		FOR BHF USE			

LL1

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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.

I. IDPH License ID Number: 0022350

Facility Name: Wesley Village

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

County: McDonough

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

HFS ID Number:

Date of Initial License for Current Owners: 04/14/1980

Type of Ownership:

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2020 to 12/31/2020 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) (Date)
(Type or Print Name) Shelly L. Martin
(Title) CEO/Administrator

Paid Preparer
(Signed) (Date)
(Print Name and Title) Deb Emerson, Principal
(Firm Name & Address) CliftonLarsonAllen LLP, 9365 Counselors Row, Suite 200, Indianapolis, IN 46240
(Telephone) 317-569-6230 Fax # 317-574-9707

In the event there are further questions about this report, please contact:
Name: Audra McQuaid Telephone Number: 309-833-2123
Email Address:

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

Facility Name & ID Number Wesley Village # 0022350 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	73	Skilled (SNF)	73	26,718	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	73	TOTALS	73	26,718	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	6,130	10,790	2,598	19,518	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,130	10,790	2,598	19,518	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.05%

D. How many bed reserve days during this year were paid by the Department? 86 (Do not include bed reserve days in Section B.)

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 4/14/1980

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 73 and days of care provided 1,876

Medicare Intermediary NGS

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2020 Fiscal Year: 12/31/2020

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

Facility Name & ID Number Wesley Village # 0022350 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	393,906	34,064	19,840	447,810		447,810		447,810			1
2	Food Purchase		250,290		250,290		250,290		250,290			2
3	Housekeeping	80,352	10,515	1,435	92,302		92,302		92,302			3
4	Laundry			43,889	43,889		43,889		43,889			4
5	Heat and Other Utilities			89,383	89,383		89,383		89,383			5
6	Maintenance	47,862	3,707	46,935	98,504		98,504		98,504			6
7	Other (specify):*											7
8	**TOTAL General Services**	522,120	298,576	201,482	1,022,178		1,022,178		1,022,178			8
	B. Health Care and Programs											
9	Medical Director			7,050	7,050		7,050		7,050			9
10	Nursing and Medical Records	2,092,057	207,310	646,403	2,945,770		2,945,770		2,945,770			10
10a	Therapy		2,685	387,133	389,818		389,818		389,818			10a
11	Activities	86,470	4,248	15,958	106,676		106,676		106,676			11
12	Social Services											12
13	CNA Training			10,124	10,124		10,124		10,124			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,178,527	214,243	1,066,668	3,459,438		3,459,438		3,459,438			16
	C. General Administration											
17	Administrative	144,569			144,569	(32,077)	112,492	(689)	111,803			17
18	Directors Fees											18
19	Professional Services			25,747	25,747		25,747		25,747			19
20	Dues, Fees, Subscriptions & Promotions			11,142	11,142		11,142		11,142			20
21	Clerical & General Office Expenses	246,817	9,148	249,419	505,384	32,077	537,461	(214,216)	323,245			21
22	Employee Benefits & Payroll Taxes			629,002	629,002		629,002		629,002			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,374	3,374		3,374		3,374			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			23,862	23,862		23,862		23,862			26
27	Other (specify):*											27
28	**TOTAL General Administration**	391,386	9,148	942,546	1,343,080		1,343,080	(214,905)	1,128,175			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,092,033	521,967	2,210,696	5,824,696		5,824,696	(214,905)	5,609,791			29

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

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

Facility Name & ID Number Wesley Village #0022350 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	D. Ownership	Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
30	Depreciation			391,196	391,196		391,196	(75,444)	315,752			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			75,253	75,253		75,253	(38,983)	36,270			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			466,449	466,449		466,449	(114,427)	352,022			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops	4,135		20	4,155		4,155		4,155			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			144,969	144,969		144,969		144,969			42
43	Other (specify):* RC/WAH/Marketi	1,488,894		1,897,968	3,386,862		3,386,862	(3,386,862)				43
44	TOTAL Special Cost Centers	1,493,029		2,042,957	3,535,986		3,535,986	(3,386,862)	149,124			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,585,062	521,967	4,720,102	9,827,131		9,827,131	(3,716,194)	6,110,937			45

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

Facility Name & ID Number Wesley Village # 0022350 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(689)	17		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(75,444)	30		9
10	Interest and Other Investment Income	(38,983)	32		10
11	Discounts, Allowances, Rebates & Refunds				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	(214,216)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG5A	(3,386,862)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (3,716,194)		$	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))**	$ (3,716,194)		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

