

		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: 0005439

Facility Name: WESLEY PLACE

Address: 1415 WEST FOSTER AVE CHICAGO 60640

County: COOK

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

HFS ID Number:

Date of Initial License for Current Owners: UNKNOWN

Type of Ownership:

X

VOLUNTARY, NON-PROFIT

X

Charitable Corp.

Trust

IRS Exemption Code

501c3

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: Jim Zoros, Chief Financial Officer

Telephone Number: (773) 769-5500

Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/20 to 12/31/20 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed)

03/18/21

(Date)

(Type or Print Name)

William A. Lowe

(Title)

Chief Executive Officer

Paid Preparer

(Signed)

(Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone)

()

Fax # ()

MAIL TO: BUREAU OF HEALTH FINANCE

ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES

201 S. Grand Avenue East

Springfield, IL 62763-0001

Phone # (217) 782-1630

Facility Name & ID Number WESLEY PLACE

0005439 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	<u>108</u>	Skilled (SNF)	<u>108</u>	<u>39,528</u>	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	<u>108</u>	TOTALS	<u>108</u>	<u>39,528</u>	7

B. Census-For the entire report period.						
	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>9,398</u>	<u>9,495</u>	<u>6,344</u>	<u>25,237</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>9,398</u>	<u>9,495</u>	<u>6,344</u>	<u>25,237</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.85%

D. How many bed reserve days during this year were paid by the Department?
0 (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)
N/A

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☒ NO ☐

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

J. Was the facility purchased or leased after January 1, 1978?
YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 108 and days of care provided 4,699

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/20 Fiscal Year: 12/31/20

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

Facility Name & ID Number WESLEY PLACE # 0005439 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	376,033	59,002	39,547	474,582		474,582		474,582			1
2	Food Purchase		226,545		226,545		226,545	(4,667)	221,878			2
3	Housekeeping	180,889	43,241		224,130		224,130		224,130			3
4	Laundry	37,754	8,636		46,390		46,390		46,390			4
5	Heat and Other Utilities			178,260	178,260		178,260		178,260			5
6	Maintenance	205,442	20,644	109,832	335,918		335,918		335,918			6
7	Other (specify):*											7
8	TOTAL General Services	800,118	358,068	327,639	1,485,825		1,485,825	(4,667)	1,481,158			8
	B. Health Care and Programs											
9	Medical Director			47,885	47,885		47,885		47,885			9
10	Nursing and Medical Records	2,625,725	325,513	32,065	2,983,303		2,983,303	(22,615)	2,960,688			10
10a	Therapy	84,610	2,374		86,984		86,984		86,984			10a
11	Activities	153,126	6,141	9,586	168,853		168,853		168,853			11
12	Social Services	116,011	90	2,930	119,031		119,031		119,031			12
13	CNA Training											13
14	Program Transportation			13,654	13,654		13,654	(6,890)	6,764			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,979,472	334,118	106,120	3,419,710		3,419,710	(29,505)	3,390,205			16
	C. General Administration											
17	Administrative	147,113			147,113		147,113		147,113			17
18	Directors Fees											18
19	Professional Services			158,894	158,894		158,894	(7,854)	151,040			19
20	Dues, Fees, Subscriptions & Promotions			164,703	164,703		164,703	(47,881)	116,822			20
21	Clerical & General Office Expenses	558,412	36,180	210,565	805,157		805,157	(140,637)	664,520			21
22	Employee Benefits & Payroll Taxes			764,075	764,075		764,075		764,075			22
23	Inservice Training & Education			7,764	7,764		7,764		7,764			23
24	Travel and Seminar			2,754	2,754		2,754		2,754			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			226,333	226,333		226,333		226,333			26
27	Other (specify):*											27
28	TOTAL General Administration	705,525	36,180	1,535,088	2,276,793		2,276,793	(196,372)	2,080,421			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,485,115	728,366	1,968,847	7,182,328		7,182,328	(230,544)	6,951,784			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			828,027	828,027		828,027	(120,000)	708,027			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			263,317	263,317		263,317	(902)	262,415			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			11,779	11,779		11,779		11,779			34
35	Rent-Equipment & Vehicles			3,808	3,808		3,808		3,808			35
36	Other (specify):*											36
37	TOTAL Ownership			1,106,931	1,106,931		1,106,931	(120,902)	986,029			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		439,143	607,044	1,046,187		1,046,187		1,046,187			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			182,136	182,136		182,136		182,136			42
43	Other (specify):*	82,098		3,148,656	3,230,754		3,230,754	(3,230,754)				43
44	TOTAL Special Cost Centers	82,098	439,143	3,937,836	4,459,077		4,459,077	(3,230,754)	1,228,323			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,567,213	1,167,509	7,013,614	12,748,336		12,748,336	(3,582,200)	9,166,136			45

