FOR BHF USE

LL1

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.

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

I. IDPH License ID Number: 0022350

Facility Name: Wesley Village Health Care Center

Address: 1200 East Grant St (Number) Macomb (City) 61455 (Zip Code)

County: McDonough

Telephone Number: 309-833-2123 **Fax #** 30-837-7500

HFS ID Number:

Date of Initial License for Current Owners: 4/14/1980

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
x	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2011 to 12/31/2011 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) 4/30/2012 (Date)

(Type or Print Name) Shelly Ward

(Title) Administrator/CEP

Paid Preparer

(Signed) (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

In the event there are further questions about this report, please contact:

Name: Britany Martin Telephone Number: 309-833-2123

Email Address:

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Wesley Village Health Care Center # 0022350 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,818	4,580	1,771	8,169	8
9	SNF/PED					9
10	ICF	7,947	8,139		16,086	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,765	12,719	1,771	24,255	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.03%

D. How many bed-hold days during this year were paid by the Department?
117 (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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 04141980

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 26 and days of care provided 1,771

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: Tax-exempt Fiscal Year: Jan-Dec

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

Facility Name & ID Number Wesley Village Health Care Center # 0022350 **Report Period Beginning:** 1/1/2011 **Ending:** 12/31/2011

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	254,903	28,324	12,781	296,008		296,008		296,008			1
2	Food Purchase		267,274		267,274		267,274	(694)	266,580			2
3	Housekeeping	108,559	10,589		119,148	18,471	137,619		137,619			3
4	Laundry	21,324		31,031	52,355		52,355		52,355			4
5	Heat and Other Utilities			80,256	80,256		80,256		80,256			5
6	Maintenance	49,341	11,237	14,341	74,919		74,919		74,919			6
7	Other (specify):*											7
8	**TOTAL General Services**	434,127	317,424	138,409	889,960	18,471	908,431	(694)	907,737			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	1,493,609	196,592	8,733	1,698,934	(68,629)	1,630,305		1,630,305			10
10a	Therapy			177,395	177,395		177,395		177,395			10a
11	Activities	43,034	14,045	10,422	67,501		67,501	(5,357)	62,144			11
12	Social Services					47,403	47,403		47,403			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,536,643	210,637	203,750	1,951,030	(21,226)	1,929,804	(5,357)	1,924,447			16
	C. General Administration											
17	Administrative	89,724			89,724		89,724		89,724			17
18	Directors Fees											18
19	Professional Services			31,548	31,548		31,548		31,548			19
20	Dues, Fees, Subscriptions & Promotions			16,435	16,435	2,755	19,190		19,190			20
21	Clerical & General Office Expenses	125,333	14,567	12,748	152,648		152,648		152,648			21
22	Employee Benefits & Payroll Taxes			428,793	428,793		428,793		428,793			22
23	Inservice Training & Education											23
24	Travel and Seminar			15,951	15,951		15,951		15,951			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			17,312	17,312		17,312		17,312			26
27	Other (specify):*											27
28	**TOTAL General Administration**	215,057	14,567	522,787	752,411	2,755	755,166		755,166			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,185,827	542,628	864,946	3,593,401		3,593,401	(6,051)	3,587,350			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Wesley Village Health Care Center #0022350 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			209,286	209,286		209,286		209,286			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			143,391	143,391		143,391		143,391			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			352,677	352,677		352,677		352,677			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			39,968	39,968		39,968		39,968			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			39,968	39,968		39,968		39,968			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,185,827	542,628	1,257,591	3,986,046		3,986,046	(6,051)	3,979,995			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 Village Health Care Center # 0022350 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	5,357	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	694	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	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 6,051		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense	7,222		33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 7,222		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 13,273		37

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

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

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		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	**TOTAL (C): (sum of lines 38-46)**			$		47

Wesley Village Health Care Center

ID# 0022350

Report Period Beginning: 1/1/2011

Ending: 12/31/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Wesley Village Health Care Center **#** 0022350 **Report Period Beginning:** 1/1/2011 **Ending:** 12/31/2011

