		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.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

I. IDPH License ID Number: 0005439

Facility Name: WESLEY PLACE

Address: 1415 W FOSTER AVENUE (Number) CHICAGO (City) 60640 (Zip Code)

County: COOK

Telephone Number: (773) 769-5500 **Fax #** (773) 769-6287

HFS ID Number:

Date of Initial License for Current Owners: UNKNOWN

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501c3			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Jim Zoros, Chief Financial Officer **Telephone Number:** (773) 769-5500
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/14 to 12/31/14 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) 03/20/15 (Date)
(Type or Print Name) William A. Lowe
(Title) Chief Executive Officer

Paid Preparer

(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

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 PLACE # 0005439 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	108	Skilled (SNF)	108	39,420	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	108	TOTALS	108	39,420	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	9,982	6,520	9,859	26,361	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,982	6,520	9,859	26,361	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.87%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

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

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

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

I. On what date did you start providing long term care at this location?
Date started 1898

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 108 and days of care provided 8,223

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

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

Tax Year: 12/31/14 Fiscal Year: 12/31/14

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

Facility Name & ID Number WESLEY PLACE # 0005439 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	311,051	37,638	170,776	519,465		519,465		519,465			1
2	Food Purchase		237,561		237,561		237,561	(14,802)	222,759			2
3	Housekeeping	153,877	54,051		207,928		207,928		207,928			3
4	Laundry	29,622	18,599		48,221		48,221		48,221			4
5	Heat and Other Utilities			188,080	188,080		188,080		188,080			5
6	Maintenance	135,649	28,267	102,853	266,769		266,769	(2,150)	264,619			6
7	Other (specify):*											7
8	**TOTAL General Services**	630,199	376,116	461,709	1,468,024		1,468,024	(16,952)	1,451,072			8
	B. Health Care and Programs											
9	Medical Director			61,120	61,120		61,120		61,120			9
10	Nursing and Medical Records	2,207,960	216,963	78,021	2,502,944		2,502,944	(15,225)	2,487,719			10
10a	Therapy	41,207	8,078		49,285		49,285		49,285			10a
11	Activities	100,552	7,518	9,262	117,332		117,332		117,332			11
12	Social Services	94,524	848	5,024	100,396		100,396		100,396			12
13	CNA Training											13
14	Program Transportation			9,886	9,886		9,886	(6,455)	3,431			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,444,243	233,407	163,313	2,840,963		2,840,963	(21,680)	2,819,283			16
	C. General Administration											
17	Administrative	138,981			138,981		138,981		138,981			17
18	Directors Fees											18
19	Professional Services			128,815	128,815		128,815		128,815			19
20	Dues, Fees, Subscriptions & Promotions			191,721	191,721		191,721	(51,206)	140,515			20
21	Clerical & General Office Expenses	402,527	43,659	208,896	655,082		655,082	(120,630)	534,452			21
22	Employee Benefits & Payroll Taxes			852,020	852,020		852,020		852,020			22
23	Inservice Training & Education			3,815	3,815		3,815		3,815			23
24	Travel and Seminar			9,770	9,770		9,770		9,770			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			126,537	126,537		126,537		126,537			26
27	Other (specify):*											27
28	**TOTAL General Administration**	541,508	43,659	1,521,574	2,106,741		2,106,741	(171,836)	1,934,905			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,615,950	653,182	2,146,596	6,415,728		6,415,728	(210,468)	6,205,260			29

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

Facility Name & ID Number WESLEY PLACE #0005439 Report Period Beginning: 01/01/14 Ending: 12/31/14

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			804,501	804,501		804,501	(120,000)	684,501			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			129,896	129,896		129,896	(3,635)	126,261			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			4,721	4,721		4,721		4,721			35
36	Other (specify):*											36
37	**TOTAL Ownership**			939,118	939,118		939,118	(123,635)	815,483			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		485,402	1,087,351	1,572,753		1,572,753		1,572,753			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			169,191	169,191		169,191		169,191			42
43	Other (specify):* **Non-Allowable**	84,287		2,303,625	2,387,912		2,387,912	(2,387,912)				43
44	**TOTAL Special Cost Centers**	84,287	485,402	3,560,167	4,129,856		4,129,856	(2,387,912)	1,741,944			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,700,237	1,138,584	6,645,881	11,484,702		11,484,702	(2,722,015)	8,762,687			45

