

		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.

I. IDPH License ID Number: 0022350 Facility Name: Wesley Village Address: 1200 East Grant St Macomb 61455 Number City 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 In the event there are further questions about this report, please contact: Name: Britany Knowles Telephone Number: 309 833 2123 Email Address:	II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/16 to 12/31/16 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) (Type or Print Name) Shelly L. Martin (Title) CEO/Administrator Paid Preparer (Signed) (Print Name and Title) (Firm Name & Address) (Telephone) () Fax # () MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630
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Facility Name & ID Number Wesley Village

0022350 Report Period Beginning: 1/1/16 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	
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
2		Skilled Pediatric (SNF/PED)			
3		Intermediate (ICF)			
4		Intermediate/DD			
5		Sheltered Care (SC)			
6		ICF/DD 16 or Less			
7	73	TOTALS		73	26,718

B. Census-For the entire report period.						
	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	7,081	13,733	3,409	24,223	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,081	13,733	3,409	24,223	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.66%

D. How many bed-hold days during this year were paid by the Department? 48 (Do not include bed-hold days in Section B.)

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES NO 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 04/14/1980

J. Was the facility purchased or leased after January 1, 1978? YES 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 2,097

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS ACCRUAL X MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO

Tax Year: Tax-Exempt Fiscal Year: Jan-Dec * All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Wesley Village # 0022350 Report Period Beginning: 1/1/16 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	265,959	19,426	12,778	298,163		298,163		298,163			1
2	Food Purchase		210,258		210,258		210,258	(596)	209,662			2
3	Housekeeping	58,062	8,257		66,319	16,936	83,255		83,255			3
4	Laundry	10,066		42,694	52,760		52,760		52,760			4
5	Heat and Other Utilities			82,318	82,318		82,318		82,318			5
6	Maintenance	44,901	3,906	27,578	76,385		76,385		76,385			6
7	Other (specify):*											7
8	TOTAL General Services	378,988	241,847	165,368	786,203	16,936	803,139	(596)	802,543			8
	B. Health Care and Programs											
9	Medical Director			8,400	8,400		8,400		8,400			9
10	Nursing and Medical Records	1,825,881	274,017	52,348	2,152,246	(76,309)	2,075,937		2,075,937			10
10a	Therapy			492,772	492,772		492,772		492,772			10a
11	Activities	83,316	7,545	14,533	105,394		105,394	(8,835)	96,559			11
12	Social Services					52,643	52,643		52,643			12
13	CNA Training	28,410		19,838	48,248		48,248		48,248			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,937,607	281,562	587,891	2,807,060	(23,666)	2,783,394	(8,835)	2,774,559			16
	C. General Administration											
17	Administrative	96,910			96,910		96,910		96,910			17
18	Directors Fees											18
19	Professional Services			26,471	26,471		26,471		26,471			19
20	Dues, Fees, Subscriptions & Promotions			5,881	5,881	6,730	12,611		12,611			20
21	Clerical & General Office Expenses	91,279	11,436	18,300	121,015		121,015		121,015			21
22	Employee Benefits & Payroll Taxes			594,697	594,697		594,697		594,697			22
23	Inservice Training & Education											23
24	Travel and Seminar			15,879	15,879		15,879		15,879			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			18,862	18,862		18,862		18,862			26
27	Other (specify):*											27
28	TOTAL General Administration	188,189	11,436	680,090	879,715	6,730	886,445		886,445			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,504,784	534,845	1,433,349	4,472,978		4,472,978	(9,431)	4,463,547			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			301,728	301,728		301,728		301,728			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			181,420	181,420		181,420		181,420			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			483,148	483,148		483,148		483,148			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			176,725	176,725		176,725		176,725			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			176,725	176,725		176,725		176,725			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	2,504,784	534,845	2,093,222	5,132,851		5,132,851	(9,431)	5,123,420			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	8,835	LN11		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	596	LN2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 9,431		\$	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	2,058		33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 2,058		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 11,489		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

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Wesley Village # 0022350 Report Period Beginning: 1/1/16 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	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	0	0	0	0	0	0	0	0	0	0	0	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Wesley Village # 0022350 Report Period Beginning: 1/1/16 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	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	0	0	0	0	0	0	0	0	0	0	0	0	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

YES

NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
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.