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

	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	(1,400)	2		4
5	Telephone, TV & Radio in Resident Rooms	(1,578)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(151)	32		10
11	Discounts, Allowances, Rebates & Refunds	(12,165)	10		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(135,612)	21		24
25	Fund Raising, Advertising and Promotional	(46,473)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(3,384,821)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (3,582,200)		\$	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	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (3,582,200)		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.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Marketing Salaries	\$ (82,098)	43	1
2	Marketing/Non Allowable Travel	(1,752)	43	2
3	Resident Transportation Revenue	(6,890)	14	3
4	Non-Allowable Legal - Collections/Guardianship	(7,854)	19	4
5	Misc Income - Other	(3,447)	21	5
6	Vending Income	(3,267)	2	6
7	Non-Nursing Home Expenses	(3,146,904)	43	7
8	Depreciation on Non-Care Asset	(120,000)	30	8
9	IL Chamber of Commerce; LeadingAge Dues - 14%	(1,408)	20	9
10	Contract Nursing Revenue	(9,162)	10	10
11	Interest AT&T Direct TV Lease	(751)	32	11
12	Patient Escort Fees	(1,288)	10	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	(3,384,821)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WESLEY PLACE# 0005439

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(4,667)	0	0	0	0	0	0	0	0	0	0	(4,667)	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	(4,667)	0	0	0	0	0	0	0	0	0	0	(4,667)	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	(22,615)	0	0	0	0	0	0	0	0	0	0	(22,615)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(6,890)	0	0	0	0	0	0	0	0	0	0	(6,890)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(29,505)	0	0	0	0	0	0	0	0	0	0	(29,505)	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	(7,854)	0	0	0	0	0	0	0	0	0	0	(7,854)	19
20	Fees, Subscriptions & Promotions	(47,881)	0	0	0	0	0	0	0	0	0	0	(47,881)	20
21	Clerical & General Office Expenses	(140,637)	0	0	0	0	0	0	0	0	0	0	(140,637)	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	(196,372)	0	0	0	0	0	0	0	0	0	0	(196,372)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(230,544)	0	0	0	0	0	0	0	0	0	0	(230,544)	29

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(120,000)	0	0	0	0	0	0	0	0	0	0	(120,000)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(902)	0	0	0	0	0	0	0	0	0	0	(902)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(120,902)	0	0	0	0	0	0	0	0	0	0	(120,902)	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):*	(3,230,754)	0	0	0	0	0	0	0	0	0	0	(3,230,754)	43
44	TOTAL Special Cost Centers	(3,230,754)	0	0	0	0	0	0	0	0	0	0	(3,230,754)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(3,582,200)	0	0	0	0	0	0	0	0	0	0	(3,582,200)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
UNITED METHODIST HOMES & SERVICE	100%			NAPER VALLEY CO	CHICAGO	INACTIVE
				UMH&S FOUNDATIO	CHICAGO	FOUNDATION
				WINWOOD APARTM	CHICAGO	ELDERLY HOUSIN
				UNITED NURSING S	CHICAGO	NURSE RECRUTE
				PARASOL ALLIANC	CHICAGO	INFORMATION TE
				MEDREHAB ALLIAN	CHICAGO	HOME HEALTH

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	19	Information Technology Support	\$ 47,958	Parasol Alliance, LLC	19.00%	\$ 47,958	\$	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			\$ 47,958			\$ 47,958	\$ *	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	*Noel DeBacker	BOD						1
2	John F. Disterhoft	BOD						2
3	Joan Dubnicka	BOD						3
4	Jesse Dudley	BOD						4
5	Michael J. Dudley	BOD						5
6	Katie Fasullo	BOD						6
7	Mary Kakenmaster	BOD						7
8	Leslie Knight	BOD						8
9	William A. Lowe	BOD						9
10	Peter D. Morris	BOD						10
11	Rahul Sharma	BOD						11
12	Martha A. Strong	BOD						12
13	Kathleen C. West	BOD						13
14	Dick Wright	BOD						14
15	Max Yuan	BOD						15
16								16
17								17
18								18
19								19
20								20
21	* Received compensation as Wesley Place Medical Director of \$39,875 during FY 2020.							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	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number WESLEY PLACE # 0005439 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	Illinois Finance Authority		X	Revenue Bonds, Series 2012		03/01/12	\$ 4,834,400	\$ 3,314,400	03/01/2042	Variable	\$ 230,322	1
2				Facility Renovations								2
3												3
4	AT&T - Direct TV		X	Satellite Dish		03/01/19	13,865	9,333	02/01/2024	0.0700	751	4
5							Non -Allowable Interest				(751)	5
	Working Capital											
6	Term Loan		X	Working Capital		09/01/17	1,000,000	350,000	09/15/2022	0.0435	19,885	6
7	Line of Credit		X	Working Capital						Variable	12,359	7
8							Interest Income Offset				(151)	8
9	TOTAL Facility Related						\$ 5,848,265	\$ 3,673,733			\$ 262,415	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 5,848,265	\$ 3,673,733			\$ 262,415	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 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	
N/A - Facility is not subject to real estate taxes.					
				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.

