,856	2,640	\$ 94,691	\$ 35.87	1
2	Assistant Director of Nursing	136	160	4,960	31.00	2
3	Registered Nurses	12,996	13,534	323,191	23.88	3
4	Licensed Practical Nurses	13,447	15,402	295,102	19.16	4
5	CNAs & Orderlies	63,494	69,624	778,399	11.18	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,211	2,080	25,527	12.27	9
10	Activity Assistants	4,182	5,099	48,949	9.60	10
11	Social Service Workers	1,813	2,080	55,126	26.50	11
12	Dietician					12
13	Food Service Supervisor	1,725	2,079	45,282	21.78	13
14	Head Cook	1,508	2,080	19,813	9.53	14
15	Cook Helpers/Assistants	14,575	15,143	128,723	8.50	15
16	Dishwashers	9,624	10,096	85,816	8.50	16
17	Maintenance Workers	2,110	2,248	46,071	20.49	17
18	Housekeepers	6,334	6,575	60,136	9.15	18
19	Laundry	1,057	1,100	10,275	9.34	19
20	Administrator	1,716	2,080	95,950	46.13	20
21	Assistant Administrator					21
22	Other Administrative	891	936	32,760	35.00	22
23	Office Manager					23
24	Clerical	3,647	3,943	43,442	11.02	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	7,523	8,320	192,166	23.10	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	149,845	165,219	\$ 2,386,379 *	\$ 14.44	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	248	\$ 8,671	LN 1 COL 3	35
36	Medical Director		7,200	LN 9 COL 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,832	LN 10 COL 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	19	1,059	LN 11 COL 3	44
45	Social Service Consultant	19	1,059	LN 10 COL 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	286	\$ 20,821		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: 1/1/15

Ending: 12/31/15

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Shelly Martin			\$ 95,950	Workers' Compensation Insurance	\$ 60,876	IDPH License Fee	\$	
				Unemployment Compensation Insurance		Advertising: Employee Recruitment		
				FICA Taxes	177,353	Health Care Worker Background Check	2,031	
				Employee Health Insurance	302,105	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	500	
				Illinois Municipal Retirement Fund (IMRF)*		DUES	7,444	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 95,950					
B. Administrative - Other								
Description			Amount			Less: Public Relations Expense	( )	
			\$			Non-allowable advertising	( )	
						Yellow page advertising	( )	
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)	\$ 540,334	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 9,975	
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
CliftonLarsonAllen LLP	Audit/Taxes		\$ 18,720			\$	Out-of-State Travel	\$
March, McMillian DeJoode	Legal		2,554					
							In-State Travel	
							Seminar Expense	12,626
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 21,274	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	\$ 12,626

\* 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		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name &amp; ID Number Wesley Village

# 0022350

Report Period Beginning:

1/1/15

Ending:

12/31/15

## 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. Leading Age Illinois - \$5,656
- (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? 8.6 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 29,778 Line 10 COL 4
- (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. \$ 179,201  
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? 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.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? YES  
Firm Name: Clifton Larson Allen LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A  
Attach invoices and a summary of services for all architect and appraisal fees.

**WESLEY VILLAGE -UMC  
2015 COST REPORT  
SCHEDULE OF RECLASSIFICATIONS - COL 5. PG 3**

LINE #	DESCRIPTION	DEBIT	CREDIT
3	SALARIES/HOUSEKEEPING	\$20,785.00	
10	SALARIES/NURSING		\$20,785.00
	** Bed maker - non patient care - Reclassify to Housekeeping to Line 3		
12	SALARIES/SOCIAL SERVIC	\$55,126.00	
10	SALARIES/NURSING		\$55,126.00
	** Reclassify Social Services Salary to Line 12		
20	FEES/ BACKGROUND CHE	\$ 2,030.50	
10	OTHER - HEALTH CARE		\$ 2,030.50
	**Background Checks - Reclassify to Line 20		
20	FEES/BACKGROUND CHEC	\$ 500.00	
10	NURSING & MEDICAL - SUPPLIES		\$ 500.00
	TOTALS	<u>\$78,441.50</u>	<u>\$78,441.50</u>

**WESLEY VILLAGE, UMC  
IDPA COST REPORT FY 2015  
ADJUSTMENTS**

LINE #	COLUMN			
2	7	<b>FOOD PURCHASE</b>		
		SCHEDULE VI. SALES TAX, LINE 13		
		SALES TAX-NOT ALLOWABLE EXPENSE ON PRIVATE PAY PATIENTS FOOD		
		NON-ALLOWABLE SALES TAX EXPENSE = (TOTAL FOOD COST/1.01 X		
		(.01) X PRIVATE PAY % OF CENSUS DIVIDE BY 2		
		 FOOD PURCHASES		
		DIVIDED BY 1.01 =	\$ 230,339	
		MULTIPLY BY .01	\$ 2,303	
		MULTIPLY BY PRIVATE PAY CENSUS	56.66%	
		EQUALS	<u>\$ 1,305</u>	
		DIVIDED BY 2	<u>\$ 653</u>	SALES TAX ADJUSTMENT
11	7	<b>ACTIVITIES COL 3</b>	<b>\$ 7,868</b>	ACTIVITIES ADJ
		CABLE TV		
		SCHEDULE VI. TELEPHONE, TV IN RESIDENT ROOMS, LINE 5		
		 <b>TOTAL OF ADJUSTMENTS</b>	 <u><u>\$ 8,521</u></u>	

Wesley Village

Dues, Subscriptions, Licenses, & Fees

2015

FEES

Secretary of State - nonprofit Annual Report Fee	39
McDonough County Health Department - Food Service License	260
West Bend Mututal Ins. - Resident funds bond Fee	100
Secretary of State - Admin License Fee	205
TOTAL	604

DUES

Leading Age Illinois - Annual Dues	5656
United Methodist Association - Annual Dues	1184
TOTAL	6840

Total 7444

EMPLOYEE BACKGROUND CHECKS 2031

RESIDENT BACKGROUND CHECKS 500

9975