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

Facility Name & ID Number WESLEY PLACE # 0005439 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(13,492)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,312)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(3,635)	32		10
11	Discounts, Allowances, Rebates & Refunds	(14,803)	10		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(115,219)	21		24
25	Fund Raising, Advertising and Promotional	(49,448)	20		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	(2,523,106)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (2,722,015)		$	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			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (2,722,015)		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 PLACE

ID# 0005439

Report Period Beginning: 01/01/14

Ending: 12/31/14

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing Salaries	$ (84,287)	43	1
2	Marketing Travel	(3,769)	43	2
3	Resident Transportation Revenue	(6,455)	14	3
4	Miscellaneous Resident Revenue	(422)	10	4
5	Misc Income - Other	(3,099)	21	5
6	Vending Income	(1,310)	2	6
7	Non-Nursing Home Expenses	(2,299,856)	43	7
8	Depreciation on Non-Care Asset	(120,000)	30	8
9	Gain on Disposal of Asset	(2,150)	6	9
10	LeadingAge Dues - 36%	(1,758)	20	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(2,523,106)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WESLEY PLACE # 0005439 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(14,802)	0	0	0	0	0	0	0	0	0	0	(14,802)	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	(2,150)	0	0	0	0	0	0	0	0	0	0	(2,150)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(16,952)	0	0	0	0	0	0	0	0	0	0	(16,952)	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	(15,225)	0	0	0	0	0	0	0	0	0	0	(15,225)	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	(6,455)	0	0	0	0	0	0	0	0	0	0	(6,455)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(21,680)	0	0	0	0	0	0	0	0	0	0	(21,680)	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	(51,206)	0	0	0	0	0	0	0	0	0	0	(51,206)	20
21	Clerical & General Office Expenses	(120,630)	0	0	0	0	0	0	0	0	0	0	(120,630)	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**	(171,836)	0	0	0	0	0	0	0	0	0	0	(171,836)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(210,468)	0	0	0	0	0	0	0	0	0	0	(210,468)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WESLEY PLACE # 0005439 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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

	Capital Expense D. Ownership	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)	
30	Depreciation	(120,000)	0	0	0	0	0	0	0	0	0	0	(120,000)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,635)	0	0	0	0	0	0	0	0	0	0	(3,635)	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**	(123,635)	0	0	0	0	0	0	0	0	0	0	(123,635)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(2,387,912)	0	0	0	0	0	0	0	0	0	0	(2,387,912)	43
44	**TOTAL Special Cost Centers**	(2,387,912)	0	0	0	0	0	0	0	0	0	0	(2,387,912)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(2,722,015)	0	0	0	0	0	0	0	0	0	0	(2,722,015)	45

Facility Name & ID Number WESLEY PLACE # 0005439 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES

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

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

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. [X] 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	6	Repairs and Maintenance	$ 2,316	Naper Valley Corporation DBA PrimeLife Home Improvement	33.00%	$ 2,316	$	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			$ 2,316			$ 2,316	$ *	14

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

Facility Name & ID Number WESLEY PLACE # 0005439 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	Maurlea Babb	BOD						1
2	Thomas Burkle	BOD						2
3	John Callen	BOD						3
4	*Noel DeBacker	BOD						4
5	Martin Deppe	BOD						5
6	Leslie Desmond	BOD						6
7	Michael Dudley	BOD						7
8	Kathleen West	BOD						8
9	J. Herbert Landon	BOD						9
10	Larry Loecker	BOD						10
11	William A. Lowe	BOD						11
12	Zoa Norman	BOD						12
13	J. Christian Slusher	BOD						13
14	Martha Strong	BOD						14
15	Samuel Witwer	BOD						15
16	Dick Wright	BOD						16
17	Lawrence Zydowsky	BOD						17
18								18
19								19
20	* Received compensation as Wesley Place Medical Director of $39,517 during FY 2014.							20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number WESLEY PLACE # 0005439 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number WESLEY PLACE # 0005439 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 [X]