FACILITY NAME	WESLEY PLACE	COUNTY	COOK
---------------	--------------	--------	------

CONTACT PERSON REGARDING THIS REPORT _____

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>ex Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u> <u>Nursing Home</u>

B. Real Estate Tax Cost Allocations

C. Tax Bills

Page 10A

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: **68,281**

B. General Construction Type: Exterior **BRICK** Frame **CONCRETE BLOCK** Number of Stories **5**

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

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

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

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

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

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

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

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

Foster Apts- 1433 W. Foster - 2 flat - intergenerational housing.; Foster Apts- 1439 W. Foster - 3 flat - market rate housing; Foster-Glen Apartments - 5135 N. Glenwood - 6 Flat - market rate housing.

Wellness Center Building - 1355 W. Foster - contains offices of United Methodist Homes & Services and UMH&S Foundation. 1st floor rented to White Crane Wellness Center.

Hiram Property - 1351 W. Foster - storage and parking for the organization.

The costs for these entities are segregated and not included as part of the financial information presented on this report for Wesley Place.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

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

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	42		1922	1922	\$ 214,000	\$		\$		\$ 214,000	4
5	48		1951	1951	297,000					297,000	5
6			1972	1972	941,207					941,207	6
7	8		1973	1973	541,942					541,942	7
8	10		1974	1974	479,275					479,275	8
	Improvement Type**										
9	Additions - 1975		1975		898,240					898,240	9
10	Additions - 1976		1976		1,203					1,203	10
11	Additions - 1980		1980		1,300					1,306	11
12	Additions - 1983		1983		215					215	12
13	Additions - 1984		1984		1,188					1,188	13
14	Additions - 1985		1985		7,958					7,958	14
15	Additions - 1986		1986		31,965					31,965	15
16	Additions - 1987		1987		3,680					3,680	16
17	Additions - 1988		1988		41,556					41,556	17
18	Additions - 1989		1989		123,634					123,634	18
19	Additions - 1990		1990		81,482					81,555	19
20	Additions - 1991		1991		155,195					154,296	20
21	Additions - 1992		1992		276,411					271,528	21
22	Additions - 1993		1993		226,117					219,587	22
23	Additions - 1994		1994		261,289					259,034	23
24	Additions - 1995		1995		162,755	7		7		162,755	24
25	Additions - 1996		1996		281,475	7,177		7,177		277,879	25
26	Additions - 1997		1997		55,643	716		716		69,067	26
27	Additions - 1998		1998		110,213	15		15		110,186	27
28	Additions - 1999		1999		34,124	240		240		33,275	28
29	Additions - 2000		2000		136,254	992		992		136,103	29
30	Additions - 2001		2001		101,321	546		546		98,321	30
31	Additions - 2002		2002		245,777	248		248		245,400	31
32	Additions - 2003		2003		230,162	1,465		1,465		226,509	32
33	Additions - 2004		2004		84,046	243		243		83,202	33
34	Additions - 2005		2005		244,694	344		344		243,138	34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number WESLEY PLACE

0005439

Report Period Beginning:

01/01/20

Ending:

12/31/20

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		\$	\$		\$	\$	\$	37
38	Additions - 2006	2006	294,917	43	43		294,680	38
39	Additions - 2007	2007	221,313	1,016	1,016		211,520	39
40	Additions - 2008	2008	149,948	2,592	2,592		120,948	40
41	Additions - 2009	2009	139,846	1,748	1,748		117,195	41
42								42
43	Hot Water Heater Circulating Pump Motor & Seals	2010	4,150	166	25	166	1,743	43
44	Boiler Fire Tube, Solenoid Strainer Valve, and Controller	2010	4,475	179	25	179	1,880	44
45	Chiller Room Ventilation Motor, Actuator and Thermostats	2010	4,488	180	25	180	1,889	45
46	Fire Pump Check Valve, Sprinkler Heads - Ground Floor	2010	8,376	416	10	416	8,376	46
47	Refinish Fire Escape Stairways	2010	7,800	390	10	390	7,800	47
48	1st, 2nd, & 3rd Floors - Drinking Fountains, Sinks, Lockers	2010	3,958	195	10	195	3,958	48
49	Construction of Built-In Laminate Counter Tops, Door - Med Reco	2010	2,960	148	10	148	2,960	49
50	Fire Sprinkler Annunciator Panel - 2nd Floor Nursing Station	2010	5,340	265	10	265	5,340	50
51	Exterior Tuckpointing, Brickwork, Flashing, Wall Caps, Weeps	2010	10,480	527	10	527	10,480	51
52	Goulds Ejector Pump - Dietary Storage Room	2010	3,465	177	10	177	3,465	52
53								53
54	HVAC - New Controller, Chilled Water Sensors, Heater Circuit &	2011	7,441	298	25	298	2,831	54
55	Main Sewer Line Replacement	2011	15,000	1,500	10	1,500	14,250	55
56	Exterior Masonry, Paving - Main Entrance Area	2011	55,349	5,535	10	5,535	52,582	56
57	Life Safety - New Emergency Generator, Vertical Shafts, Elevator I	2011	465,050	23,253	20	23,253	220,903	57
58	1st Fl-Locker Room Renovation- Install Tile Floor, Ceiling, Painting	2011	16,735	1,674	10	1,674	15,900	58
59	3rd, 4th Floor Resident Bathroom Renovation - Flooring, Painting,	2011	66,570	6,657	10	6,657	63,243	59
60	3rd, 4th Floor Resident Room Renovations - Flooring, Blinds, Paint	2011	101,732	10,173	10	10,173	96,645	60
61	3rd, 4th Floor - Install Handrails on Hallway Walls	2011	8,110	811	10	811	7,706	61
62	Exterior - Tuckpointing, Brickwork, Chemical Treatment	2011	26,404	2,640	10	2,640	25,080	62
63	3rd, 4th, & 5th Floors - Install Nurse Call/Wander System	2011	95,715	9,572	10	9,572	90,934	63
64	Ground Floor - Sewage Ejector Pump	2011	3,367	337	10	337	3,200	64
65	Boiler Room - Pneumatic Controls for Hot Water & Fire Pump Pre	2011	3,403	340	10	340	3,230	65
66	Architect and General Contractor Fees	2011	195,567	19,556	10	19,556	185,782	66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)		\$ 8,193,280	\$ 102,381		\$ 102,381	\$ 7,830,724	70

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 8,193,280	\$ 102,381		\$ 102,381	\$	\$ 7,830,724	1
2									2
3	HVAC - New Fan Coil Units, Duct Detectors, Compressor, Pneuma	2012	35,367	1,415	25	1,415		12,027	3
4	Carpeting/Flooring - Admission Office, Business Office - 1st Floor	2012	8,762		5			8,762	4
5	Life Safety - Fire Protection, Vertical Shafts, Elevator Recall, Emer	2012	258,870	12,944	20	12,944		110,024	5
6	Parking Lot Excavation, Sewer Replacement, Paving, and Canopy/I	2012	178,074	17,807	10	17,807		151,360	6
7	Architect, General Contractor Fees	2012	2,018,871	201,887	10	201,887		1,716,044	7
8	Rooftop EMR Wireless Installation	2012	6,981	698	10	698		5,933	8
9	Interior, exterior signs and signage	2012	41,881	4,188	10	4,188		35,598	9
10	Exterior Brickwork and Roof Drainage	2012	26,902	2,690	10	2,690		22,865	10
11	2nd, 3rd, 4th Floor Resident Rooms - Lighting, Electrical, Painting,	2012	153,754	15,376	10	15,376		130,691	11
12	2nd, 3rd, 4th Floor - Hallway Handrails, Wall Protection, Nurse Ca	2012	81,092	8,109	10	8,109		68,927	12
13	Flooring - Stairwell and 2nd Floor Hallways	2012	42,700	4,270	10	4,270		36,295	13
14	Ground Floor - New Entrance Door, Flooring/Painting - Women's I	2012	21,857	2,186	10	2,186		18,581	14
15	1st Floor - Ceiling Tile, Painting, Dietary Sewage Pump Installation	2012	16,703	1,670	10	1,670		14,195	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,085,094	\$ 375,621		\$ 375,621	\$	\$ 10,162,026	34