STATE OF ILLINOIS

Wesley Village

ID# 0022350

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	RC/WAH/Marketing Costs	$ (3,386,862)	43	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(3,386,862)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Wesley Village # 0022350 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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

	Operating Expenses A. General Services	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)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(689)	0	0	0	0	0	0	0	0	0	0	(689)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(214,216)	0	0	0	0	0	0	0	0	0	0	(214,216)	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**	(214,905)	0	0	0	0	0	0	0	0	0	0	(214,905)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(214,905)	0	0	0	0	0	0	0	0	0	0	(214,905)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Wesley Village # 0022350 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	(75,444)	0	0	0	0	0	0	0	0	0	0	(75,444)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(38,983)	0	0	0	0	0	0	0	0	0	0	(38,983)	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**	(114,427)	0	0	0	0	0	0	0	0	0	0	(114,427)	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):*	(3,386,862)	0	0	0	0	0	0	0	0	0	0	(3,386,862)	43
44	**TOTAL Special Cost Centers**	(3,386,862)	0	0	0	0	0	0	0	0	0	0	(3,386,862)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(3,716,194)	0	0	0	0	0	0	0	0	0	0	(3,716,194)	45

Facility Name & ID Number Wesley Village # 0022350 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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
See PG6-Supp						

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

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

Facility Name & ID Number Wesley Village # 0022350 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	Ray Bunch	BOD						1
2	Lorraine Epperson	BOD						2
3	Linda Engel	BOD						3
4	Robert Fleming	BOD						4
5	Karen Ingledue	BOD						5
6	William B. Jacobs	BOD						6
7	Steve Knowles	BOD						7
8	Pamella McLean	BOD						8
9	Dr. Darlos Mummert	BOD						9
10	Rev. Timothy Wynne	BOD						10
11	Rev. Robert Green	BOD						11
12	Rev. Scott Grulke	BOD						12
13	Bishop Frank Beard	BOD						13
14	Rev. Stephen Granadosin	BOD						14
15	Sue Dunseth	BOD						15
16	Bill Maakestad	BOD						16
17	Steve Hopper	BOD						17
18	Donna Hughes	BOD						18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Wesley Village # 0022350 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Wesley Village # 0022350 Report Period Beginning: 01/01/2020 Ending: 2/31/2020

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 Village # 0022350 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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**		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	Citizens National Bank, A Division of I		X	Refinance & New Projects	$32,631.00	11/15/12	$ 6,250,000	$ 5,323,137	11/15/2037	4.6900	$ 75,253	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$32,631.00		$ 6,250,000	$ 5,323,137			$ 75,253	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 6,250,000	$ 5,323,137			$ 75,253	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ ____________ Line # __________

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

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

Facility Name & ID Number Wesley Village # 0022350 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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 2019 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 2020 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:			
	2015		**8**
	2016		**9**
	2017		**10**
	2018		**11**
	2019		**12**

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2019	$	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.**

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Wesley Village COUNTY McDonough

FACILITY IDPH LICENSE NUMBER 0022350

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2019 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 2019.

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 39,393 B. General Construction Type: Exterior Brick Frame Prestressed Concrete Number of Stories 1

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

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

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

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

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

Wesley Village Retirement Center - 69 units
Wesley Estates independent Living Duplexes - 34 units