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 PLACE # 0005439 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	Illinois Finance Authority		X	Revenue Bonds, Series 2012		03/01/12	$ 4,834,400	$ 4,454,400	03/01/2042	Variable	$ 129,896	1
2				Facility Renovations								2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8							Interest Income Offset				(3,635)	8
9	TOTAL Facility Related						$ 4,834,400	$ 4,454,400			$ 126,261	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 4,834,400	$ 4,454,400			$ 126,261	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 PLACE **#** 0005439 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 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 2014 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:			
	2009		**8**
	2010		**9**
	2011		**10**
	2012		**11**
	2013		**12**

N/A - Facility is not subject to real estate taxes.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	**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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WESLEY PLACE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0005439

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	N/A - Facility is not subject to real estate taxes.		$	$
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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

Facility Name & ID Number WESLEY PLACE # 0005439 Report Period Beginning: 01/01/14 Ending: 12/31/14

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [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. [X] (c) Rent equipment from Completely Unrelated Organization.

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

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

Related business entities are identified on page 6, Schedule VII - Related Parties. Specific facilities located adjacent to Wesley Place are
Winwood Apartments, Inc. - 1406 W. Winona - a 31 unit HUD subsidized apartment building for very low income adults
Glenwood Apartments - 5027 N. Glenwood - a 13 unit apartment complex for very low income adults
Foster Apartments - 1433 W. Foster - 2 flat - intergenerational housing.; Foster-Glen Apartments - 5135 N. Glenwood - 6 Flat - market rate housing
Wellness Center Building - 1355 W. Foster - contains offices of United Methodist Homes & Services, UMH&S Foundation, and Home Care. 1st floor rented to White Crane Wellness Center
Hiram Property - 1351 W. Foster - storage and parking for the organization.
The costs for these entities are segregated and not included as part of the financial information presented on this report for Wesley Place

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number WESLEY PLACE # 0005439 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	42		1922	1922	$ 214,000	$		$	$	$ 214,000	4
5	48		1951	1951	297,000					297,000	5
6			1972	1972	941,207					941,207	6
7	8		1973	1973	541,942					541,942	7
8	10		1974	1974	479,275					479,275	8
	Improvement Type**										
9	Additions - 1975			1975	898,240					898,240	9
10	Additions - 1976			1976	1,203					1,203	10
11	Additions - 1980			1980	1,300					1,306	11
12	Additions - 1983			1983	215					215	12
13	Additions - 1984			1984	1,188					1,188	13
14	Additions - 1985			1985	7,958					7,958	14
15	Additions - 1986			1986	31,965					31,965	15
16	Additions - 1987			1987	3,680					3,680	16
17	Additions - 1988			1988	41,556					41,556	17
18	Additions - 1989			1989	123,634					123,634	18
19	Additions - 1990			1990	81,482					81,555	19
20	Additions - 1991			1991	155,195					154,296	20
21	Additions - 1992			1992	276,411					271,528	21
22	Additions - 1993			1993	226,117					219,587	22
23	Additions - 1994			1994	261,289	312		312		257,630	23
24	Additions - 1995			1995	162,755	14		14		162,678	24
25	Additions - 1996			1996	281,475	7,177		7,177		234,817	25
26	Additions - 1997			1997	55,643	716		716		64,771	26
27	Additions - 1998			1998	110,213	15		15		110,096	27
28	Additions - 1999			1999	34,124	240		240		31,835	28
29	Additions - 2000			2000	136,254	1,967		1,967		125,276	29
30	Additions - 2001			2001	101,321	546		546		95,045	30
31	Additions - 2002			2002	245,777	248		248		243,912	31
32	Additions - 2003			2003	230,162	1,465		1,465		217,719	32
33	Additions - 2004			2004	84,046	2,951		2,951		81,744	33
34	Additions - 2005			2005	244,694	24,125		24,125		229,187	34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number WESLEY PLACE # 0005439 Report Period Beginning: 01/01/14 Ending: 12/31/14