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Wesley Village # 0022350 Report Period Beginning: 1/1/16 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

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 M	X		Refinance & New Projects	\$32,630.57		\$ 6,250,000	\$ 5,825,963		4.6900	\$ 173,728	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$32,630.57		\$ 6,250,000	\$ 5,825,963			\$ 173,728	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	\$ 5,825,963			\$ 173,728	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	
		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.

FACILITY NAME Wesley Village COUNTY McDonough
FACILITY IDPH LICENSE NUMBER 0022350
CONTACT PERSON REGARDING THIS REPORT _____
TELEPHONE () _____ FAX #: () _____

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.

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?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

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

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

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

Wesley Village Retirement Center - 69 units

Wesley Estates Independent Living Duplexes - 32 units

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☐ NO

If so, please complete the following:

1. Total Amount Incurred:

58,242

2. Number of Years Over Which it is Being Amortized:

25

3. Current Period Amortization:

2,058

4. Dates Incurred:

November 2012

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.					
	1	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

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	47		1980	1980	\$ 1,304,649	\$ 25,968	50	\$ 25,968	\$	\$ 952,337	4
5	26		1998	1997	1,934,404	50,214	50	50,214		919,488	5
6											6
7											7
8											8
	Improvement Type**										
9	LAND IMPROVEMENTS										9
10	Paved Parking lot			1981	28,080		15			28,080	10
11	Landscaping			1981	2,943		10			2,943	11
12	Landscaping			1984	227		10			227	12
13	Blacktop driveway			1985	559		10			559	13
14	Landscaping, install cement patio			1982	488		20			448	14
15	Landscaping			1983	681		20			681	15
16	Blacktop driveway			1986	2,668		15			2,668	16
17	Blacktop driveway			1987	15,464		15			15,464	17
18	Improve drainage			1987	1,036		15			1,036	18
19	Landscaping costs			1988	599		10			599	19
20	Improve drainage from roof area			1989	946		15			946	20
21	Blacktop driveway			1990	1,396		15			1,396	21
22	Blacktop sealer			1991	1,054		15			1,054	22
23	Blacktop sealer			1994	1,307		15			1,307	23
24	Turf & garden mix 38%			1997	322		10			322	24
25	Walking path 50%			1997	418	10	20	10		200	25
26	Concrete curbing 38%			1997	562	28	20	28		251	26
27	Walking path 50%			2000	17,911	896	20	896		15,232	27
28	Alzheimers garden enhancement			2000	4,468	223	20	223		3,791	28
29	Walking path 50%			2001	15,264		10			15,264	29
30	Glider walking path			2002	1,346		10			1,346	30
31	Seal & Asphalt drive and parking lot			2003	7,888		15			7,888	31
32	Landscape gazebo area			2003	1,202		10			1,202	32
33	Landscaping around wheelchair swing			2001	856		10			856	33
34	Landscaping south garden area 50%			2004	5,618		10			5,618	34
35	Landscape HC/SCU signs			2005	519		10			519	35
36	Parking Lot Striping - 50%			2010	360		5			360	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Wesley Village

0022350

Report Period Beginning:

1/1/16

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	
37	Loading Dock Resurface	2012	\$ 8,350	\$ 835	10	\$ 835	\$	\$ 3,688	37
38	HCC Parking Lot Expansion	2013	2,570	171	15	171		584	38
39	HCC Sidewalk	2013	1,500	100	15	100		317	39
40	Rehab/HCC Entrance Landscaping	2014	8,497	850	10	850		1,700	40
41	Rehab Unit Garden	2016	637	25	15	25		25	41
42									42
43	BUILDING IMPROVEMENTS								43
44	Screen Doors	1981	4,500		10			4,500	44
45	Constructed Carports	1981	2,000	40	50	40		1,400	45
46	Wallpaper	1981	2,264		20			2,264	46
47	Entrance signs	1981	5,920		30			5,920	47
48	Signs	1981	58		12			58	48
49	Intangibles	1981	5,742		20			5,742	49
50	Overhang roof Drain	1982	342		20			342	50
51	Remodel bathroom	1982	371	8	50	8		272	51
52	Exhaust fans & lights	1982	426		20			426	52
53	Carpet	1983	169		5			169	53
54	Install Satellite system	1983	4,122		15			4,122	54
55	Remodeling	1983	389	8	50	8		263	55
56	Wheelchair ramp	1984	407		10			407	56
57	Remodel showers	1986	501		30			501	57
58	install décor	1985	450		15			450	58
59	Redecorate resident rooms	1985	10,126		15			10,126	59
60	install tornado siren	1986	3,056		15			3,056	60
61	Carpet	1987	538		5			538	61
62	Install TV Filter	1987	68		15			68	62
63	Redecorate resident rooms	1987	7,274		15			7,274	63
64	remodeling hallway	1988	68		15			68	64
65	roof repair	1989	3,704		15			3,704	65
66	emergency light	1989	35		10			35	66
67	redecorating	1989	13,802		15			13,802	67
68	nurse call system	1990	4,919		13			4,919	68
69	elevator jack	1990	3,780		15			3,780	69
70	TOTAL (lines 4 thru 69)		\$ 3,449,820	\$ 79,376		\$ 79,376	\$	\$ 2,062,602	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:

1/1/16

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 12A, Carried Forward		\$ 3,449,820	\$ 79,376		\$ 79,376	\$	\$ 2,062,602	1
2	Solid Core Door	1990	735		10			735	2
3	Water system repairs	1991	1,410		10			1,410	3
4	Water heater repairs	1991	1,323		10			1,323	4
5	replace window panes	1991	9,051		20			9,051	5
6	install A/C food service	1992	866		20			866	6
7	roof repair	1992	8,685		15			8,685	7
8	redesign water system	1992	2,385		20			2,385	8
9	remodeling	1992	9,845		15			9,845	9
10	carpeting	1993	851		15			851	10
11	remodeling	1993	1,540		10			1,540	11
12	new entryway	1994	7,888		20			7,888	12
13	remodeling	1994	3,216		10			3,216	13
14	painting entryway & carpet	1995	2,456		10			2,456	14
15	diningroom floor	1996	116	1	20	1		116	15
16	roof repairs - west end	1996	385		15			385	16
17	12 air conditioning units	1996	3,698		15			3,698	17
18	shingle east entrance	1997	398		15			398	18
19	border resident rooms	1997	484		10			484	19
20	carpet installment hallway	1997	265	13	20	13		249	20
21	vinyl flooring covering	1997	1,507	75	20	75		1,425	21
22	remote annunciator panel	1997	705	34	20	34		664	22
23	heating/air conditioning units	1997	1,602	80	20	80		1,527	23
24	3 windows	1997	116	6	20	6		115	24
25	12 window screens	1997	126		20			126	25
26	Carpet	1997	432		20			432	26
27	drainage from SE corner of building	1997	378		15			378	27
28	additional wiring to pass inspection	1998	4,748	237	20	237		4,405	28
29	window treatments	1998	10,940	547	20	547		10,211	29
30	mixing valve	1998	2,695		15			2,695	30
31	tuckpointing building exterior	1998	4,511	180	20	180		3,270	31
32	flooring	1998	665		15			665	32
33	new mfire alarms in health care	1998	10,468	523	20	523		9,502	33
34	TOTAL (lines 1 thru 33)		\$ 3,544,310	\$ 81,072		\$ 81,072	\$	\$ 2,153,598	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:

1/1/16

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 12B, Carried Forward		\$ 3,544,310	\$ 81,072		\$ 81,072	\$	\$ 2,153,598	1
2	Additional strobe due to inspection	1998	1,381	69	20	69		1,294	2
3	Roof repairs kitchen & SE section	1998	9,060	362	25	362		6,245	3
4	Alzheimer unit lounge flooring	1999	1,074		15			1,074	4
5	Health care lighting upgrade	1999	2,019		10			2,019	5
6	fire alarm upgrade	1999	2,814		10			2,814	6
7	Heating/cooling laundry room & kitchen corridor	2000	9,000	450	20	450		7,650	7
8	Sewer line	2000	8,868	355	25	355		6,035	8
9	smoking patio	2000	2,590	130	20	130		2,210	9
10	decorate healthcare diningroom	2001	7,887	3,282	15	3,282		7,887	10
11	A/C compressor healthcare diningroom	2001	9,076	6,046	15	6,046		9,076	11
12	Wallguards healthcare diningroom	2001	970	490	15	490		970	12
13	Kitchen walk-in cooler compressor	2001	1,769		7			1,769	13
14	Generator healthcare	2001	989		7			989	14
15	Alzheimers water system	2001	14,079	704	20	704		8,209	15
16	Glider walking path	2002	1,346		10			134	16
17	storage shed-cement work	2002	9,357	469	20	469		7,024	17
18	healthcare center core area roof	2002	8,800	440	20	440		6,600	18
19	Outside door - healthcare center hall	2003	5,600		10			5,600	19
20	Healthcare center shower room tile	2003	1,475		10			1,475	20
21	Healthcare center core area remodeling	2003	1,000		10			1,000	21
22	water softening system	2003	12,470		10			12,470	22
23	Garage/storage	2003	17,861	893	20	893		12,502	23
24	Healthcare center diningroom remodeling	2004	27,065	1,804	15	1,804		23,452	24
25	Healthcare center core area floor plans	2004	7,414	494	15	494		6,422	25
26	Garage Storage 50%	2004	1,737	87	20	87		1,131	26
27	Carpet - 7 healthcare rooms	2004	3,910	260	15	260		3,380	27
28	Healthcare center activity room remodeling	2005	2,606		15			2,606	28
29	Food service department drain	2005	2,655		10			2,655	29
30	Healthcare center door locks	2005	529		10			529	30
31	Healthcare center doors	2005	4,395		10			4,395	31
32	A/C units	2005	5,291		10			5,291	32
33	Garage/workshop 50%	2005	927	46	20	46		552	33
34	TOTAL (lines 1 thru 33)		\$ 3,730,324	\$ 97,453		\$ 97,453	\$	\$ 2,309,057	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:

1/1/16

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		\$ 3,730,324	\$ 97,453		\$ 97,453	\$	\$ 2,309,057	1
2	Outdoor Electrical	2005	1,464	98	15	98		1,176	2
3	Resurface driveway and parking lot	2005	65,430	4,492	15	4,492		47,465	3
4	Healthcare center remodeling	2006	2,783	185	15	185		1,943	4
5	Healthcare center carpet	2006	468	23	20	23		248	5
6	garage door opener	2006	433	32	10	32		433	6
7	Healthcare center electrical panel	2006	2,340	156	15	156		1,573	7
8	PTAC units	2006	12,849	856	15	856		8,988	8
9	Elevator upgrade	2006	4,980	332	15	332		3,542	9
10	Healthcare center plumbing replacement	2006	70,249	1,756	40	1,756		17,706	10
11	Healthcare center replace bathroom floor	2006	10,299	257	40	257		2,613	11
12	Upgrade sprinkler system	2006	1,632	109	15	109		1,117	12
13	Food service fire system	2006	3,479		7			3,479	13
14	generator upgrade	2006	965		7			965	14
15	Air conditioning PTAC units	2006	1,601	107	15	107		1,088	15
16	Food service/laundry water heater	2006	2,921	195	15	195		2,129	16
17	Food Service booster heater	2006	1,982	132	15	132		1,386	17
18	Healthcare center spa bath	2006	24,334	1,622	15	1,622		16,220	18
19	Generator 1000KW	2006	387,059	15,482	25	15,482		170,172	19
20	Healthcare center remodeling architect fees	2007	32,169	1,608	20	1,608		15,411	20
21	Breakroom floore tile paint counter	2007	3,293	220	15	220		2,181	21
22	Replace kitchen wall	2007	3,709	185	20	185		1,805	22
23	Healthcare center plumbing project	2007	3,990	133	30	133		1,330	23
24	Major repairs water heaters	2007	6,919	346	20	346		3,315	24
25	rehab signing	2008	510		5			510	25
26	healthcare center remodel flooring lighting ceilings demo	2008	434,525	21,726	20	21,726		173,808	26
27	New parking lot/sidewalk/railing	2008	57,631	2,882	20	2,882		23,297	27
28	A/C heat in Healthcare center	2008	54,566	2,728	20	2,728		23,416	28
29	Nurse call system	2008	16,690	2,344	7	2,344		19,034	29
30	fire door - HCC office	2008	724	36	20	36		315	30
31	Rehab roof	2008	10,418	521	20	521		4,472	31
32	HC halway remodeling	2008	2,353	118	20	118		1,022	32
33	Maintenance building	2008	66,103	1,653	40	1,653		13,224	33
34	TOTAL (lines 1 thru 33)		\$ 5,019,192	\$ 157,787		\$ 157,787	\$	\$ 2,874,440	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:

1/1/16

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 12D, Carried Forward		\$ 5,019,192	\$ 157,787		\$ 157,787	\$	\$ 2,874,440	1
2	HC Entrance canopies	2008	3,770	186	20	186		1,488	2
3	Rehab new flooring at nurses station	2008	3,239	162	20	162		1,296	3
4	Garage lighting	2008	2,337	117	20	117		936	4
5	Water heaters	2008	102,723	5,136	20	5,136		41,098	5
6	Healthcare center remodeling, flooring, paint & Wallpaper	2009	181,019	9,051	20	9,051		67,128	6
7	Maintenance building	2009	16,473	412	40	412		2,918	7
8	Elevator renovation - upgrade to new standards	2009	38,550	1,928	20	1,928		13,978	8
9	Rehab lobby remodel	2009	2,923	146	20	146		1,132	9
10	HC entrance canopies	2009	6,030	302	20	302		2,142	10
11	Kitchen receiving wall replacement	2009	3,076	154	20	154		1,142	11
12	elevator upgrade	2010	1,932	97	20	97		663	12
13	Kitchen ceiling 50%	2011	423	28	15	28		168	13
14	HC windows	2011	50,789	2,540	20	2,540		13,758	14
15	HC Shower room - flooring, paint, furniture, plumbing	2011	7,616	508	15	508		2,752	15
16	Rehab remodel - flooring, paint, furniture, wallpaper	2011	52,178	2,609	20	2,609		13,262	16
17	Kitchen, lounge, HC roof - 50%	2011	6,418	642	10	642		3,531	17
18	HC diningroom - flooring, wallpaper, paint, tables, & chairs	2012	14,098	940	15	940		4,230	18
19	Rehab diningroom - flooring, wallpaper, paint, tables, chairs	2012	40,167	2,678	15	2,678		11,382	19
20	Utility room remodel - flooring & plumbing	2012	718	479	15	479		1,956	20
21	Breakroom 50% - move to basement, plumbing, cabinets, vending	2012	9,322	621	15	621		2,743	21
22	PTAC units - painting & patching holes on buildings	2012	1,321	132	10	132		550	22
23	Therapy addition - flooring, furniture, equipment	2013	723,946	18,099	40	18,099		55,805	23
24	Tuckpointing of brick around HC	2013	127,994	4,266	30	4,266		13,865	24
25	Chiller & boiler - 50%	2013	534	107	5	107		348	25
26	Rehab unit roof	2013	805	161	5	161		550	26
27	HC roof recoat	2013	4,350	870	5	870		2,828	27
28	HC Hallway flooring	2013	911	183	5	183		595	28
29	Therapy addition - doors, alarms, wallpaper	2014	5,336	267	20	267		623	29
30	HCC Room 1 flooring, paint, wallpaper	2014	3,333	222	15	222		555	30
31	RHU Roof Recoating	2014	11,752	1,175	10	1,175		2,938	31
32	Therpay pool project	2014	4,685	312	15	312		754	32
33	HCC Room 2 flooring, paint, wallpaper	2014	3,129	209	15	209		435	33
34	TOTAL (lines 1 thru 33)		\$ 6,451,089	\$ 212,526		\$ 212,526	\$	\$ 3,141,989	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:

1/1/16

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 12E, Carried Forward		\$ 6,451,089	\$ 212,526		\$ 212,526	\$	\$ 3,141,989	1
2	Rehab Unit Electronic Keypad for Door	2015	720	144	5	144		276	2
3	Healthcare Center Electrical outlets	2015	8,433	562	15	562		713	3
4	Rehab Center Electrical outlets	2015	1,580	105	15	105		202	4
5	HCC/Rehab Center Corridor Wallpaper	2015	688	69	10	69		126	5
6	HCC Room 10: Paint, wall covering, Flooring	2015	643	43	15	43		68	6
7	HCC Room 13: paint, wall covering, flooring	2015	1,847	123	15	123		154	7
8	HCC Room 14: paint, wall covering, Flooring	2015	2,273	152	15	152		190	8
9	Rehab unit entrance Door	2015	920	61	15	61		71	9
10	FS Walk-in Freezer - 60%	2015	25,336	1,689	15	1,689		2,393	10
11	Nursing Center Sprinkler Riser	2016	816	54	10	54		54	11
12	Nursing Center Entry Door	2016	1,536	90	10	90		90	12
13	Room 9 Flooring, wall covering, and paint	2016	1,818	40	15	40		40	13
14	Nursing Center Wall Molding	2016	5,181	389	10	389		389	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,502,880	\$ 216,047		\$ 216,047	\$	\$ 3,146,755	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,307,308	\$ 77,440	\$ 77,440	\$		\$ 631,443	71
72	Current Year Purchases	35,494	1,462	1,462			1,462	72
73	Fully Depreciated Assets	27,509					27,509	73
74								74
75	TOTALS	\$ 1,370,311	\$ 78,902	\$ 78,902	\$		\$ 660,414	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	\$	\$	\$		\$ 48,364	76
77	White Wheelchair van	Dodge 2010 Model	2010	37,632					37,632	77
78	2006 Lincoln	Lincoln 2006 Model	2011	14,750					14,750	78
79	Blue Wheelchair Van	Dodge 2010 Model	2014	33,895	6,779	6,779			14,970	79
80	TOTALS			\$ 134,641	\$ 6,779	\$ 6,779	\$		\$ 115,716	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)	\$ 8,056,432	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 301,728	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 301,728	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)	\$ 3,922,885	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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

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.	/2017	\$
13.	/2018	\$
14.	/2019	\$

* 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.