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

1. Total Amount Incurred: 58,242 2. Number of Years Over Which it is Being Amortized: 25

3. Current Period Amortization: 2,330 4. Dates Incurred: November 2012

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Wesley Village # 0022350 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	47		1980	1980	$ 1,304,649	$	50	$ 25,968	$ 25,968	$ 1,056,209	4
5	26		1998	1997	1,934,404		50	50,214	50,214	1,120,304	5
6											6
7											7
8											8
	Improvement Type**										
9	1981 Additions			1981	51,507			40	40	51,067	9
10	1982 Additions			1982	1,627			8	8	1,560	10
11	1983 Additions			1983	5,361			8	8	5,267	11
12	1984 Additions			1984	634					634	12
13	1985 Additions			1985	11,135					11,135	13
14	1986 Additions			1986	6,225					6,225	14
15	1987 Additions			1987	24,380					24,380	15
16	1988 Additions			1988	667					667	16
17	1989 Additions			1989	18,487					18,487	17
18	1990 Additions			1990	10,830					10,830	18
19	1991 Additions			1991	12,838					12,838	19
20	1992 Additions			1992	21,781					21,781	20
21	1993 Additions			1993	2,391					2,391	21
22	1994 Additions			1994	12,411					12,411	22
23	1995 Additions			1995	2,456					2,456	23
24	1996 Additions			1996	4,199					4,199	24
25	1997 Additions			1997	7,315					7,315	25
26	1998 Additions			1998	44,468			560	560	42,616	26
27	1999 Additions			1999	5,907					5,907	27
28	2000 Additions			2000	42,837			1,577	1,577	42,837	28
29	2001 Additions			2001	50,890			704	704	47,836	29
30	2002 Additions			2002	20,849			909	909	19,952	30
31	2003 Additions			2003	47,496			893	893	45,709	31
32	2004 Additions			2004	45,744			106	106	45,505	32
33	2005 Additions			2005	83,816			4,636	4,636	83,686	33
34	2006 Additions			2006	528,374			21,212	21,212	318,343	34
35	2007 Additions			2007	50,080			2,492	2,492	34,010	35
36	2008 Additions			2008	755,589			37,609	37,609	454,352	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Wesley Village # 0022350 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1	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	2009 Additions	2009	$ 248,071	$		$ 11,993	$ 11,993	$ 136,412	37
38	2010 Additions	2010	2,292			97	97	1,411	38
39	2011 Additions	2011	117,424			6,327	6,327	58,779	39
40	2012 Additions	2012	73,976			5,254	5,254	43,792	40
41	2013 Additions	2013	862,610			22,636	22,636	167,715	41
42	2014 Additions	2014	36,732			3,035	3,035	19,145	42
43	2015 Additions	2015	42,440			2,948	2,948	13,037	43
44	2016 Additions	2016	9,988			917	917	4,266	44
45	Parking Lot Striping - 50% of project	2017	5,824			146	146	583	45
46	McCreery Household Construction	2017	123,007			4,920	4,920	18,451	46
47	McCreery Household Cabinets & Countertop	2017	1,103			74	74	263	47
48	McCreery Household Flooring	2017	13,014			868	868	3,253	48
49	Water Meter & Valve Replacement - 50%	2017	7,647			510	510	1,870	49
50	McCreery Bathroom - Shower, tile, cabinets, paint	2017	38,122			2,541	2,541	7,836	50
51	McCreery Room 3 - flooring and paint	2017	3,833			383	383	1,246	51
52	Nursing Center Entrance Flooring	2017	4,645			664	664	2,046	52
53	McCreery Room 15 - Flooring & paint	2017	570			57	57	181	53
54	Grant Household Livingroom Wall Covering	2017	894			128	128	393	54
55	Epperson/Memory Household Exit Doors	2017	1,181			118	118	370	55
56	Grant Household Kitchen Cabniets & Countertops	2017	2,842			189	189	584	56
57	HCC Parking Lot Expansion	2018	111,745		20	5,587	5,587	14,899	57
58	McCreery Four Seasons Landscaping	2018	1,734		10	173	173	447	58
59	Roof Repair	2018	4,955		10	495	495	1,485	59
60	Basement Electrical Box Repair	2018	421		10	42	42	123	60
61	Memory/Rehab Wing Construction to sunroom addition	2018	37,230		25	1,489	1,489	4,219	61
62	McCreery 4 Seasons Room, addition on to building	2018	136,122		25	5,445	5,445	16,335	62
63	Rehab Shower Room, plumbing updates (piping)	2018	782		10	78	78	215	63
64	McCreery Household Air Conditioning	2018	11,478		15	765	765	1,849	64
65	Campus Wide Security System	2018	11,979		10	1,198	1,198	2,496	65
66	Households Entrance Door	2018	4,400		10	440	440	1,027	66
67	Room 42 Waterline	2018	755		10	76	76	171	67
68	Grant House Bathroom plumbing repairs (pipes, tubing)	2019	13,537		15	827	827	1,654	68
69	FS Gas Line	2019	1,440		15	88	88	176	69
70	TOTAL (lines 4 thru 69)		$ 7,042,140	$		$ 227,443	$ 227,443	$ 4,037,638	70