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

	Operating Expenses	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)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	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	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	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	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	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (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 Health Care Center # 0022350 **Report Period Beginning:** 1/1/2011 **Ending:** 12/31/2011

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)	
	D. Ownership													
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	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	0	0	0	0	0	0	0	0	0	0	0	0	45

Facility Name & ID Number Wesley Village Health Care Center # 0022350 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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
		NOT APPLICABLE				

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

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

1 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			$	NOT APPLICABLE		$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

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

Facility Name & ID Number Wesley Village Health Care Center # 0022350 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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

Facility Name & ID Number Wesley Village Health Care Center # 0022350 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION**

Facility Name & ID Number Wesley Village Health Care Center # 0022350 Report Period Beginning: 1/1/2011 Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Wesley Village Health Care Center # 0022350 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	CITIZENS NATIONAL BANK		x		$32,178.18		$ 4,192,000	$ 3,937,078		5.5000	$ 143,391	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$32,178.18		$ 4,192,000	$ 3,937,078			$ 143,391	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 4,192,000	$ 3,937,078			$ 143,391	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.)**

Facility Name & ID Number Wesley Village Health Care Center # 0022350 **Report Period Beginning:** 1/1/2011 **Ending:** 12/31/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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 2011 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:		
	2006	8
	2007	9
	2008	10
	2009	11
	2010	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Wesley Village Health Care Center COUNTY McDonough

FACILITY IDPH LICENSE NUMBER 0022350

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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

Facility Name & ID Number Wesley Village Health Care Center # 0022350 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,893 B. General Construction Type: Exterior Brick Frame PrestressedConcrete Number of Stories 1

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Wesley Village Retirement Center - 70 units
Wesley Estates Independent Living Duplexes - 26 units

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	235,224	1975	$ 48,600	1
2					2
3	TOTALS	235,224		$ 48,600	3

Facility Name & ID Number Wesley Village Health Care Center # 0022350 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	47		1980	1980	$ 1,304,649	$ 25,968	50	$ 25,968	$	$ 822,497	4
5	26		1998	1997	1,934,404	50,214	50	50,214		668,418	5
6											6
7											7
8											8
	Improvement Type**										
9	LAND IMPROVEMENTS										9
10	Paved parking lot			1981	28,080		15			28,080	10
11	Landscaping			1981	2,943		10			2,943	11
12	Landscaping			1984	227		10			227	12
13	Blacktop driveway			1985	559		10			559	13
14	Landscaping, install cement patio			1982	488		20			488	14
15	Landscaping			1983	681		20			681	15
16	Blacktop driveway			1986	2,668		15			2,668	16
17	Blacktop driveway			1987	15,464		15			15,464	17
18	Improve drainage			1987	1,036		15			1,036	18
19	Landscaping costs			1988	599		10			599	19
20	Improve drainage from roof area			1989	946		15			946	20
21	Blacktop driveway			1990	1,396		15			1,396	21
22	Blacktop sealer			1991	1,054		15			1,054	22
23	Blacktop sealer			1994	1,307		15			1,307	23
24	Turf & garden mix 38%			1997	322		10			322	24
25	Walking path 50%			1997	418	10	20	10		150	25
26	Concrete curbing 38%			1997	562	7	20	7		105	26
27	Walking path 50%			2000	17,911	896	20	896		10,752	27
28	Alzheimers garden enhancement			2000	4,468	223	20	223		2,676	28
29	Walking path 50%			2001	15,264	890	10	890		15,264	29
30	Glider walking path			2002	1,346	135	10	135		1,215	30
31	Seal and asphalt drive and parking lot			2003	7,888	367	15	367		3,203	31
32	Landscape gazebo area			2003	1,202	120	10	120		640	32
33	Landscaping around wheelchair swing			2004	856	85	10	85		680	33
34	Landscaping south garden are 50%			2004	5,618	562	10	562		4,496	34
35	Landscape HC/SCU signs			2005	519	51	10	51		357	35
36	Parking lot striping 50%			2010	360	12	5	12		24	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 Village Health Care Center # 0022350 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	BUILDING IMPROVEMENTS		$	$		$	$	$	37
38	Screen & Doors	1981	4,500		10			4,500	38
39	Constructed carports	1981	2,000	40	50	40		1,200	39
40	Wallpaper	1981	2,264		20			2,264	40
41	Entrance signs	1981	5,920	208	30	208		5,920	41
42	signs	1981	58		12			58	42
43	Intangibles	1981	5,742		20			5,742	43
44	Overhang roof drain	1982	342		20			342	44
45	Remodel bathroom	1982	371	8	50	8		232	45
46	Exhaust fans & lights	1982	426		20			426	46
47	Carpet	1983	169		5			169	47
48	Install satellite system	1983	4,122		15			4,122	48
49	Remodeling	1983	389	8	50	8		223	49
50	Wheelchair ramp	1984	407		10			407	50
51	Remodel showers	1984	501	17	30	17		443	51
52	Install décor	1985	450		15			450	52
53	Redecorate resident rooms	1985	10,126		15			10,126	53
54	Install tornado siren	1986	3,056		15			3,056	54
55	Carpet	1987	538		5			538	55
56	Install TV Filter	1987	68		15			68	56
57	Redecorate resident rooms	1987	7,274		15			7,274	57
58	Remodeling hallway	1988	68		15			68	58
59	Roof repair	1989	3,704		15			3,704	59
60	Emergency light	1989	35		10			35	60
61	Redecorating	1989	13,802		15			13,802	61
62	Nurse call system	1990	4,919		13			4,919	62
63	Elevator jack	1990	3,780		15			3,780	63
64	Solid Core Door	1990	735		10			735	64
65	Water system repairs	1991	1,410		10			1,410	65
66	Water heater repairs	1991	1,323		10			1,323	66
67	Replace window panes	1991	9,051	476	20	476		9,051	67
68	Install A/C food service	1992	866	43	20	43		860	68
69	Roof repair	1992	8,685		15			8,685	69
70	TOTAL (lines 4 thru 69)		$ 3,450,336	$ 80,340		$ 80,340	$	$ 1,684,179	70