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM☐

IN OTHER FACILITY☐

COMMUNITY COLLEGE☒

HOURS PER CNA90

3. CLINICAL PORTION:

IN-HOUSE PROGRAM☐

IN OTHER FACILITY☒

HOURS PER CNA56

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$ 1,417	\$ 18,421	\$	\$ 19,838
2	Books and Supplies				
3	Classroom Wages (a)	870	16,211		17,081
4	Clinical Wages (b)	505	9,979		10,484
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests		845		845
9	TOTALS	\$ 2,792	\$ 45,456	\$	\$ 48,248
10	SUM OF line 9, col. 1 and 2 (e)	\$ 48,248			

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		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

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

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	\$ 268,321	\$ 422,079	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	667,654	834,653	3
4	Supply Inventory (priced at)	51,962	69,282	4
5	Short-Term Investments	7,534	10,045	5
6	Prepaid Insurance	3,690	4,920	6
7	Other Prepaid Expenses	500	500	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>WE Investment & Bequest</u>		283,796	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 999,660	\$ 1,625,275	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	25,336	3,352,291	12
13	Land	48,600	424,160	13
14	Buildings, at Historical Cost	6,341,808	12,309,630	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,504,952	3,007,444	16
17	Accumulated Depreciation (book methods)	(3,922,885)	(9,151,879)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		58,242	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(8,401)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe <u>Constr. In Progress</u>		35,932	22
23	Other(specify): <u>Land Improvements</u>	135,736	624,568	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,133,547	\$ 10,651,987	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,133,207	\$ 12,277,262	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 140,389	\$ 187,185	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	127,364	425,000	29
30	Accrued Salaries Payable	51,849	69,132	30
31	Accrued Taxes Payable (excluding real estate taxes)	71,208	76,882	31
32	Accrued Real Estate Taxes(Sch.IX-B)		72,400	32
33	Accrued Interest Payable	14,271	19,028	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Expenses</u>	59,704	238,820	36
37	<u>Life Member Fees, Apt Dep</u>		880,808	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 464,785	\$ 1,969,255	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,512,098	5,825,963	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,512,098	\$ 5,825,963	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,976,883	\$ 7,795,218	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,156,324	\$ 4,482,044	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,133,207	\$ 12,277,262	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,039,793	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,039,793	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	116,531	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)	\$ 116,531	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)	\$ 1,156,324	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Wesley Village

0022350

Report Period Beginning:

1/1/16

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,004,266	1
2	Discounts and Allowances for all Levels	(14,100)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,990,166	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions	259,216	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 259,216	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,249,382	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	786,203	31
32	Health Care	2,807,060	32
33	General Administration	879,715	33
	B. Capital Expense		
34	Ownership	483,148	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	176,725	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,132,851	40
41	Income before Income Taxes (line 30 minus line 40)**	116,531	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 116,531	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 875,438	44
45	Private Pay - Net Inpatient Revenue	2,701,608	45
46	Medicare - Net Inpatient Revenue	906,688	46
47	Other-(specify) <u>Skilled Stay Insurance</u>	506,432	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,990,166	49

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

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

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

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

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	2,051	2,115	\$ 69,871	\$ 33.04	1
2	Assistant Director of Nursing					2
3	Registered Nurses	14,013	17,731	413,126	23.30	3
4	Licensed Practical Nurses	14,856	19,510	382,398	19.60	4
5	CNAs & Orderlies	66,299	70,097	782,069	11.16	5
6	CNA Trainees	2,036	2,036	28,410	13.95	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,920	1,968	25,581	13.00	9
10	Activity Assistants	4,325	4,820	57,735	11.98	10
11	Social Service Workers	1,838	2,080	52,643	25.31	11
12	Dietician					12
13	Food Service Supervisor	1,986	2,080	36,868	17.73	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,751	15,417	147,605	9.57	15
16	Dishwashers	8,917	9,412	81,486	8.66	16
17	Maintenance Workers	2,046	2,182	44,901	20.58	17
18	Housekeepers	6,118	6,302	58,062	9.21	18
19	Laundry	1,088	1,096	10,066	9.18	19
20	Administrator	1,879	2,080	96,910	46.59	20
21	Assistant Administrator					21
22	Other Administrative	905	936	33,653	35.95	22
23	Office Manager					23
24	Clerical	3,718	4,169	60,626	14.54	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	5,335	5,910	122,774	20.77	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	154,081	169,941	\$ 2,504,784 *	\$ 14.74	34