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

Facility Name & ID Number Wesley Village # 0022350 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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		$ 7,042,140	$		$ 227,443	$ 227,443	$ 4,037,638	1
2	Pearson Home - sunroom addition	2019	145,050		25	967	967	1,934	2
3	New HCC Coordinator Offices addition between McCreery House	2019	7,824		15	174	174	348	3
4	& Epperson House (walls, electrical, flooring)								4
5	Pearson Home - New Flooring in sunroom addition	2019	3,276		10	82	82	164	5
6	Loading Dock Doors	2019	5,063		10	169	169	338	6
7	RC/HC Hallways Flooring	2019	3,511		10	117	117	234	7
8	Nurse Coordinators Office in Pearson House (walls, fooring, electr	2019	2,934		10	24	24	49	8
9	Time Clock Hallway New Door	2019	1,457		5	73	73	146	9
10	Grant House Living & Dining Room Lighting/Electrical	2019	3,095		10	52	52	104	10
11	McCreery Flooring	2019	1,644		10	14	14	28	11
12	Service Drive	2019	2,525		15	14	14	28	12
13	Pearson Shower Room - Spa Bathroom reno	2020	1,621		10	162	162	162	13
14	Pearson 4 Seasons Room-electric, fooring, painting	2020	3,910		10	358	358	358	14
15	Pearson Remodel-resident rooms (paint,flooring,cabinets,								15
16	countertops), dining room and kitchen added	2020	165,494		25	552	552	552	16
17	Adinistrator Office - New Flooring	2020	639		15	39	39	39	17
18	Epperson Room Floor - Room 30	2020	1,153		10	96	96	96	18
19	Epperson Remodel-granite,lighting, begin remodel of wing	2020	35,965		25	360	360	360	19
20	HC Rm 1 Shower	2020	2,359		10	20	20		20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31	Financial Statement Depreciation			391,196			(391,196)		31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,429,661	$ 391,196		$ 230,716	$ (160,480)	$ 4,042,578	34

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

Facility Name & ID Number Wesley Village # 0022350 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	$ 1,729,970	$	$ 67,703	$ 67,703		$ 886,456	71
72	Current Year Purchases	140,403		15,285	15,285		15,285	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,870,373	$	$ 82,988	$ 82,988		$ 901,741	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	14 passenger bus with lift	Chevy 2008 Model	2008	$ 48,364	$	$	$		$	76
77	2006 Lincoln	Lincoln 2006 Model	2011	14,750						77
78	Blue Wheelchair Van	Dodge 2010 Model	2014	33,895					33,895	78
79	Black Wheelchair Van	Dodge 2014 Model	2017	34,403		2,048	2,048		8,192	79
80	TOTALS			$ 131,412	$	$ 2,048	$ 2,048		$ 42,087	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)	$ 9,480,046	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 391,196	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 315,752	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (75,444)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,986,406	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	Residential Center/WAH	$ 7,640,347	$ 314,642	$ 5,159,130	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 7,640,347	$ 314,642	$ 5,159,130	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	$ 631	92
93			93
94			94
95		$ 631	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	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.	/2021	$
13.	/2022	$
14.	/2023	$

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

15. Is Movable equipment rental included in building rental? YES NO
16. Rental Amount for movable equipment: $ Description:
   (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Wesley Village # 0022350 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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? [X] YES [ ] 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 [X]
- HOURS PER CNA 136

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$ 4,882	$	$ 4,882
2	Books and Supplies		197		197
3	Classroom Wages (a)		4,970		4,970
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests		75		75
9	TOTALS	$	$ 10,124	$	$ 10,124
10	SUM OF line 9, col. 1 and 2 (e)	$ 10,124			

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.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-3	hrs	$		$ 203,537	$		$ 203,537	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs			64,786			64,786	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs			118,810			118,810	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$ 387,133	$		$ 387,133	14

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

Facility Name & ID Number Wesley Village # 0022350 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2020 (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	$ 501,619	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 178,025)	591,327		3
4	Supply Inventory (priced at)	278,796		4
5	Short-Term Investments	1,578,416		5
6	Prepaid Insurance	45,539		6
7	Other Prepaid Expenses	85,057		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,080,754	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	1,897,086		12
13	Land	424,160		13
14	Buildings, at Historical Cost	12,716,475		14
15	Leasehold Improvements, at Historical Cost	811,041		15
16	Equipment, at Historical Cost	3,168,717		16
17	Accumulated Depreciation (book methods)	(10,145,556)		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 CIP	631		22
23	Other(specify): Other Receivables	294,269		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 9,166,823	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 12,247,577	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 419,221	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	471,470		29
30	Accrued Salaries Payable	377,636		30
31	Accrued Taxes Payable (excluding real estate taxes)	31,094		31
32	Accrued Real Estate Taxes(Sch.IX-B)	73,600		32
33	Accrued Interest Payable	3,380		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Liabilities	28,131		36
37	Life Member Fees	383,291		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,787,823	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	5,161,690		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 5,161,690	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,949,513	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 5,298,064	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 12,247,577	$	48

*(See instructions.)

