

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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

<p>I. IDPH License ID Number: <u>0005439</u></p> <p>Facility Name: <u>WESLEY PLACE</u></p> <p>Address: <u>1415 WEST FOSTER AVE</u> <u>CHICAGO</u> <u>60640</u> Number City Zip Code</p> <p>County: <u>COOK</u></p> <p>Telephone Number: <u>(773) 769-5500</u> Fax # <u>(773) 769-6287</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>UNKNOWN</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code <u>501c3</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other</td> <td>_____</td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Jim Zoros, Chief Financial Officer</u> Telephone Number: <u>(773) 769-5500</u> Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code <u>501c3</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.	_____		<input type="checkbox"/> Limited Liability Co.	_____		<input type="checkbox"/> Trust	_____		<input type="checkbox"/> Other	_____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/16</u> to <u>12/31/16</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 20%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td><u>03/17/17</u></td> </tr> <tr> <td>(Type or Print Name) <u>William A. Lowe</u></td> <td>(Date)</td> </tr> <tr> <td></td> <td>(Title) <u>Chief Executive Officer</u></td> <td></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) _____</td> <td>(Date)</td> </tr> <tr> <td>(Print Name and Title) _____</td> <td></td> </tr> <tr> <td>(Firm Name & Address) _____</td> <td></td> </tr> <tr> <td>(Telephone) () _____</td> <td>Fax # () _____</td> </tr> </table> <p>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____	<u>03/17/17</u>	(Type or Print Name) <u>William A. Lowe</u>	(Date)		(Title) <u>Chief Executive Officer</u>		Paid Preparer	(Signed) _____	(Date)	(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) () _____	Fax # () _____
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																								
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	(Telephone) () _____	Fax # () _____																																								

Facility Name & ID Number WESLEY PLACE

0005439 Report Period Beginning: 01/01/16 Ending: 12/31/16

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	108	Skilled (SNF)	108	39,528	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	39,528	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	9,368	7,980	9,668	27,016	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,368	7,980	9,668	27,016	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.35%

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

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

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

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

N/A

F. Does the facility maintain a daily midnight census?

Yes

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

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

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

Date started 1898

J. Was the facility purchased or leased after January 1, 1978?

YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 108 and days of care provided 7,838

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/16 Fiscal Year: 12/31/16

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

Facility Name & ID Number **WESLEY PLACE** # **0005439** Report Period Beginning: **01/01/16** Ending: **12/31/16**