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	203	\$ 7,298	LN 1 COL 3	35
36	Medical Director		8,400	LN 9 COL 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,751	LN 10 COL 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	15	1,093	LN 10 COL 3	44
45	Social Service Consultant	15	1,093	LN 10 COL 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	234	\$ 20,635		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

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

** See instructions.

XIX. SUPPORT SCHEDULES

[illegible]

*** Attach copy of IMRF notifications**

****See instructions.**

Facility Name & ID Number Wesley Village	STATE OF ILLINOIS # 0022350	Report Period Beginning: 1/1/16	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. Leading Age Illinois -

(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? 6.9 years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 46,920 Line 10 COL 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. \$ 176,725
 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 benefit on Schedule V. \$ N/A Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____

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

(17) Has an audit been performed by an independent certified public accounting firm? YES
 Firm Name: CLIFTONLARSONALLEN LLP

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
 Attach invoices and a summary of services for all architect and appraisal fees

WESLEY VILLAGE -UMC
2016 COST REPORT
SCHEDULE OF RECLASSIFICATIONS - COL 5. PG 3

LINE #	DESCRIPTION	DEBIT	CREDIT
3	SALARIES/HOUSEKEEPING	\$16,935.90	
10	SALARIES/NURSING		\$16,935.90
	** Bed maker - non patient care - Reclassify to Housekeeping to Line 3		
12	SALARIES/SOCIAL SERVICE	\$52,642.72	
10	SALARIES/NURSING		\$52,642.72
	** Reclassify Social Services Salary to Line 12		
20	FEES/ BACKGROUND CHEC	\$ 5,430.00	
10	OTHER - HEALTH CARE		\$ 5,430.00
	**Background Checks - Reclassify to Line 20		
20	FEES/BACKGROUND CHECK	\$ 1,300.00	
10	NURSING & MEDICAL - SUPPLIES		\$ 1,300.00
	TOTALS	<u>\$76,308.62</u>	<u>\$76,308.62</u>

**WESLEY VILLAGE, UMC
IDPA COST REPORT FY 2016
ADJUSTMENTS**

LINE #	COLUMN
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2 7 FOOD PURCHASE

SCHEDULE VI. SALES TAX, LINE 13

SALES TAX-NOT ALLOWALBE EXPENSE ON PRIVATE PAY PATIENTS FOOD

NON-ALLOWABLE SALES TAX EXPENSE = (TOTAL FOOD COST/1.01 X

(.01) X PRIVATE PAY % OF CENSUS DIVIDE BY 2

FOOD PURCHASES

DIVIDED BY 1.01 = \$ 210,258

MUTILIPY BY .01	\$ 2,103
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MUTIPLY BY PRIVATE PAY CENSUS	56.66%
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EQUALS \$ 1,191

DIVIDED BY 2 \$ 596 SALES TAX ADJUSTMENT

11	7	ACTIVITIES COL 3	CABLE TV	\$ 8,835	ACTIVITES ADJ
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SCHEDULE VI. TELEPHONE, TV IN RESIDENT ROOMS, LINE 5

TOTAL OF ADJUSTMENTS	\$ 9,431
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Wesley Village

Dues, Subscriptions, Licenses, & Fees

2016

FEES		
Secretary of State - nonprofit Annual Report Fee		19.25
West Bend Mututal Ins. - Resident funds bond Fee		100
	TOTAL	119.25
DUES		
Leading Age Illinois - Annual Dues		2756
United Methodist Association - Annual Dues		3006
	TOTAL	5762
	Total	5881.25

EMPLOYEE BACKGROUND CHECKS	5430
RESIDENT BACKGROUND CHECKS	1300
	12611.25

WESLEY VILLAGE, UMC
IDPA COST REPORT FY 2016
C.N.A Training

Training Conducted at

Spoon River College
23235 N. Co Hwy 22
Canton, IL 61520

Cost Per C.N.A \$1,417.20