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

Facility Name & ID Number Wesley Village Health Care Center # 0022350 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,450,336	$ 80,340		$ 80,340	$	$ 1,684,179	1
2	Redesign water system	1992	2,385	95	20	95		1,805	2
3	Remodeling	1992	9,845		15				3
4	Carpeting	1993	851		15				4
5	Remodeling	1993	1,540		10				5
6	New Entryway	1994	7,888	484	20	484		7,889	6
7	Remodeling	1994	3,216		10				7
8	Painting entryway & carpet	1995	2,456		10				8
9	Diningroom floor	1996	116	6	20	6		91	9
10	Roof repairs - west end	1996	385	26	15	26		385	10
11	12 air conditioning units	1996	3,698	247	15	247		3,698	11
12	Shingle east entrance	1997	398	26	15	26		371	12
13	Border resident rooms	1997	484		10				13
14	Carpet installment hallway	1997	265	13	20	13		184	14
15	Vinyl floor covering	1997	1,507	75	20	75		1,050	15
16	Remote annuncator panel	1997	705	34	20	34		494	16
17	Heating/air conditioning units	1997	1,602	80	20	80		1,127	17
18	3 windows	1997	116	6	20	6		85	18
19	12 window screens	1997	126	6	20	6		6	19
20	Carpet	1997	432	36	20	36		504	20
21	Drainage from SE corner of building	1997	378	24	15	24		349	21
22	Additional wiring to pass inspection	1998	4,748	237	20	237		3,220	22
23	Window treatments	1998	10,940	547	20	547		7,476	23
24	Mixing valve	1998	2,695	180	15	180		2,370	24
25	Tuckpointing building exterior	1998	4,511	180	20	180		2,370	25
26	Flooring	1998	665	44	15	44		613	26
27	New fire alarms in health care	1998	10,468	523	20	523		6,887	27
28	Additional strobes due to inspection	1998	1,381	69	20	69		949	28
29	Roof repairs kitchen & SE section	1998	9,060	362	25	362		4,435	29
30	Alzheimer unit lounge flooring	1999	1,074	54	15	54		702	30
31	Health care lighting upgrade	1999	2,019		10			2,019	31
32	Fire alarm upgrade	1999	2,814		10			2,814	32
33	Heating/cooling laundry room & kitchen corridor	2000	9,000	450	20	450		5,400	33
34	TOTAL (lines 1 thru 33)		$ 3,548,104	$ 84,144		$ 84,144	$	$ 1,741,472	34