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	368,483	43,688	53,568	465,739		465,739		465,739		1
2	Food Purchase		222,445		222,445		222,445	(10,206)	212,239		2
3	Housekeeping	177,621	55,322		232,943		232,943		232,943		3
4	Laundry	39,147	15,010		54,157		54,157		54,157		4
5	Heat and Other Utilities			177,202	177,202		177,202		177,202		5
6	Maintenance	190,214	28,323	121,994	340,531		340,531	(363)	340,168		6
7	Other (specify):*										7
8	TOTAL General Services	775,465	364,788	352,764	1,493,017		1,493,017	(10,569)	1,482,448		8
	B. Health Care and Programs										
9	Medical Director			61,120	61,120		61,120		61,120		9
10	Nursing and Medical Records	2,419,711	242,972	97,244	2,759,927		2,759,927	(23,270)	2,736,657		10
10a	Therapy	57,540	12,978		70,518		70,518		70,518		10a
11	Activities	124,895	8,927	8,692	142,514		142,514		142,514		11
12	Social Services	116,102	675	5,414	122,191		122,191		122,191		12
13	CNA Training										13
14	Program Transportation			21,406	21,406		21,406	(21,406)			14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,718,248	265,552	193,876	3,177,676		3,177,676	(44,676)	3,133,000		16
	C. General Administration										
17	Administrative	197,494			197,494		197,494		197,494		17
18	Directors Fees										18
19	Professional Services			261,873	261,873		261,873		261,873		19
20	Dues, Fees, Subscriptions & Promotions			259,089	259,089		259,089	(97,955)	161,134		20
21	Clerical & General Office Expenses	572,013	43,012	185,833	800,858		800,858	(111,326)	689,532		21
22	Employee Benefits & Payroll Taxes			782,288	782,288		782,288		782,288		22
23	Inservice Training & Education			4,996	4,996		4,996		4,996		23
24	Travel and Seminar			8,319	8,319		8,319		8,319		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			144,279	144,279		144,279		144,279		26
27	Other (specify):*										27
28	TOTAL General Administration	769,507	43,012	1,646,677	2,459,196		2,459,196	(209,281)	2,249,915		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,263,220	673,352	2,193,317	7,129,889		7,129,889	(264,526)	6,865,363		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			788,439	788,439		788,439	(120,000)	668,439		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			98,436	98,436		98,436	(151)	98,285		32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds			15,797	15,797		15,797		15,797		34
35	Rent-Equipment & Vehicles			5,360	5,360		5,360		5,360		35
36	Other (specify):*										36
37	TOTAL Ownership			908,032	908,032		908,032	(120,151)	787,881		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		541,155	1,013,471	1,554,626		1,554,626		1,554,626		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			173,909	173,909		173,909		173,909		42
43	Other (specify):* Non-Allowable	86,372		1,586,881	1,673,253		1,673,253	(1,673,253)			43
44	TOTAL Special Cost Centers	86,372	541,155	2,774,261	3,401,788		3,401,788	(1,673,253)	1,728,535		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,349,592	1,214,507	5,875,610	11,439,709		11,439,709	(2,057,930)	9,381,779		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:

01/01/16

Ending:

12/31/16

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(9,582)	2		4
5	Telephone, TV & Radio in Resident Rooms	(917)	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	(151)	32		10
11	Discounts, Allowances, Rebates & Refunds	(18,027)	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	(107,250)	21		24
25	Fund Raising, Advertising and Promotional	(95,427)	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	(1,826,576)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (2,057,930)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (2,057,930)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

WESLEY PLACE

ID# 0005439

Report Period Beginning: 01/01/16

Ending: 12/31/16

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Marketing Salaries	\$ (86,372)	43	1
2	Marketing/Non Allowable Travel	(4,300)	43	2
3	Resident Transportation Revenue	(21,406)	14	3
4	Miscellaneous Resident Revenue	(5,243)	10	4
5	Misc Income - Other	(3,159)	21	5
6	Vending Income	(624)	2	6
7	Non-Nursing Home Expenses	(1,582,581)	43	7
8	Depreciation on Non-Care Asset	(120,000)	30	8
9	LeadingAge Dues - 36%	(2,528)	20	9
10	Contract Services - EVS	(363)	6	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	(1,826,576)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WESLEY PLACE

0005439

Report Period Beginning:

01/01/16

Ending:

12/31/16

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	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(10,206)	0	0	0	0	0	0	0	0	0	0	(10,206)	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	(363)	0	0	0	0	0	0	0	0	0	0	(363)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(10,569)	0	0	0	0	0	0	0	0	0	0	(10,569)	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	(23,270)	0	0	0	0	0	0	0	0	0	0	(23,270)	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	(21,406)	0	0	0	0	0	0	0	0	0	0	(21,406)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(44,676)	0	0	0	0	0	0	0	0	0	0	(44,676)	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	(97,955)	0	0	0	0	0	0	0	0	0	0	(97,955)	20
21	Clerical & General Office Expenses	(111,326)	0	0	0	0	0	0	0	0	0	0	(111,326)	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	(209,281)	0	0	0	0	0	0	0	0	0	0	(209,281)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(264,526)	0	0	0	0	0	0	0	0	0	0	(264,526)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WESLEY PLACE # 0005439 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS
													(to Sch V, col.7)
30	Depreciation	(120,000)	0	0	0	0	0	0	0	0	0	0	(120,000) 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(151)	0	0	0	0	0	0	0	0	0	0	(151) 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	(120,151)	0	0	0	0	0	0	0	0	0	0	(120,151) 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):*	(1,673,253)	0	0	0	0	0	0	0	0	0	0	(1,673,253) 43
44	TOTAL Special Cost Centers	(1,673,253)	0	0	0	0	0	0	0	0	0	0	(1,673,253) 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(2,057,930)	0	0	0	0	0	0	0	0	0	0	(2,057,930) 45