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

Facility Name & ID Number WESLEY PLACE

0005439

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 11,085,094	\$ 375,621		\$ 375,621	\$	\$ 10,162,026	1
2									2
3	*Architect, General Contractor Fees, Legal Review of Renovation I	2013	671,463	67,146	10	67,146		503,595	3
4	First Floor - Conference Room/Living Room - New Ceiling Tiles, Pa	2013	4,123	412	10	412		3,090	4
5	Ground Floor - Cafeteria/Admin Office/Utility Room - New Ceiling	2013	4,539	454	10	454		3,405	5
6	Exterior Signage for WP/Internal Signage for Resident Rooms/Offic	2013	11,836	1,184	10	1,184		8,879	6
7	4th Floor Hallways/Dining Room/Stairwell Painting	2013	3,025	302	10	302		2,267	7
8	2nd Floor Fire Exit Door/New Magnetic Locks/New Door Holder C	2013	6,222	622	10	622		4,665	8
9	Parking Lot - Landscaping	2013	9,561	956	10	956		7,170	9
10	Boiler and Freezer Repair - Installed Modulation Motor, Required	2013	68,674	2,747	25	2,747		20,602	10
11	Fire Sprinkler Replacements, Installed Fire Exit Devices on 1st and	2013	19,728	986	20	986		7,396	11
12									12
13	Parking Lot - Paving, Fencing, Masonry, Backflow Preventer Irriga	2013	7,411	741	10	741		5,558	13
14	HVAC - Heating and Cooling Pipings - 2nd Floor, Compressor/Mot	2013	2,140	86	25	86		645	14
15	Life Safety - Fire Protection, Vertical Shafts, Elevator Recall	2013	3,696	185	20	185		1,387	15
16	Stairwell - Grids for Fall Protection - IDPH Required	2013	23,056	2,306	10	2,306		17,295	16
17	Ground Floor - Ceiling Tiles, Painting, Generator Kill Switch	2013	3,725	373	10	373		2,797	17
18	1st Floor - Ceiling Tiles, Flooring, Lighting, Tiling, Wall Protection,	2013	145,139	14,514	10	14,514		108,854	18
19	2nd, 3rd, 4th Floors - Ceiling Tiles, Electrical Conduits, Magnetic D	2013	8,586	859	10	859		6,442	19
20	Resident Wander System with Door Units, Transmitters, Pull Cords	2013	16,053	1,605	10	1,605		12,038	20
21	Exterior Roof Replacement, Tuckpointing, Masonry	2013	15,221	1,522	10	1,522		11,415	21
22									22
23	HVAC - Cooling Tower - Hot/Cold Basin Liner, Hydro Motors, Fan	2014	60,484	2,419	25	2,419		15,724	23
24	Carpeting - 1st Floor Nursing Office	2014	600		5			600	24
25	Landscaping - Acer Ruburn Red Sunset Tree/Installation	2014	2,150	215	10	215		1,398	25
26	Flooring/Painting - Resident Rooms, Nursing Station - 1st, 2nd, 3rd	2014	40,468	4,047	10	4,047		26,305	26
27	Brickwork/Tuckpointing - Exterior - Miller & Swift Halls	2014	30,828	3,083	10	3,083		20,040	27
28	Art Studio Construction - Lower Level - Framing, Electrical, Painti	2014	10,000	1,000	10	1,000		6,500	28
29	Fire Safety - Sprinkler Heads, Exit Devices, Stairwell Interrupter G	2014	15,507	1,551	10	1,551		10,080	29
30	Vault Room - Replace Metal Door	2014	3,925	392	10	392		2,549	30
31	Water Heater - Laundry Room - Lower Level	2014	6,425	642	10	642		4,174	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 12,279,679	\$ 485,970		\$ 485,970	\$	\$ 10,976,896	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 12,279,679	\$ 485,970		\$ 485,970	\$	\$ 10,976,896	1
2									2
3	Sump Pump - Parking Lot	2015	5,800	580	10	580		3,190	3
4	1st Floor - Carpeting - Human Resources Offices	2015	1,588	157	5	157		1,588	4
5	HVAC - Blowers Resident Rooms - all Fl; Boiler Tubes; Heating Pu	2015	19,007	760	25	760		4,180	5
6	Emergency Generator - Electrical Box	2015	3,681	184	20	184		1,012	6
7	New Grease Trap - Kitchen	2015	8,500	850	10	850		4,675	7
8	Emergency Lighting Circuits - Ground Fl, 1st Floor, 5th Fl	2015	10,713	1,071	10	1,071		5,890	8
9	Painting - Human Resources Department - 1st Fl; Resident Rooms -	2015	5,911	591	10	591		3,251	9
10	Ceiling Tile and Grid Replacement - 3rd Floor; Art Studio - Ground	2015	9,118	912	10	912		5,016	10
11	Wander Guard/Nurse Call System - 4th Floor	2015	3,418	342	10	342		1,881	11
12	Life Safety - Fire Exit Devices - 4th Fl; Automatic Flush Bolts - 2nd	2015	3,720	372	10	372		2,046	12
13									13
14	Carpeting - Front Entrance	2016	1,851	370	5	370		1,665	14
15	Sewer Connection from Bldg to Street; Parking Lot Fence - Weldin	2016	23,972	2,397	10	2,397		10,787	15
16	HVAC - New Boiler and Valves	2016	12,416	497	25	497		2,236	16
17	Nurse Wander System	2016	69,074	6,907	10	6,907		31,081	17
18	Kitchen Sewer Pipe and Flooring Replacement	2016	36,052	3,605	10	3,605		16,223	18
19	New Exterior Building Signage and Canopies	2016	15,140	1,514	10	1,514		6,813	19
20	Vinyl Flooring - Reception Area	2016	8,165	817	10	817		3,676	20
21	Flooring - 3rd Floor Resident Rooms - #378, 361, 382, 380, 354, 362,	2016	7,690	769	10	769		3,461	21
22	Dampers - SE Stairwell - Ground Floor; 1st Floor; Dining Room	2016	3,140	314	10	314		1,413	22
23	Drywall, Painting, Celing Tiles - Activities/Volunteer Offices	2016	9,535	954	10	954		4,293	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 12,538,170	\$ 509,933		\$ 509,933	\$	\$ 11,091,273	34