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			$	$		$	$	$	37
38	Additions - 2006	2006	294,917	27,828		27,828		252,746	38
39	Additions - 2007	2007	221,313	17,945		17,945		163,097	39
40	Additions - 2008	2008	149,948	6,806		6,806		90,650	40
41	Additions - 2009	2009	139,846	11,458		11,458		74,085	41
42									42
43	Hot Water Heater Circulating Pump Motor & Seals	2010	4,150	166	25	166		747	43
44	Boiler Fire Tube, Solenoid Strainer Valve, and Controller	2010	4,475	179	25	179		806	44
45	Chiller Room Ventilation Motor, Actuator and Thermostats	2010	4,488	180	25	180		809	45
46	Fire Pump Check Valve, Sprinkler Heads - Ground Floor	2010	8,376	838	10	838		3,770	46
47	Refinish Fire Escape Stairways	2010	7,800	780	10	780		3,510	47
48	1st, 2nd, & 3rd Floors - Drinking Fountains, Sinks, Lockers	2010	3,958	396	10	396		1,783	48
49	Construction of Built-In Laminate Counter Tops, Door - Med Recc	2010	2,960	296	10	296		1,332	49
50	Fire Sprinkler Annunciator Panel - 2nd Floor Nursing Station	2010	5,340	534	10	534		2,403	50
51	Exterior Tuckpointing, Brickwork, Flashing, Wall Caps, Weeps	2010	10,480	1,048	10	1,048		4,716	51
52	Goulds Ejector Pump - Dietary Storage Room	2010	3,465	346	10	346		1,557	52
53									53
54	HVAC - New Controller, Chilled Water Sensors, Heater Circuit &	2011	7,441	298	25	298		1,043	54
55	Main Sewer Line Replacement	2011	15,000	1,500	10	1,500		5,250	55
56	Exterior Masonry, Paving - Main Entrance Area	2011	55,349	5,535	10	5,535		19,372	56
57	Life Safety - New Emergency Generator, Vertical Shafts, Elevator	2011	465,050	23,253	20	23,253		81,385	57
58	1st Fl-Locker Room Renovation- Install Tile Floor, Ceiling, Paintir	2011	16,735	1,674	10	1,674		5,856	58
59	3rd, 4th Floor Resident Bathroom Renovation - Flooring, Painting,	2011	66,570	6,657	10	6,657		23,301	59
60	3rd, 4th Floor Resident Room Renovations - Flooring, Blinds, Pain	2011	101,732	10,173	10	10,173		35,607	60
61	3rd, 4th Floor - Install Handrails on Hallway Walls	2011	8,110	811	10	811		2,840	61
62	Exterior - Tuckpointing, Brickwork, Chemical Treatment	2011	26,404	2,640	10	2,640		9,240	62
63	3rd, 4th, & 5th Floors - Install Nurse Call/Wander System	2011	95,715	9,572	10	9,572		33,502	63
64	Ground Floor - Sewage Ejector Pump	2011	3,367	337	10	337		1,178	64
65	Boiler Room - Pnuematic Controls for Hot Water & Fire Pump Pr	2011	3,403	340	10	340		1,190	65
66	Architect and General Contractor Fees	2011	195,567	19,556	10	19,556		68,446	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 8,193,280	$ 190,922		$ 190,922	$	$ 7,056,266	70

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

Facility Name & ID Number WESLEY PLACE # 0005439 Report Period Beginning: 01/01/14 Ending: 12/31/14

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		$ 8,193,280	$ 190,922		$ 190,922	$	$ 7,056,266	1
2									2
3	HVAC - New Fan Coil Units, Duct Detectors, Compressor, Pneuma	2012	35,367	1,415	25	1,415		3,537	3
4	Carpeting/Flooring - Admission Office, Business Office - 1st Floor	2012	8,762	1,752	5	1,752		4,380	4
5	Life Safety - Fire Protection, Vertical Shafts, Elevator Recall, Emer	2012	258,870	12,944	20	12,944		32,360	5
6	Parking Lot Excavation, Sewer Replacement, Paving, and Canopy/	2012	178,074	17,807	10	17,807		44,518	6
7	Architect, General Contractor Fees	2012	2,018,871	201,888	10	201,888		504,719	7
8	Rooftop EMR Wireless Installation	2012	6,981	698	10	698		1,745	8
9	Interior, exterior signs and signage	2012	41,881	4,188	10	4,188		10,470	9
10	Exterior Brickwork and Roof Drainage	2012	26,902	2,690	10	2,690		6,725	10
11	2nd, 3rd, 4th Floor Resident Rooms - Lighting, Electrical, Painting	2012	153,754	15,375	10	15,375		38,438	11
12	2nd, 3rd, 4th Floor - Hallway Handrails, Wall Protection, Nurse Ca	2012	81,092	8,109	10	8,109		20,273	12
13	Flooring - Stairwell and 2nd Floor Hallways	2012	42,700	4,270	10	4,270		10,675	13
14	Ground Floor - New Entrance Door, Flooring/Painting - Women's	2012	21,857	2,186	10	2,186		5,465	14
15	1st Floor - Ceiling Tile, Painting, Dietary Sewage Pump Installatio	2012	16,703	1,670	10	1,670		4,175	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)		$ 11,085,094	$ 465,914		$ 465,914	$	$ 7,743,746	34