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 & SERVICE	100%			NAPER VALLEY CO	CHICAGO	SR HOME IMPROV
				UMH&S FOUNDATI	CHICAGO	FOUNDATION
				WINWOOD APARTM	CHICAGO	ELDERLY HOUSIN
				UNITED NURSING S	CHICAGO	NURSE RECRUTE
				PARASOL ALLIANC	CHICAGO	INFORMATION TE

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
	V	19 Information Technology Support	\$ 42,788	Parasol Alliance, LLC	19.00%	\$ 42,788	\$	1
	V							2
	V							3
	V							4
	V							5
	V							6
	V							7
	V							8
	V							9
	V							10
	V							11
	V							12
	V							13
14	Total		\$ 42,788			\$ 42,788	\$ *	14

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

Facility Name & ID Number

WESLEY PLACE

0005439

Report Period Beginning:

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Ending:

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VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Thomas Burkle	BOD						1
2	John Callen	BOD						2
3	*Noel DeBacker	BOD						3
4	Martin Deppe	BOD						4
5	Leslie Desmond	BOD						5
6	John F. Disterhoft	BOD						6
7	Michael Dudley	BOD						7
8	Kathleen West	BOD						8
9	Maurlea Babb	BOD						9
10	Larry Loecker	BOD						10
11	William A. Lowe	BOD						11
12	Peter D. Morris	BOD						12
13	Zoa Norman	BOD						13
14	J. Christian Slusher	BOD						14
15	Martha Strong	BOD						15
16	Samuel Witwer, Jr.	BOD						16
17	Dick Wright	BOD						17
18	Lawrence Zydowsky	BOD						18
19								19
20								20
21	* Received compensation as Wesley Place Medical Director of \$39,545 during FY 2016.							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: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

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

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

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

Facility Name & ID Number WESLEY PLACE

0005439 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number

WESLEY PLACE

0005439

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IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	Illinois Finance Authority		X	Revenue Bonds, Series 2012		03/01/12	\$ 4,834,400	\$ 4,074,400	03/01/2042	Variable	\$ 98,436	1						
2				Facility Renovations								2						
3												3						
4												4						
5												5						
Working Capital																		
6												6						
7												7						
8							Interest Income Offset				(151)	8						
9	TOTAL Facility Related						\$ 4,834,400	\$ 4,074,400			\$ 98,285	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	\$ 4,074,400			\$ 98,285	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2015 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 2016 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:	2011	8
	2012	9
	2013	10
	2014	11
	2015	12

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

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2015	\$	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.

2015 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 2015 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 2015.

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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:

01/01/16 Ending:

12/31/16

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

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

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

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

Foster Apartments - 1433 W. Foster - 2 flat - intergenerational housing; Foster-Glen Apartments - 5135 N. Glenwood - 6 Flat - market rate housing.

Wellness Center Building - 1355 W. Foster - contains offices of United Methodist Homes & Services and UMH&S Foundation. 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 NO
If so, please complete the following:

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

Nature of Costs:

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

XI. OWNERSHIP COSTS:

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

Facility Name & ID Number WESLEY PLACE

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	42	1922	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		258,254	23
24	Additions - 1995		1995	162,755	14		14		162,706	24
25	Additions - 1996		1996	281,475	7,177		7,177		249,171	25
26	Additions - 1997		1997	55,643	716		716		66,203	26
27	Additions - 1998		1998	110,213	15		15		110,126	27
28	Additions - 1999		1999	34,124	240		240		32,315	28
29	Additions - 2000		2000	136,254	1,967		1,967		129,210	29
30	Additions - 2001		2001	101,321	546		546		96,137	30
31	Additions - 2002		2002	245,777	248		248		244,408	31
32	Additions - 2003		2003	230,162	1,465		1,465		220,649	32
33	Additions - 2004		2004	84,046	243		243		82,230	33
34	Additions - 2005		2005	244,694	344		344		241,762	34
35										35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number WESLEY PLACE