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

Facility Name & ID Number WESLEY PLACE

0005439

Report Period Beginning:

01/01/20

Ending:

12/31/20

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		\$ 12,538,170	\$ 509,933		\$ 509,933	\$	\$ 11,091,273	1
2									2
3	Plumbing - Barnes Submersible Pumps, Valves & Controls - Boiler	2017	14,731	737	20	737		2,579	3
4	HVAC - Boiler Pump, Chiller, Air Conditioners - Resident Rooms	2017	5,372	215	25	215		752	4
5	Carpeting - 1st Floor Living Room; Dietary Office	2017	7,135	1,427	5	1,427		4,994	5
6	Sprinkler System, Landscaping, Signage - Terrace Addition	2017	35,605	3,560	10	3,560		12,460	6
7	Terrace/Patio Addition - North Exterior	2017	354,592	35,459	10	35,459		124,106	7
8	Wander Guard/ Nurse Call System	2017	82,913	8,291	10	8,291		29,019	8
9	Brick Restoration/Masonry - North Side of Building	2017	31,855	3,186	10	3,186		11,151	9
10	Signage - Exterior - East Side of Building	2017	23,082	2,308	10	2,308		8,078	10
11	Door Replacement - Suski Garden - Miller Hall	2017	5,200	520	10	520		1,820	11
12	Living Room - Bush Hall - Architect Design, Track Lighting, Alter	2017	5,750	575	10	575		2,013	12
13	Bistro Project - Dietary - Lower Level - Plumbing, Electrical, Sink	2017	11,068	1,107	10	1,107		3,874	13
14									14
15	Elevator - New Gear Drive and Infared Lazer Door Arm	2018	4,638	232	20	232		580	15
16	2 Submersible Pumps & Motors for Kitchen Grease Pit	2018	14,731	736	20	736		1,840	16
17	2 Upright Sprinkler Heads - Mechanical Room - 4th Floor	2018	3,996	200	20	200		500	17
18	HVAC - Boiler Pump and Motor Wheel - Ground Floor Boiler Room	2018	2,872	115	25	115		287	18
19	HVAC- Boiler Controls & Relays for Steam/Water - Grd Floor - Bo	2018	3,908	156	25	156		391	19
20	Wall Graphics/Painting - Grd Floor offices, 2nd Floor - Therapy Gy	2018	7,686	769	10	769		1,922	20
21	Flooring, Fireblock, Wall Protection - Dining Room - Grd Floor	2018	6,910	691	10	691		1,727	21
22	Window Shades - Day Room - 3rd Floor	2018	4,815	481	10	481		1,203	22
23	Nurse Call Wander System and Magnetic Doors - All Floors	2018	2,674	267	10	267		668	23
24									24
25	Roof Replacement - Wesley Place	2019	511,111	20,444	25	20,444		30,666	25
26	Backflow Preventers - Kitchen, Ice Room, Laundry Areas	2019	19,953	998	20	998		1,497	26
27	HVAC - New Chiller Compressor	2019	9,160	366	25	366		549	27
28	HVAC - Boiler Feed Tank and Pump/Motor Assemblies	2019	49,622	1,984	25	1,984		2,976	28
29	HVAC - Hot Water Circulator Pump and Meter	2019	4,227	170	25	170		255	29
30	Tuckpointing - Exterior Windows - Bush and Swift Hall - Floors 1-4	2019	5,000	500	10	500		750	30
31	Painting - Ground Floor - Lobby, Dinning Room, Hallway	2019	10,600	1,060	10	1,060		1,590	31
32	Bathroom - New Tiles, Fixtures, Ceiling, Painting - Ground Floor	2019	9,435	944	10	944		1,416	32
33	New Water Supply, Pipes, Plumbing - Laundry Room and Ground	2019	4,934	494	10	494		741	33
34	TOTAL (lines 1 thru 33)		\$ 13,791,745	\$ 597,925		\$ 597,925	\$	\$ 11,341,677	34