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

Facility Name & ID Number WESLEY PLACE # 0005439 Report Period Beginning: 01/01/14 Ending: 12/31/14

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		$ 11,085,094	$ 465,914		$ 465,914	$	$ 7,743,746	1
2									2
3	*Architect, General Contractor Fees, Legal Review of Renovation I	2013	671,463	67,146	10	67,146		100,719	3
4	First Floor - Conference Room/Living Room - New Ceiling Tiles, P	2013	4,123	412	10	412		618	4
5	Ground Floor - Cafeteria/Admin Office/Utility Room - New Ceiling	2013	4,539	454	10	454		681	5
6	Exterior Signage for WP/Internal Signage for Resident Rooms/Offi	2013	11,836	1,184	10	1,184		1,776	6
7	4th Floor Hallways/Dining Room/Stairwell Painting	2013	3,025	302	10	302		453	7
8	2nd Floor Fire Exit Door/New Magnetic Locks/New Door Holder C	2013	6,222	622	10	622		933	8
9	Parking Lot - Landscaping	2013	9,561	956	10	956		1,434	9
10	Boiler and Freezer Repair - Installed Modulation Motor, Required	2013	68,674	2,747	25	2,747		4,120	10
11	Fire Sprinkler Replacements, Installed Fire Exit Devices on 1st and	2013	19,728	986	20	986		1,480	11
12									12
13	Parking Lot - Paving, Fencing, Masonry, Backflow Preventer Irrig	2013	7,411	741	10	741		1,112	13
14	HVAC - Heating and Cooling Pipings - 2nd Floor, Compressor/Mo	2013	2,140	86	25	86		129	14
15	Life Safety - Fire Protection, Vertical Shafts, Elevator Recall	2013	3,696	185	20	185		277	15
16	Stairwell - Grids for Fall Protection - IDPH Required	2013	23,056	2,306	10	2,306		3,459	16
17	Ground Floor - Ceiling Tiles, Painting, Generator Kill Switch	2013	3,725	373	10	373		559	17
18	1st Floor - Ceiling Tiles, Flooring, Lighting, Tiling, Wall Protection	2013	145,139	14,514	10	14,514		21,771	18
19	2nd, 3rd, 4th Floors - Ceiling Tiles, Electrical Conduits, Magnetic I	2013	8,586	859	10	859		1,288	19
20	Resident Wander System with Door Units, Transmitters, Pull Cord	2013	16,053	1,605	10	1,605		2,408	20
21	Exterior Roof Replacement, Tuckpointing, Masonry	2013	15,221	1,522	10	1,522		2,283	21
22									22
23	HVAC - Cooling Tower - Hot/Cold Basin Liner, Hydro Motors, Fa	2014	60,484	1,210	25	1,210		1,210	23
24	Carpeting - 1st Floor Nursing Office	2014	600	60	5	60		60	24
25	Landscaping - Acer Ruburn Red Sunset Tree/Installation	2014	2,150	108	10	108		108	25
26	Flooring/Painting - Resident Rooms, Nursing Station - 1st, 2nd, 3rd	2014	40,468	2,024	10	2,024		2,024	26
27	Brickwork/Tuckpointing - Exterior - Miller & Swift Halls	2014	30,828	1,542	10	1,542		1,542	27
28	Art Studio Construction - Lower Level - Framing, Electrical, Paint	2014	10,000	500	10	500		500	28
29	Fire Safety - Sprinkler Heads, Exit Devices, Stairwell Interrupter C	2014	15,507	775	10	775		775	29
30	Vault Room - Replace Metal Door	2014	3,925	196	10	196		196	30
31	Water Heater - Laundry Room - Lower Level	2014	6,425	321	10	321		321	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,279,679	$ 569,650		$ 569,650	$	$ 7,895,982	34