0005439

Report Period Beginning:

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Ending:

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38	Additions - 2006	2006	294,917	13,934		13,934		294,508	38
39	Additions - 2007	2007	221,313	17,945		17,945		198,987	39
40	Additions - 2008	2008	149,948	6,806		6,806		104,262	40
41	Additions - 2009	2009	139,846	8,997		8,997		92,079	41
42									42
43	Hot Water Heater Circulating Pump Motor & Seals	2010	4,150	166	25	166		1,079	43
44	Boiler Fire Tube, Solenoid Strainer Valve, and Controller	2010	4,475	179	25	179		1,164	44
45	Chiller Room Ventilation Motor, Actuator and Thermostats	2010	4,488	180	25	180		1,169	45
46	Fire Pump Check Valve, Sprinkler Heads - Ground Floor	2010	8,376	838	10	838		5,446	46
47	Refinish Fire Escape Stairways	2010	7,800	780	10	780		5,070	47
48	1st, 2nd, & 3rd Floors - Drinking Fountains, Sinks, Lockers	2010	3,958	396	10	396		2,575	48
49	Construction of Built-In Laminate Counter Tops, Door - Med Rec	2010	2,960	296	10	296		1,924	49
50	Fire Sprinkler Annunciator Panel - 2nd Floor Nursing Station	2010	5,340	534	10	534		3,471	50
51	Exterior Tuckpointing, Brickwork, Flashing, Wall Caps, Weeps	2010	10,480	1,048	10	1,048		6,812	51
52	Goulds Ejector Pump - Dietary Storage Room	2010	3,465	346	10	346		2,249	52
53									53
54	HVAC - New Controller, Chilled Water Sensors, Heater Circuit &	2011	7,441	298	25	298		1,639	54
55	Main Sewer Line Replacement	2011	15,000	1,500	10	1,500		8,250	55
56	Exterior Masonry, Paving - Main Entrance Area	2011	55,349	5,535	10	5,535		30,442	56
57	Life Safety - New Emergency Generator, Vertical Shafts, Elevator	2011	465,050	23,253	20	23,253		127,891	57
58	1st Fl-Locker Room Renovation- Install Tile Floor, Ceiling, Painti	2011	16,735	1,674	10	1,674		9,204	58
59	3rd, 4th Floor Resident Bathroom Renovation - Flooring, Painting	2011	66,570	6,657	10	6,657		36,615	59
60	3rd, 4th Floor Resident Room Renovations - Flooring, Blinds, Pair	2011	101,732	10,173	10	10,173		55,953	60
61	3rd, 4th Floor - Install Handrails on Hallway Walls	2011	8,110	811	10	811		4,462	61
62	Exterior - Tuckpointing, Brickwork, Chemical Treatment	2011	26,404	2,640	10	2,640		14,520	62
63	3rd, 4th, & 5th Floors - Install Nurse Call/Wander System	2011	95,715	9,572	10	9,572		52,646	63
64	Ground Floor - Sewage Ejector Pump	2011	3,367	337	10	337		1,852	64
65	Boiler Room - Pnuematic Controls for Hot Water & Fire Pump Pr	2011	3,403	340	10	340		1,870	65
66	Architect and General Contractor Fees	2011	195,567	19,556	10	19,556		107,559	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 8,193,280	\$ 148,078		\$ 148,078	\$	\$ 7,378,204	70