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

Facility Name & ID Number Wesley Village Health Care Center # 0022350 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,548,104	$ 84,144		$ 84,144	$	$ 1,741,472	1
2	Sewer line	2000	8,868	355	25	355		4,260	2
3	Smoking patio	2000	2,590	130	20	130		1,560	3
4	Decorate health care dining room	2001	7,887	307	15	307		3,377	4
5	A/C compressor health care core	2001	9,076	202	15	202		222	5
6	Wallguards health care dining room	2001	970	32	15	32		352	6
7	Kitchen walk-in cooler compressor	2001	1,769		7			1,769	7
8	Generator health care	2001	989		7			989	8
9	Alzheimer water system	2001	14,079	469	20	469		5,159	9
10	Glider walking path	2002	1,346	135	10	135		1,350	10
11	Storage shed - cement work	2002	9,357	468	20	468		4,680	11
12	Health care center core area roof	2002	8,800	440	20	440		4,400	12
13	Outside door - health care center hall	2003	5,600	560	10	560		5,040	13
14	Health care center shower room tile	2003	1,475	147	10	147		1,323	14
15	Health care center core are remodeling	2003	1,000	100	10	100		800	15
16	Water softening system	2003	12,470	1,247	10	1,247		11,223	16
17	Garage/storage	2003	17,861	893	20	893		8,037	17
18	Health care center dining room remodeling	2004	27,065	1,804	15	1,804		14,432	18
19	Health care center core area floor plans	2004	7,414	494	15	494		3,952	19
20	Garage/storage 50%	2004	1,737	87	20	87		696	20
21	Carpet - 7 health care rooms	2004	3,910	260	15	260		2,080	21
22	Health care center activity room remodeling	2005	2,606	261	15	261		2,607	22
23	Food service department drain	2005	2,655	265	10	265		1,855	23
24	Health care center door locks	2005	529	53	10	53		371	24
25	Health care center doors	2005	4,395	440	10	440		3,080	25
26	A/C Units	2005	5,291	529	10	529		3,703	26
27	Garage/workshop 50%	2005	927	46	20	46		322	27
28	Outdoor electrical	2005	1,464	98	15	98		686	28
29	Resurfacing driveway and parking lot	2005	65,430	4,492	15	4,492		25,005	29
30	Health care center remodeling	2006	2,783	185	15	185		1,018	30
31	Health care center carpet	2006	468	23	20	23		133	31
32	Garage door opener	2006	433	43	10	43		229	32
33	Health care center electrical panel	2006	2,340	156	15	156		793	33
34	TOTAL (lines 1 thru 33)		$ 3,781,688	$ 98,865		$ 98,865	$	$ 1,856,975	34