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

Facility Name & ID Number WESLEY PLACE # 0005439 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	$ 1,494,516	$ 107,954	$ 107,954	$		$ 918,070	71
72	Current Year Purchases	41,135	2,057	2,057			2,057	72
73	Fully Depreciated Assets	1,277,010					1,277,010	73
74								74
75	TOTALS	$ 2,812,661	$ 110,011	$ 110,011	$		$ 2,197,137	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	Dodge Caravan, 2014	2014	$ 38,716	$ 4,840	$ 4,840	$		$ 4,840	76
77										77
78										78
79										79
80	TOTALS			$ 38,716	$ 4,840	$ 4,840	$		$ 4,840	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)	$ 17,131,056	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 684,501	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 684,501	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)	$ 10,097,959	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Non-Nursing Home Assets/2006-2014	$ 1,099,830	$ 17,285	$ 69,938	86
87	2010 NH Bldg Mkt Value Write Up	3,000,000	120,000	420,000	87
88					88
89					89
90					90
91	TOTALS	$ 4,099,830	$ 137,285	$ 489,938	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 PLACE # 0005439 Report Period Beginning: 01/01/14 Ending: 12/31/14

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

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

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.	/2015	$
13.	/2016	$
14.	/2017	$

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: $ 4,721 Description: Copiers - Leased - $3,337, Dishwasher - Leased - $1,384
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number WESLEY PLACE # 0005439 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 PLACE # 0005439 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L39, C3	hrs	$	5,708	$ 416,665	$	5,708	$ 416,665	1
2	Licensed Speech and Language Development Therapist	L39, C3	hrs		2,413	101,768		2,413	101,768	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L39, C3	hrs		10,445	510,926		10,445	510,926	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				410,637		410,637	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Med Suppl, Lab, X-Ra	L39, C2, C3				57,992	74,765		132,757	13
14	TOTAL			$	18,566	$ 1,087,351	$ 485,402	18,566	$ 1,572,753	14

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

STATE OF ILLINOIS

Facility Name & ID Number WESLEY PLACE # 0005439 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/14 (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	$ 113,392	$	1
2	Cash-Patient Deposits	19,543		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 253,364)	1,559,453		3
4	Supply Inventory (priced at)	27,620		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(1,597,770)		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 122,238	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	35,000		12
13	Land	2,800,000		13
14	Buildings, at Historical Cost	15,502,963		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,927,923		16
17	Accumulated Depreciation (book methods)	(10,587,897)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe **Goodwill**	1,000,000		22
23	Other(specify): **Unamortized Financing Costs**	93,971		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 11,771,960	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 11,894,198	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 201,011	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	101,004		28
29	Short-Term Notes Payable	240,000		29
30	Accrued Salaries Payable	676,184		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	60,784		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	**Unexpended Restricted Gifts**	41,737		36
37	**Due to Third-Party Payor**	148,783		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,469,503	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	5,131,700		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 5,131,700	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,601,203	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 5,292,995	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 11,894,198	$	48

***(See instructions.)**

Facility Name & ID Number WESLEY PLACE # 0005439 Report Period Beginning: 01/01/14 Ending: 12/31/14

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 5,622,186	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 5,622,186	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(569,191)	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) **Equity Transfer from Parent Corporation**	240,000	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (329,191)	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)**	$ 5,292,995	24 *

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

Facility Name & ID Number WESLEY PLACE # 0005439 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,177,305	1
2	Discounts and Allowances for all Levels	(1,161,833)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,015,472	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,155,202	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,155,202	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	13,492	14
15	Telephone, Television and Radio	2,312	15
16	Rental of Facility Space		16
17	Sale of Drugs	413,375	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	27,186	19
20	Radiology and X-Ray	8,673	20
21	Other Medical Services	103,966	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 569,004	23
	D. Non-Operating Revenue		
24	Contributions	550	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 550	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Other - See attached schedule	2,175,283	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,175,283	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,915,511	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,468,024	31
32	Health Care	2,840,963	32
33	General Administration	2,106,741	33
	B. Capital Expense		
34	Ownership	939,118	34
	C. Ancillary Expense		
35	Special Cost Centers	3,960,665	35
36	Provider Participation Fee	169,191	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,484,702	40
41	**Income before Income Taxes (line 30 minus line 40)****	(569,191)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (569,191)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,575,060	44
45	Private Pay - Net Inpatient Revenue	1,599,119	45
46	Medicare - Net Inpatient Revenue	2,561,763	46
47	Other-(specify) Managed Care	279,530	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,015,472	49