Facility Name & ID Number Wesley Village # 0022350 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,875,248	1
2	Restatements (describe):		2
3	Reporting Correction	135,687	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 5,010,935	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	287,129	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 287,129	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)**	$ 5,298,064	24 *

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

Facility Name & ID Number Wesley Village # 0022350 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	$ 4,940,119	1
2	Discounts and Allowances for all Levels	933	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,941,052	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	6,035	13
14	Non-Patient Meals	689	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 6,724	23
	D. Non-Operating Revenue		
24	Contributions	411,869	24
25	Interest and Other Investment Income***	34,904	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 446,773	26
	E. Other Revenue (specify):******		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	RC/WAH Revenues	2,764,302	28
28a	Other - See Attached Schedule	1,955,409	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,719,711	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,114,260	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,022,178	31
32	Health Care	3,459,438	32
33	General Administration	1,343,080	33
	B. Capital Expense		
34	Ownership	466,449	34
	C. Ancillary Expense		
35	Special Cost Centers	3,391,017	35
36	Provider Participation Fee	144,969	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,827,131	40
41	**Income before Income Taxes (line 30 minus line 40)****	287,129	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 287,129	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 901,410	44
45	Private Pay - Net Inpatient Revenue	2,656,845	45
46	Medicare - Net Inpatient Revenue	1,113,660	46
47	Other-(specify) Insurance	268,204	47
48	Other-(specify) Charity Care	933	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,941,052	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.

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,856	1,976	$ 104,122	$ 52.69	1
2	Assistant Director of Nursing	1,737	1,938	59,501	30.70	2
3	Registered Nurses	17,599	19,111	577,135	30.20	3
4	Licensed Practical Nurses	12,350	13,132	324,258	24.69	4
5	CNAs & Orderlies	61,124	67,610	1,027,041	15.19	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,528	1,788	44,105	24.67	9
10	Activity Assistants	3,800	4,261	42,365	9.94	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	29,123	30,473	393,906	12.93	15
16	Dishwashers					16
17	Maintenance Workers	2,088	2,369	47,862	20.20	17
18	Housekeepers	8,514	9,470	80,352	8.48	18
19	Laundry	1,886	2,098	23,561	11.23	19
20	Administrator	1,406	1,651	112,492	68.14	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,825	2,108	43,186	20.49	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	1,665	1,878	27,468	14.63	31
32	Other Health Care(specify)	994	1,009	13,783	13.66	32
33	Other(specify)	83,759	91,151	1,663,925	18.25	33
34	TOTAL (lines 1 - 33)	231,254	252,023	$ 4,585,062 *	$ 18.19	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	259	$ 10,257	01-3	35
36	Medical Director		7,050	09-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,224	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		1,800	11-3	44
45	Social Service Consultant		1,650	10-3	45
46	Other(specify) MD Consultant		4,223	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	259	$ 28,204		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	41	$ 1,958	10-3	50
51	Licensed Practical Nurses	2,001	92,433	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	2,042	$ 94,391		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Shelly Martin	Administrator		$ 112,492
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 112,492

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
CLA	Accounting	$ 25,679
Mcmillan, Hennenfent,		
Dejoode & Humbert	Legal	68
(general counsel)		
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 25,747

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 70,568
Unemployment Compensation Insurance	20
FICA Taxes	229,389
Employee Health Insurance	328,687
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K	338
TOTAL (agree to Schedule V, line 22, col.8)	$ 629,002

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 8,442
Advertising: Employee Recruitment	6,531
Health Care Worker Background Check (Indicate # of checks performed)	2,297
Patient Background Checks	1,040
Dues & Memberships	13,671
Subscriptions	233
Employee Physicals	9,786
Less (RC/WAH/Mktg)	(30,858)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,142

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,374
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,374

**See instructions.

Facility Name & ID Number Wesley Village # 0022350 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Leading Age IL - $9,182**

(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? **10-15 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **48,286** Line **10-2**

(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. $ **144,969**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

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

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

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **CLA - CliftonLarsonAllen LLP**

(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.