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

Facility Name & ID Number Wesley Village Health Care Center # 0022350 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,781,688	$ 98,865		$ 98,865	$	$ 1,856,975	1
2	PTAC Units	2006	12,849	856	15	856		4,708	2
3	Elevator upgrade	2006	4,980	332	15	332		1,882	3
4	Health care center plumbing replacement	2006	70,249	1,756	40	1,756		8,926	4
5	Health care center replace bathroom floor	2006	10,299	257	40	257		1,328	5
6	Upgrade sprinkler system	2006	1,632	109	15	109		572	6
7	Food service fire system	2006	3,479	497	7	497		2,941	7
8	Generator upgrade	2006	965	115	7	115		690	8
9	Air conditioning P-TAC units	2006	1,601	107	15	107		553	9
10	Food service laundry water heater upgrade	2006	2,921	195	15	195		1,154	10
11	Food service booster heater	2006	1,982	132	15	132		726	11
12	Health care center spa bath	2006	24,334	1,622	15	1,622		8,110	12
13	Generator 1000KW	2006	387,059	15,482	25	15,482		92,762	13
14	Health care center remodeling architect fees	2007	32,169	1,608	20	1,608		7,371	14
15	Breakroom floor tile paint counter	2007	3,293	220	15	220		1,081	15
16	Replace kitchen wall	2007	3,709	185	20	185		880	16
17	Health care center plumbing project	2007	3,990	133	30	133		665	17
18	Major repairs to water heaters	2007	6,919	346	20	346		1,585	18
19	Rehab signing	2008	510	102	5	102		408	19
20	Health care remodel flooring lighting ceilings demo	2008	434,525	21,726	20	21,726		65,178	20
21	New parking lot/sidewalk/railing	2008	57,631	2,882	20	2,882		8,887	21
22	A/C Heat in health care center	2008	54,566	2,728	20	2,728		9,776	22
23	Nurse call system	2008	16,690	2,384	7	2,384		7,194	23
24	Fire door - hcc office	2008	724	36	20	36		135	24
25	Rehab roof	2008	10,418	521	20	521		1,867	25
26	Hcc hallway remodeling	2008	2,353	118	20	118		432	26
27	Maintenance building	2008	66,103	1,653	40	1,653		4,959	27
28	Hcc entrace canopies	2008	3,770	186	20	186		558	28
29	Rehab new flooring at nurses station	2008	3,239	162	20	162		486	29
30	Garage lighting	2008	2,337	117	20	117		351	30
31	water heaters	2008	102,723	5,136	20	5,136		15,408	31
32	Health care center remodeling flooring paint wallpaper	2009	181,019	9,051	20	9,051		21,873	32
33	Maintenance building	2009	16,473	412	40	412		858	33
34	TOTAL (lines 1 thru 33)		$ 5,307,199	$ 170,031		$ 170,031	$	$ 2,131,279	34

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

Facility Name & ID Number Wesley Village Health Care Center # 0022350 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 5,307,199	$ 170,031		$ 170,031	$	$ 2,131,279	1
2	Elevator rennovation - update to new standards	2009	38,550	1,928	20	1,928		4,338	2
3	Rehab lobby remodel	2009	2,923	146	20	146		402	3
4	Hcc entrance canopies	2009	6,030	302	20	302		629	4
5	Kitchen receiving wall replacement	2009	3,076	154	20	154		372	5
6	Elevator upgrade	2010	1,932	97	20	97		178	6
7	Kitchen Ceiling 50%	2011	423	28	15	28		28	7
8	HCC WINDOWS	2011	50,789	1,058	20	1,058		1,058	8
9	HCC SHOWER ROOM	2011	7,616	212	15	212		212	9
10	REHAB REMODEL	2011	52,178	217	20	217		217	10
11	KITCHEN, LOUNGE, HCC ROOF 50%	2011	6,418	321	10	321		321	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	TOTAL (lines 1 thru 33)		$ 5,477,134	$ 174,494		$ 174,494	$	$ 2,139,034	34

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

Facility Name & ID Number Wesley Village Health Care Center # 0022350 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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	$ 1,004,751	$ 23,911	$ 23,911	$		$ 307,726	71
72	Current Year Purchases	14,294	3,075	3,075			3,075	72
73	Fully Depreciated Assets	27,509					27,509	73
74								74
75	TOTALS	$ 1,046,554	$ 26,986	$ 26,986	$		$ 338,310	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	$ 9,673	$ 9,673	$	5	$ 32,243	76
77	Wheelchair van	Dodge 2010 model	2010	37,632	7,526	7,526		5	8,153	77
78	2006 Lincoln	Lincoln 2006 model	2011	14,750	2,950	2,950		5	2,950	78
79										79
80	TOTALS			$ 100,746	$ 20,149	$ 20,149	$		$ 43,346	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,673,034	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 221,629	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 221,629	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,520,690	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.