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

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

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

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

Facility Name & ID Number WESLEY PLACE # 0005439 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	942	1,063	$ 53,171	$ 50.02	1
2	Assistant Director of Nursing					2
3	Registered Nurses	35,232	38,652	1,111,758	28.76	3
4	Licensed Practical Nurses	4,814	5,321	137,751	25.89	4
5	CNAs & Orderlies	73,927	80,126	822,626	10.27	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,042	3,192	41,207	12.91	8
9	Activity Director					9
10	Activity Assistants	6,189	6,771	100,552	14.85	10
11	Social Service Workers	3,802	4,016	94,524	23.54	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	3,696	4,202	62,019	14.76	14
15	Cook Helpers/Assistants	16,794	18,317	196,692	10.74	15
16	Dishwashers	4,919	5,297	52,340	9.88	16
17	Maintenance Workers	5,945	6,661	135,649	20.36	17
18	Housekeepers	13,215	14,281	153,877	10.77	18
19	Laundry	2,787	2,939	29,622	10.08	19
20	Administrator	2,156	2,538	138,981	54.76	20
21	Assistant Administrator					21
22	Other Administrative	1,640	2,078	67,308	32.39	22
23	Office Manager					23
24	Clerical	14,475	16,050	335,219	20.89	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	910	1,043	20,223	19.39	31
32	Other Health Care(specify)					32
33	Other(specify) See Suppl Sched.	5,031	5,563	146,718	26.37	33
34	TOTAL (lines 1 - 33)	199,516	218,110	$ 3,700,237 *	$ 16.97	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		$		35
36	Medical Director	624	61,120	L9, C3	36
37	Medical Records Consultant	96	4,616	L10, C3	37
38	Nurse Consultant	208	10,616	L10, C3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	45	2,448	L11, C3	44
45	Social Service Consultant	48	3,264	L12, C3	45
46	Other(specify)				46
47	Dietary Management Fees	Monthly	168,170	L1, C3	47
48					48
49	TOTAL (lines 35 - 48)	1,021	$ 250,234		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 PLACE # 0005439 Report Period Beginning: 01/01/14 Ending: 12/31/14

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
E.D. Barnett	Administrator		$ 46,387
Jay Evans	Administrator		34,524
William Lowe	CEO		58,070
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 138,981

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Frost Ruttenberg & Rothblatt	Audit	$ 20,483
FR&R Consulting	Accounting/Consulting	5,518
Switchfast	Data Processing	228
KPMG	Data Processing	495
IVANS/Ability Network	Data Processing	5,588
Provinet Solutions	Data Processing/EMR	22,920
Legal - See Attached Schedule		23,717
Coporate Allocation -	Data Processing	33,779
Coporate Allocation -	Consulting	16,087
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 128,815

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 92,738
Unemployment Compensation Insurance	53,983
FICA Taxes	269,410
Employee Health Insurance	426,051
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Recognition	9,745
Employee Wellness	93
TOTAL (agree to Schedule V, line 22, col.8)	$ 852,020

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	36,460
Health Care Worker Background Check	1,465
(Indicate # of checks performed 84)	
Patient Background Checks 535	5,395
Books and Subscriptions	14,140
Membership Fees & Fees	9,691
Resident Relations	1,018
Advertising	49,448
Sequestration Reduction Fees	72,346
Less: Public Relations Expense	( )
Non-allowable advertising	(49,448)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 140,515

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	2,010
Seminar Expense	7,760
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,770

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number WESLEY PLACE # 0005439 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number WESLEY PLACE # 0005439 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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. LeadingAge Network of IL - $4,883

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 67,821 Line L10, C2

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ 169,191
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ N/A Has any meal income been offset against related costs? YES Indicate the amount. $ 13,492

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 100% of L14,
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: FROST RUTTENBERG & ROTHBLATT, P.C.

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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. YES
Attach invoices and a summary of services for all architect and appraisal fees.