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

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 12E, Carried Forward		\$ 13,791,745	\$ 597,925		\$ 597,925	\$	\$ 11,341,677	1
2									2
3	Base Molding, Corner Guards, Handrails - Ground Floor and 1st F	2019	13,982	1,396	10	1,396		2,094	3
4	Door Controller, Nurse Call/Wander System, Call Cords - Nursing	2019	7,593	760	10	760		1,140	4
5	Painting - Resident Rooms - 1st and 2nd Floors; Admissions Office	2019	14,018	1,402	10	1,402		2,103	5
6	Wall Protector Stoppers, Wood Blinds - Resident Rooms - 1st/2nd F	2019	5,199	520	10	520		780	6
7									7
8	Tuck-Pointing - Exterior Walls - Swift Hall - West Side	2020	5,800	290	10	290		290	8
9	New Tiles - Bathrooms - Ground Floor & Painting	2020	4,584	229	10	229		229	9
10	Painting - Resident Rooms - 2nd and 4th Floors	2020	11,028	552	10	552		552	10
11	Painting - Back Stairwell and Elevator	2020	12,526	627	10	627		627	11
12	Ejector Pumps and Panel - Sewage System - Ground Floor	2020	21,425	536	20	536		536	12
13	Sprinkler Heads, Water Pressure Gauges, Fire Dept Connection	2020	6,850	171	20	171		171	13
14	HVAC - Boiler Feed Tank Unit with Pump and Motor Assemblies	2020	23,595	472	25	472		472	14
15	HVAC - Chiller Compressor & Chiller Pumps - Mechanical Room -	2020	22,628	452	25	452		452	15
16	HVAC - Boiler Feed Tank Unit with Pump and Motor Assemblies	2020	5,501	110	25	110		110	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)		\$ 13,946,474	\$ 605,442		\$ 605,442	\$	\$ 11,351,233	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	\$1,457,038	\$98,757	\$98,757	\$		\$1,083,789	71
72	Current Year Purchases	76,552	3,828	3,828			3,828	72
73	Fully Depreciated Assets	1,747,167					1,747,167	73
74								74
75	TOTALS	\$3,280,757	\$102,585	\$102,585	\$		\$2,834,784	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	Dodge Caravan	2014	\$38,716	\$	\$	\$		\$38,716	76
77										77
78										78
79										79
80	TOTALS			\$38,716	\$	\$	\$		\$38,716	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$19,265,947	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$708,027	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$708,027	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)	\$14,224,733	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Non-Nursing Home Assets	\$1,202,156	\$22,471	\$194,889	86
87	2010 NH Mkt Value Write Up	3,000,000	120,000	1,140,000	87
88					88
89					89
90					90
91	TOTALS	\$4,202,156	\$142,471	\$1,334,889	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: United Methodist Homes & Services
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

☐ YES

☒ NO
- If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Corporate office space rental				11,779	Annual		5
6								6
7	TOTAL				\$ 11,779			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: \$ 3,808 Description: Copiers - Leased - \$1,567; Dishwasher - Leased - \$2,241
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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 CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

ALLOCATION OF COSTS (d)

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

(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.

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	

(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.)

12345678										
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L39, C3	hrs	\$	4,215	\$ 236,227	\$	4,215	\$ 236,227	1
2	Licensed Speech and Language Development Therapist	L39, C3	hrs		1,145	80,007		1,145	80,007	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L39, C3	hrs		4,582	229,780		4,582	229,780	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescripts				341,742		341,742	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)									
10			hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Med Suppl, Lab, X-Ray	L39, C2, C3				61,030	97,401		158,431	13
14	TOTAL			\$	9,942	\$ 607,044	\$ 439,143	9,942	\$ 1,046,187	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	\$ 205,892	\$	1
2	Cash-Patient Deposits	16,281		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 265,862)	945,778		3
4	Supply Inventory (priced at)	109,603		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	3,406		7
8	Accounts Receivable (owners or related parties)	(1,451,768)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (170,808)	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	35,000		12
13	Land	2,000,000		13
14	Buildings, at Historical Cost	18,148,630		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,319,473		16
17	Accumulated Depreciation (book methods)	(15,559,622)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Unamortized Financing Costs</u>	73,307		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 8,016,788	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,845,980	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 171,640	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	132,634		28
29	Short-Term Notes Payable	3,050,328		29
30	Accrued Salaries Payable	720,290		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	302,471		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Deferred Revenue</u>	391,121		36
37	<u>Unexp Restr Gifts/Due to 3rd-Party Payor</u>	122,394		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,890,878	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	150,000		39
40	Mortgage Payable			40
41	Bonds Payable	3,698,305		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)	\$ 3,848,305	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 8,739,183	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (893,203)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,845,980	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (175,423)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (175,423)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(957,780)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Equity Transfer from Parent Corporation	240,000	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (717,780)	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)	\$ (893,203)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number WESLEY PLACE