Facility Name & ID Number Wesley Village Health Care Center # 0022350 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

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

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

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

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.	/2012	$
13.	/2013	$
14.	/2014	$

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

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

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

C. Vehicle Rental (See instructions.)

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

* 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 Village Health Care Center # 0022350 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [x] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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.

Facility Name & ID Number Wesley Village Health Care Center # 0022350 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		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	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Wesley Village Health Care Center # 0022350 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2011 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 249,486	$ 415,810	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	381,070	635,116	3
4	Supply Inventory (priced at)	17,629	53,422	4
5	Short-Term Investments	100,000	228,837	5
6	Prepaid Insurance	19,635	39,270	6
7	Other Prepaid Expenses	60,890	121,780	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): WE Investment/Bequest Rec		259,410	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 828,710	$ 1,753,646	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable		384,791	11
12	Long-Term Investments	236,085	2,749,226	12
13	Land	48,600	180,000	13
14	Buildings, at Historical Cost	5,245,888	10,028,104	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,147,300	2,322,922	16
17	Accumulated Depreciation (book methods)	(2,520,690)	(6,638,560)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Land Improvements	113,822	558,095	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,271,005	$ 9,584,578	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,099,715	$ 11,338,224	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 71,603	$ 89,504	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	89,678	112,097	29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)		73,000	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	5,793	7,241	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	138,519	173,148	36
37	Member Fee/Apt Dep	189,187	550,192	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 494,779	$ 1,005,182	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,937,087	4,809,250	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,937,087	$ 4,809,250	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,431,866	$ 5,814,432	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 667,849	$ 5,523,792	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,099,715	$ 11,338,224	48

***(See instructions.)**

Facility Name & ID Number Wesley Village Health Care Center # 0022350 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 795,729	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 795,729	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(127,880)	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)**	$ (127,880)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 667,849	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Wesley Village Health Care Center # 0022350 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,700,087	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,700,087	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions	158,079	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 158,079	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,858,166	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	889,960	31
32	Health Care	1,951,030	32
33	General Administration	752,411	33
	B. Capital Expense		
34	Ownership	352,677	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	39,968	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,986,046	40
41	**Income before Income Taxes (line 30 minus line 40)****	(127,880)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (127,880)	43

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

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

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

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

Facility Name & ID Number Wesley Village Health Care Center # 0022350 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,817	2,080	$ 59,956	$ 28.83	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,827	11,307	256,330	22.67	3
4	Licensed Practical Nurses	20,399	21,463	377,856	17.60	4
5	CNAs & Orderlies	57,844	61,540	630,515	10.25	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,896	2,080	24,676	11.86	9
10	Activity Assistants	1,845	1,900	18,358	9.66	10
11	Social Service Workers	1,839	2,080	47,403	22.79	11
12	Dietician					12
13	Food Service Supervisor	1,387	1,664	41,466	24.92	13
14	Head Cook	1,742	2,080	21,840	10.50	14
15	Cook Helpers/Assistants	15,588	16,700	151,487	9.07	15
16	Dishwashers	4,008	4,472	40,110	8.97	16
17	Maintenance Workers	3,252	3,252	49,341	15.17	17
18	Housekeepers	10,545	11,427	108,559	9.50	18
19	Laundry	2,017	2,118	21,324	10.07	19
20	Administrator	2,080	2,080	89,724	43.14	20
21	Assistant Administrator					21
22	Other Administrative	2,080	2,080	38,603	18.56	22
23	Office Manager					23
24	Clerical	5,573	6,059	86,730	14.31	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	5,309	5,940	121,549	20.46	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	150,048	160,322	$ 2,185,827 *	$ 13.63	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	147	$ 4,403	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	1	165	LN 10 Col 3	39
40	Physical Therapy Consultant	14	855	LN 10 Col 3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	17	592	LN 11 Col 3	44
45	Social Service Consultant	17	592	LN 10 Col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	196	$ 13,807		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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 Health Care Center # 0022350 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Shelly Ward	ADM		$ 80,351
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 80,351