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

Facility Name & ID Number WESLEY PLACE

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 8,193,280	\$ 148,078		\$ 148,078	\$	\$ 7,378,204	1
2									2
3	HVAC - New Fan Coil Units, Duct Detectors, Compressor, Pneum	2012	35,367	1,415	25	1,415		6,367	3
4	Carpeting/Flooring - Admission Office, Business Office - 1st Floor	2012	8,762	1,752	5	1,752		7,884	4
5	Life Safety - Fire Protection, Vertical Shafts, Elevator Recall, Eme	2012	258,870	12,944	20	12,944		58,248	5
6	Parking Lot Excavation, Sewer Replacement, Paving, and Canopy	2012	178,074	17,807	10	17,807		80,132	6
7	Architect, General Contractor Fees	2012	2,018,871	201,888	10	201,888		908,495	7
8	Rooftop EMR Wireless Installation	2012	6,981	698	10	698		3,141	8
9	Interior, exterior signs and signage	2012	41,881	4,188	10	4,188		18,846	9
10	Exterior Brickwork and Roof Drainage	2012	26,902	2,690	10	2,690		12,105	10
11	2nd, 3rd, 4th Floor Resident Rooms - Lighting, Electrical, Painting	2012	153,754	15,375	10	15,375		69,188	11
12	2nd, 3rd, 4th Floor - Hallway Handrails, Wall Protection, Nurse C	2012	81,092	8,109	10	8,109		36,491	12
13	Flooring - Stairwell and 2nd Floor Hallways	2012	42,700	4,270	10	4,270		19,215	13
14	Ground Floor - New Entrance Door, Flooring/Painting - Women's	2012	21,857	2,186	10	2,186		9,837	14
15	1st Floor - Ceiling Tile, Painting, Dietary Sewage Pump Installatio	2012	16,703	1,670	10	1,670		7,515	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	\$ 423,070		\$ 423,070	\$	\$ 8,615,668	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:

01/01/16

Ending:

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 11,085,094	\$ 423,070		\$ 423,070	\$	\$ 8,615,668	1
2									2
3	*Architect, General Contractor Fees, Legal Review of Renovation	2013	671,463	67,146	10	67,146		235,011	3
4	First Floor - Conference Room/Living Room - New Ceiling Tiles, F	2013	4,123	412	10	412		1,442	4
5	Ground Floor - Cafeteria/Admin Office/Utility Room - New Ceilin	2013	4,539	454	10	454		1,589	5
6	Exterior Signage for WP/Internal Signage for Resident Rooms/Off	2013	11,836	1,184	10	1,184		4,144	6
7	4th Floor Hallways/Dining Room/Stairwell Painting	2013	3,025	302	10	302		1,057	7
8	2nd Floor Fire Exit Door/New Magnetic Locks/New Door Holder C	2013	6,222	622	10	622		2,177	8
9	Parking Lot - Landscaping	2013	9,561	956	10	956		3,346	9
10	Boiler and Freezer Repair - Installed Modulation Motor, Required	2013	68,674	2,747	25	2,747		9,614	10
11	Fire Sprinkler Replacements, Installed Fire Exit Devices on 1st an	2013	19,728	986	20	986		3,452	11
12									12
13	Parking Lot - Paving, Fencing, Masonry, Backflow Preventer Irrig	2013	7,411	741	10	741		2,594	13
14	HVAC - Heating and Cooling Pipings - 2nd Floor, Compressor/Mo	2013	2,140	86	25	86		301	14
15	Life Safety - Fire Protection, Vertical Shafts, Elevator Recall	2013	3,696	185	20	185		647	15
16	Stairwell - Grids for Fall Protection - IDPH Required	2013	23,056	2,306	10	2,306		8,071	16
17	Ground Floor - Ceiling Tiles, Painting, Generator Kill Switch	2013	3,725	373	10	373		1,305	17
18	1st Floor - Ceiling Tiles, Flooring, Lighting, Tiling, Wall Protectio	2013	145,139	14,514	10	14,514		50,799	18
19	2nd, 3rd, 4th Floors - Ceiling Tiles, Electrical Conduits, Magnetic	2013	8,586	859	10	859		3,006	19
20	Resident Wander System with Door Units, Transmitters, Pull Cor	2013	16,053	1,605	10	1,605		5,618	20
21	Exterior Roof Replacement, Tuckpointing, Masonry	2013	15,221	1,522	10	1,522		5,327	21
22									22
23	HVAC - Cooling Tower - Hot/Cold Basin Liner, Hydro Motors, Fa	2014	60,484	2,419	25	2,419		6,048	23
24	Carpeting - 1st Floor Nursing Office	2014	600	120	5	120		300	24
25	Landscaping - Acer Ruburn Red Sunset Tree/Installation	2014	2,150	215	10	215		538	25
26	Flooring/Painting - Resident Rooms, Nursing Station - 1st, 2nd, 3r	2014	40,468	4,047	10	4,047		10,118	26
27	Brickwork/Tuckpointing - Exterior - Miller & Swift Halls	2014	30,828	3,083	10	3,083		7,708	27
28	Art Studio Construction - Lower Level - Framing, Electrical, Pain	2014	10,000	1,000	10	1,000		2,500	28
29	Fire Safety - Sprinkler Heads, Exit Devices, Stairwell Interrupter	2014	15,507	1,551	10	1,551		3,877	29
30	Vault Room - Replace Metal Door	2014	3,925	392	10	392		980	30
31	Water Heater - Laundry Room - Lower Level	2014	6,425	642	10	642		1,605	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 12,279,679	\$ 533,539		\$ 533,539	\$	\$ 8,988,842	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:

01/01/16

Ending:

12/31/16

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12C, Carried Forward	\$ 12,279,679	\$ 533,539		\$ 533,539	\$	\$ 8,988,842		1
2									2
3	Sump Pump - Parking Lot	2015 5,800	580	10	580		870		3
4	1st Floor - Carpeting - Human Resources Offices	2015 1,588	318	5	318		477		4
5	HVAC - Blowers Resident Rooms - all Fl; Boiler Tubes; Heating P	2015 19,007	760	25	760		1,140		5
6	Emergency Generator - Electrical Box	2015 3,681	184	20	184		276		6
7	New Grease Trap - Kitchen	2015 8,500	850	10	850		1,275		7
8	Emergency Lighting Circuits - Ground Fl, 1st Floor, 5th Fl	2015 10,713	1,071	10	1,071		1,606		8
9	Painting - Human Resources Department - 1st Fl; Resident Rooms	2015 5,911	591	10	591		887		9
10	Ceiling Tile and Grid Replacement - 3rd Floor; Art Studio - Grou	2015 9,118	912	10	912		1,368		10
11	Wander Guard/Nurse Call System - 4th Floor	2015 3,418	342	10	342		513		11
12	Life Safety - Fire Exit Devices - 4th Fl; Automatic Flush Bolts - 2n	2015 3,720	372	10	372		558		12
13									13
14	Carpeting - Front Entrance	2016 1,851	185	5	185		185		14
15	Sewer Connection from Bldg to Street; Parking Lot Fence - Weldi	2016 23,972	1,199	10	1,199		1,199		15
16	HVAC - New Boiler and Valves	2016 12,416	248	25	248		248		16
17	Nurse Wander System	2016 69,074	3,453	10	3,453		3,453		17
18	Kitchen Sewer Pipe and Flooring Replacement	2016 36,052	1,803	10	1,803		1,803		18
19	New Exterior Building Signage and Canopies	2016 15,140	757	10	757		757		19
20	Vinyl Flooring - Reception Area	2016 8,165	408	10	408		408		20
21	Flooring - 3rd Floor Resident Rooms - #378, 361, 382, 380, 354, 36	2016 7,690	385	10	385		385		21
22	Dampers - SE Stairwell - Ground Floor; 1st Floor; Dining Room	2016 3,140	157	10	157		157		22
23	Drywall, Painting, Celing Tiles - Activities/Volunteer Offices	2016 9,535	477	10	477		477		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)	\$ 12,538,170	\$ 548,591		\$ 548,591	\$	\$ 9,006,884		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:

01/01/16

Ending:

12/31/16

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	\$ 1,458,944	\$ 106,310	\$ 106,310	\$		\$ 891,369	71
72	Current Year Purchases	77,172	3,859	3,859			3,859	72
73	Fully Depreciated Assets	1,415,833					1,415,833	73
74							106,310	74
75	TOTALS	\$ 2,951,949	\$ 110,169	\$ 110,169	\$		\$ 2,417,371	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	\$ 9,679	\$ 9,679	\$		\$ 24,198	76
77										77
78										78
79										79
80	TOTALS			\$ 38,716	\$ 9,679	\$ 9,679	\$		\$ 24,198	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)	\$ 17,528,835	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 668,439	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 668,439	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)	\$ 11,448,453	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	\$ 1,125,076	\$ 18,956	\$ 106,758	86
87	2010 NH Mkt Value Write Up	3,000,000	120,000	660,000	87
88					88
89					89
90					90
91	TOTALS	\$ 4,125,076	\$ 138,956	\$ 766,758	91

G. Construction-in-Progress

	Description	Cost	
92	Terrace Addition	\$ 42,989	92
93			93
94			94
95		\$ 42,989	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: United Methodist Homes & Services

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	Corporate office space rental				15,797	Annual		5
6								6
7	TOTAL				\$ 15,797			7

10. Effective dates of current rental agreement:

Beginning _____
Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2017</u>	\$ _____
13.	<u>/2018</u>	\$ _____
14.	<u>/2019</u>	\$ _____

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 5,360 Description: Copiers - Leased - \$3,277, Dishwasher - Leased - \$2,083

(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.

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L39, C3	hrs	\$	6,826	\$ 404,268	\$	6,826	\$ 404,268	1
2	Licensed Speech and Language Development Therapist	L39, C3	hrs		2,445	92,657		2,445	92,657	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L39, C3	hrs		9,237	455,265		9,237	455,265	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescripts				468,894		468,894	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>Med Suppl, Lab, X-Ray</u>	L39, C2, C3				61,281	72,261		133,542	13
14	TOTAL			\$	18,508	\$ 1,013,471	\$ 541,155	18,508	\$ 1,554,626	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/16**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (259,232)	\$	1
2	Cash-Patient Deposits	10,064		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (270,640))	1,478,170		3
4	Supply Inventory (priced at)	28,099		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(2,018,158)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (761,057)	\$	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	15,804,442		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,092,458		16
17	Accumulated Depreciation (book methods)	(12,215,211)		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): Unamortized Financing Costs	87,083		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 9,603,772	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,842,715	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 201,345	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	118,774		28
29	Short-Term Notes Payable	240,000		29
30	Accrued Salaries Payable	515,860		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	41,579		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Unexpended Restricted Gifts	45,608		36
37	Due to Third-Party Party	31,063		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,194,229	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	4,651,700		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)	\$ 4,651,700	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,845,929	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,996,786	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 8,842,715	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,763,013	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,763,013	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,006,227)	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)	\$ (766,227)	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)	\$ 2,996,786	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number WESLEY PLACE

0005439

Report Period Beginning: 01/01/16

Ending: 12/31/16

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		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 8,594,972	1
2	Discounts and Allowances for all Levels	(2,256,851)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,338,121	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,065,601	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,065,601	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	9,582	14
15	Telephone, Television and Radio	917	15
16	Rental of Facility Space		16
17	Sale of Drugs	466,944	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	22,888	19
20	Radiology and X-Ray	12,799	20
21	Other Medical Services	192,202	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 705,332	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	151	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 151	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Rev - Patient Escort Fees	14,509	28
28a	Other - See attached schedule	1,309,768	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,324,277	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,433,482	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,493,017	31
32	Health Care	3,177,676	32
33	General Administration	2,459,196	33
B. Capital Expense			
34	Ownership	908,032	34
C. Ancillary Expense			
35	Special Cost Centers	3,227,879	35
36	Provider Participation Fee	173,909	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,439,709	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,006,227)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,006,227)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 1,622,016	44
45	Private Pay - Net Inpatient Revenue	2,118,819	45
46	Medicare - Net Inpatient Revenue	2,205,556	46
47	Other-(specify) Managed Care	391,730	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,338,121	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:

01/01/16

Ending:

12/31/16

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	984	1,086	\$ 66,169	\$ 60.93	1
2	Assistant Director of Nursing	1,808	2,080	72,800	35.00	2
3	Registered Nurses	39,041	42,258	1,190,613	28.17	3
4	Licensed Practical Nurses	3,535	3,939	108,197	27.47	4
5	CNAs & Orderlies	74,310	78,773	919,973	11.68	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,879	4,107	57,540	14.01	8
9	Activity Director	1,960	2,091	35,504	16.98	9
10	Activity Assistants	6,362	6,769	89,391	13.21	10
11	Social Service Workers	4,730	5,184	116,102	22.40	11
12	Dietician					12
13	Food Service Supervisor	750	837	30,452	36.38	13
14	Head Cook	4,764	5,227	81,407	15.57	14
15	Cook Helpers/Assistants	14,407	15,804	200,206	12.67	15
16	Dishwashers	5,099	5,232	56,418	10.78	16
17	Maintenance Workers	7,043	7,864	190,214	24.19	17
18	Housekeepers	13,812	15,385	177,621	11.55	18
19	Laundry	3,433	3,715	39,147	10.54	19
20	Administrator	2,486	2,759	197,494	71.58	20
21	Assistant Administrator					21
22	Other Administrative	1,730	2,106	62,273	29.57	22
23	Office Manager					23
24	Clerical	16,346	17,729	509,740	28.75	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	918	1,046	20,688	19.78	31
32	Other Health Care(specify)					32
33	Other(specify)	3,178	3,877	127,643	32.92	33
34	TOTAL (lines 1 - 33)	210,575	227,868	\$ 4,349,592 *	\$ 19.09	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	1,078	\$ 50,610	L1, C3	35
36	Medical Director	624	61,120	L9, C3	36
37	Medical Records Consultant	96	4,800	L10, C3	37
38	Nurse Consultant				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	32	1,760	L11, C3	44
45	Social Service Consultant	48	3,264	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,878	\$ 121,554		49

C. CONTRACT NURSES

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

Facility Name & ID Number **WESLEY PLACE**

0005439

Report Period Beginning: **01/01/16**

Ending: **12/31/16**

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Jay Evans	Administrator		\$ 108,849	Workers' Compensation Insurance	\$ 93,666	IDPH License Fee	\$	
William Lowe	CEO		88,645	Unemployment Compensation Insurance	47,829	Advertising: Employee Recruitment	62,180	
				FICA Taxes	311,612	Health Care Worker Background Check	1,420	
				Employee Health Insurance	312,122	(Indicate # of checks performed <u>95</u>)		
				Employee Meals		Patient Background Checks	292 2,520	
				Illinois Municipal Retirement Fund (IMRF)*		Books and Subscriptions	17,670	
				Employee Recognition	17,023	Membership Fees & Fees	7,471	
				Employee Wellness	36	Resident Relations	1,539	
						Advertising	95,427	
						Sequestration Expense	68,334	
						Less: Public Relations Expense	()	
						Non-allowable advertising	(95,427)	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 197,494	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 782,288		\$ 161,134		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	2,212
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$				Seminar Expense	6,107
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 261,873	TOTAL		\$	TOTAL	\$ 8,319

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number WESLEY PLACE

0005439

Report Period Beginning:

01/01/16

Ending:

12/31/16

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 - \$7,023
- (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. \$ 68,446 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. \$ 173,909
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? YES Indicate the amount. \$ 9,582
- (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: MARCUM LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. YES
Attach invoices and a summary of services for all architect and appraisal fees