0005439

Report Period Beginning: 01/01/20

Ending:

12/31/20

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	\$ 8,028,924	1
2	Discounts and Allowances for all Levels	(1,050,898)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,978,026	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,126,693	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,126,693	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	1,400	14
15	Telephone, Television and Radio	1,578	15
16	Rental of Facility Space		16
17	Sale of Drugs	341,879	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	46,599	19
20	Radiology and X-Ray	3,890	20
21	Other Medical Services	155,370	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 550,716	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	151	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 151	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>HHS/CARES Forgiveness Revenue</u>	360,000	28
28a	<u>Other - See attached schedule</u>	2,774,970	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,134,970	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,790,556	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,485,825	31
32	Health Care	3,419,710	32
33	General Administration	2,276,793	33
	B. Capital Expense		
34	Ownership	1,106,931	34
	C. Ancillary Expense		
35	Special Cost Centers	4,276,941	35
36	Provider Participation Fee	182,136	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,748,336	40
41	Income before Income Taxes (line 30 minus line 40)**	(957,780)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (957,780)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,665,469	44
45	Private Pay - Net Inpatient Revenue	2,915,208	45
46	Medicare - Net Inpatient Revenue	1,953,726	46
47	Other-(specify) <u>Managed Care</u>	443,623	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,978,026	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.

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	960	1,103	\$ 73,802	\$ 66.91	1
2	Assistant Director of Nursing	480	496	17,384	35.05	2
3	Registered Nurses	34,597	37,277	1,254,842	33.66	3
4	Licensed Practical Nurses	3,341	3,687	111,146	30.15	4
5	CNAs & Orderlies	67,322	74,093	1,145,397	15.46	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,722	5,030	84,610	16.82	8
9	Activity Director	1,808	2,091	58,687	28.07	9
10	Activity Assistants	5,152	5,618	94,439	16.81	10
11	Social Service Workers	4,363	4,724	116,011	24.56	11
12	Dietician					12
13	Food Service Supervisor	678	732	34,865	47.63	13
14	Head Cook	5,179	5,644	94,033	16.66	14
15	Cook Helpers/Assistants	10,522	11,261	170,446	15.14	15
16	Dishwashers	5,123	5,370	76,689	14.28	16
17	Maintenance Workers	7,085	7,951	205,442	25.84	17
18	Housekeepers	10,566	11,823	180,889	15.30	18
19	Laundry	2,526	2,671	37,754	14.13	19
20	Administrator	1,858	2,005	147,113	73.37	20
21	Assistant Administrator					21
22	Other Administrative	1,311	2,222	53,268	23.97	22
23	Office Manager					23
24	Clerical	15,219	21,362	505,144	23.65	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	709	856	18,955	22.14	31
32	Other Health Care(specify)					32
33	Other(specify) <u>see attached schedu</u>	2,010	2,234	86,297	38.63	33
34	TOTAL (lines 1 - 33)	185,531	208,250	\$ 4,567,213 *	\$ 21.93	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	761	\$ 37,289	L1, C3	35
36	Medical Director	272	47,885	L9, C3	36
37	Medical Records Consultant	48	2,400	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	29	1,639	L11, C3	44
45	Social Service Consultant	9	595	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,119	\$ 89,808		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	89	\$ 5,969	L10, C3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	89	\$ 5,969		53

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 Network of IL - \$4,200

(3) Did the nursing home make political contributions or payments to a political action organization?

NO

If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

NO

If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases?

YES

What was the average life used for new equipment added during this period?

10 YEARS

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$

77,098

 Line

L10, C2

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

YES

If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement?

NO

If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement?

YES

X

NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO

X

 If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$

182,136

This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

NO

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

N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

NO

 For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$

N/A

 Has any meal income been offset against related costs?

YES

 Indicate the amount. \$

1,400

(16) Travel and Transportation

a. Are there costs included for out-of-state travel?

NO

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

NO

 If YES, please indicate the amount of income earned from such a program during this reporting period. \$

c. What percent of all travel expense relates to transportation of nurses and patients?

100% of L14,j

d. Have vehicle usage logs been maintained?

YES

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

YES

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

N/A

g. Does the facility transport residents to and from day training?

NO

Indicate the amount of income earned from providing such transportation during this reporting period. \$

N/A

(17) Has an audit been performed by an independent certified public accounting firm?

YES

Firm Name:

MARCUM LLP

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