B. Administrative - Other

Description	Amount
NOT APPLICABLE	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
CLIFTON GUNDERSON LLP	AUDIT/TAX	$ 30,080
MARCH, MCMILLAN, & DEJOOD	LEGAL	1,468
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 31,548

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 65,134
Unemployment Compensation Insurance	
FICA Taxes	157,805
Employee Health Insurance	205,854
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	$ 428,793

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
NOT APPLICABLE		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	2,291
(Indicate # of checks performed 57)	
Patient Background Checks 29	464
Dues - See Attached	16,435
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,190

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	15,951
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 15,951

**See instructions.

Facility Name & ID Number Wesley Village Health Care Center # 0022350 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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

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

Facility Name & ID Number Wesley Village Health Care Center # 0022350 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **LIFE SERVICES NETWORK**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **42,705** 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. $ **39,968**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(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) 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? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees

WESLEY VILLAGE -UMC
2011 COST REPORT
SCHEDULE OF RECLASSIFICATIONS - COL 5. PG 3

LINE #	DESCRIPTION	DEBIT	CREDIT
3	SALARIES/HOUSEKEEPING	$18,470.92	
10	SALARIES/NURSING		$18,470.92
	** Bed maker - non patient care - Reclassify to Housekeeping to Line 3		
12	SALARIES/SOCIAL SERVICES	$47,403.00	
10	SALARIES/NURSING		$47,403.00
	** Reclassify Social Services Salary to Line 12		
20	FEES/ BACKGROUND CHECKS	$ 2,291.00	
10	OTHER - HEALTH CARE		$ 2,291.00
	**Background Checks - Reclassify to Line 20		
20	FEES/BACKGROUND CHECKS-RESIDENT	$ 464.00	
10	NURSING & MEDICAL - SUPPLIES		$ 464.00
	TOTALS	$68,628.92	$68,628.92

WESLEY VILLAGE, UMC
IDPA COST REPORT FY 2011
ADJUSTMENTS

LINE #	COLUMN					
2	**7**	**FOOD PURCHASE**				
		SCHEDULE VI. SALES TAX, LINE 13				
		SALES TAX-NOT ALLOWALBE 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	$267,274			
		DIVIDED BY 1.01 =	$264,628			
		MUTILIPY BY .01	$ 2,646			
		MUTIPLY BY PRIVATE PAY CENSUS	52.43%			
		EQUALS	$ 1,387			
		DIVIDED BY 2		**$**	**694**	SALES TAX ADJUSTMENT
11	**7**	**ACTIVITIES COL 3**	CABLE TV	**$**	**5,357**	ACTIVITES ADJ
		SCHEDULE VI. TELEPHONE, TV IN RESIDENT ROOMS, LINE 5				
		TOTAL OF ADJUSTMENTS		**$**	**6,051**	

WESLEY VILLAGE

DUES, SUBSCRIPTIONS, LICENSE, & FEES

2010

Fees		
Benefit Planning Consultants - 401K Administration		$ 2,210.00
Illinois Secretary of State - annual report		$ 10.00
Illinois Secretary of State - truck license fee		$ 126.00
Illinois Secretary of State - Van license fee		$ 99.00
United Methodist Association - Eagle Maintenance fee		$ 956.00
Illinois Dept of Public Health License		$ 3,980.00
McDonough County Health Department - Food Service		$ 400.00
West Bend Mutual Insurance Co. - Resident fund bond fee		$ 100.00
Dues		
Life Services Network - annual dues		$ 3,716.00
United Methodist Association - annual Dues		$ 2,595.00
Macomb Chamber of Commerce - annual Dues		$ 273.00
Illinois Nursing Home Administrators Association - annual dues		$ 100.00
American Association of Homes & Services for the Aging - annual dues		$ 1,730.00
MES/HPSI of IL - annual dues		$ 140.00
Employee Background Checks	57	$ 2,291.00
Resident Background Checks	29	$ 464.00
TOTAL		#########